Morgan Family Medicine

New Patient Medical History and Physical Form

Today's Date: ____________________

Name: ______________________________________ Date of Birth: ___________________

Reason for your visit: ____

Personal Medical History: Have you ever had any of the following conditions? (Check all that apply)

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer Type: _____________ ☐ Chronic Obstructive Pulmonary (COPD) ☐ Clotting Disorder ☐ Congestive Heart Failure (CHF)	☐ Crohn's Disease ☐ Depression ☐ Anxiety ☐ Suicidal ☐ Diabetes ☐ Emphysema ☐ Endocrine Problems ☐ GERD ☐ Glaucoma ☐ Hepatitis ☐ HIV/AIDS	☐ Hypertension (High Blood Pressure) ☐ Kidney Disease ☐ Myocardial Infarction (Heart Attack) ☐ Peptic Ulcer Disease ☐ Seizures ☐ Stroke ☐ Ulcerative Colitis ☐ Kidney Stones ☐ Urinary Tract Infections (UTI)

Personal Surgical History: Have you ever had any of the following surgeries? (Check all that apply)

☐ Adrenal Gland Surgery ☐ Appendectomy ☐ Bariatric Surgery Type: Date: Gastric Bypass ______ Gastric Sleeve ______ ☐ Bladder Surgery ☐ Breast Surgery ☐ Breast Augmentation	☐ Colon Surgery ☐ Coronary Artery Bypass Graft ☐ Esophagus Surgery ☐ Hemorrhoid Surgery ☐ Hernia Repair ☐ Hysterectomy Date: _____________ ☐ Cesarean Section ☐ Cholecystectomy (Gallbladder)	☐ Stomach Surgery ☐ Small Intestine Surgery ☐ Kidney Surgery ☐ Prostate Surgery ☐ Thyroid Surgery ☐ Neck Surgery ☐ Spine Surgery ☐ Other: __________________

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Medications/Dosage/Frequency (Current):

____
____
____

Allergies/Reactions:

- ☐ None
- ☐ ____
  ____
  ____

Family History: Has anyone in your family had any of the following conditions? (Check all that apply. If applies, indicate the relationship to you)

☐ Cancer:	☐ Hepatitis ______________________
Colon ______________________	☐ Anemia ______________________
Rectum ______________________	☐ Diabetes ______________________
Anal ______________________	☐ Blood Clots ______________________
Stomach ______________________	☐ Heart Disease ______________________
Breast ______________________	☐ High Blood Pressure ______________________
Prostate ______________________	☐ Anesthesia Reaction ______________________
Uterus ______________________	☐ Bleeding Problems ______________________
Ovarian ______________________	
Thyroid ______________________	
Blood ______________________	
Lymphoma ______________________	
Other ______________________	

Social History:

Alcohol Use:	Never	Occasionally	Daily	Type ______________________	
Tobacco Use:	Never	Previously, but quit	Packs Per Day _____ for _______ years		
Drug(s) Use:	Never	Occasionally	Daily	Type ______________________	
Marital Status:	Single	Married	Divorced	Widowed	Separated

Name of spouse or significant other: ____

Children: Number of Children ______________ Number of Grandchildren ______________

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Women: Number of Pregnancies ___________ Number of Deliveries _________________

Vaginal ___________ C-Sections ____________ Miscarriages ____________

VIP's (abortions) _____________

Cancer Health Habits: (Circle Response)

Women:		**Men:**	
Breast: Monthly Self-exam	Y N	Prostate: Yearly Rectal Exam	Y N
Yearly Physician Exam	Y N	Yearly PSA Blood Test	Y N
Last Mammogram __________	Y N	**All:**	
GYN: Yearly Exam	Y N	Skin: High Sun Exposure	Y N
Yearly PAP Exam	Y N	Yearly Skin Exam	Y N

Colon:

Yearly Rectal Exam Y N

Yearly Stool Test for Blood Y N

Date of Last Colonoscopy _______________________

Patient Safety:

Do you feel safe in your home? Y N

Do you feel as if anyone is going to hurt you in your home? Y N

If you feel that someone will hurt you in your home, who? _______________________________

For Office Use Only

B/P: ______/______ **Pulse: ___________** **Temp: _____________**

Weight: ____________ **Glucose: ____________**

Nurses Notes:

____

____

____

____

Phone: (281)592-8000
Fax: (281)592-8001

117 South William Barnett Ave.,
Suite A
Cleveland, TX 77327

www.morganfamilymedicine.org

Morgan Family Medicine

Medical Consent and Authorization for Treatment

Patient Name: ____________________________ Phone #: _______________________

DOB: ___________________

Consent for Services:

I ___________________________________ consent to medical treatment from Morgan Family Medicine for ____.

(Name of Patient)

I consent to allow the release of medical information when needed for treatment, payment and for state agencies.

I allow Morgan Family Medicine to speak for me when working with insurance companies on my eligibility.

I allow Morgan Family Medicine to do procedures and treatments per orders of Nurse Practitioners.

I have received a copy of Privacy Practice from Morgan Family Medicine.

I have received a copy of the Privacy Practice from Morgan Family Medicine.

My signature below shows that I understand and agree with the above information and age consent for all healthcare services by Morgan Family Medicine.

_______________________________________ ____________________

Patient or Representative Date

_______________________________________ _____________________

Relationship to Patient Reason Patient Can't Sign

_______________________________________ _____________________

Witness Date

General Information Sheet

Patient Information:

Patient's Name: ______________________________________ Date of Birth: ____________

Address: ____

City: _______________________ State: ________________ Zip Code: _____________

Home Phone #: ___________________________ Cell Phone#: __________________________

Email Address: ____

Race: ________________ Ethnicity: _________________ Preferred Language: ______________

Social Security Number (SSN): ________ - _______- ___________

Preferred Pharmacy:

Name: ____

Address: ____

City: ________________________ State: ______________ Zip Code: _______________________

Phone: ______________________________ Fax: __________________________________

Emergency Contact Information:

Name: _________________________________ Phone Number: _______________________

Relation to Patient: ____

Medical Information Release:

My Medical information can be released to the following person(s):

Name: ____________________________________ Phone Number: _______________________

Address: ____

Name: ____________________________________ Phone Number: _______________________

Address: ____

Authorization to Release Healthcare Information

Patient's Name: _______________________________ Date of Birth: _________________

Previous Name: _______________________________ SS#: _________________________

I request and authorize ______________________________________ to release healthcare information of the patient named above to:

Name: Morgan Family Medicine

Address: 117 South William Barnett Ave.

City: Cleveland State: Texas Zip Code: 77327

This request and authorization apply to:

- ☐ Healthcare information relating to the following treatment, condition and/or dates:
  ____
  ____
  ____
  ____
- ☐ All healthcare information
- ☐ Other:
  ____
  ____
  ____
  ____

Signature of Responsible Party: _________________________ Date: _____________________

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Fax: (281)592-8001

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Morgan Family Medicine

Financial Policy/Payment of Services

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager or call our billing company, MYEMED at 1-877-769-3633. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Payment in full is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept checks, cash or credit cards (i.e.; VISA, Mastercard, Discover and American Express)

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept and assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment. If your insurance requires a referral it is your responsibility to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit payment in full will be required at the time of the visit.
- If you have Medicare, Part B only you are responsible for your Medicare deductible and your 20% of the charges at the time of service.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- Morgan Family Medicine charges a $30.00 fee for failure to cancel your appointment within 24 hours of your scheduled appointment time.
- Morgan Family Medicine charges a $50.00 NSF fee for all returned or stop payment checks. In the event that you have two (2) NSF checks, Morgan Family Medicine will require you to pay cash for all copays and visits.

Signature of Responsible Party: ____________________________________ Date: _________

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Follow up Care Policy & Procedure

Receiving Test Results and Lab Results from Morgan Family Medicine

The office will only make three (3) attempt to reach a patient via phone.

Abnormal lab value refers to a result that falls outside of a pre-determined normal range.

Abnormal test results are not necessarily clinically significant or critical results.

Normal lab value refers to a result that falls within a pre-determined normal range.

Critical values - Test results that fall significantly outside the normal range and/or may represent life-threatening values, requiring rapid communication of results to the responsible caregiver. A delay in action on the result may result in an adverse outcome for the patient.

Clinically Significant Test Result is a result determined by a licensed provider based on his or her clinical judgment which requires follow-up with appropriate urgency. A licensed provider will determine clinical significance based on his or her knowledge of the patient's symptoms, previous test results, and/or diagnosis.

Follow-up - clinically appropriate action taken following receipt of a patient's test results

Authorized staff – Medical Assistants, or CNAs.

Licensed caregiver – Registered Nurses, LVNs

Licensed provider: MD, Physician Assistant, or **Nurse Practitioner**

Scope/Purpose: To provide a consistent, orderly process for the ordering and tracking of lab tests ordered by a licensed provider.

POLICY: Accurate diagnosis of clinical conditions and efficient treatment requires appropriate tracking of necessary medical labs and timely follow up on results.

PROCEDURE:

For the communication of Lab results, per the provider's orders:

1. A clinical staff member will attempt to contact the patient or legal guardian three (3) times via phone. After three attempts it is the patient's responsibility to contact provider for results.
2. At the provider's discretion, an appointment may be required to discuss lab results.
3. All communication (or efforts to communicate) will be documented within the patient's medical record typically in the notes section of the lab result window or within a telephone encounter.

Signature of Responsible Party: ____________________________________ Date: ___________________

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HIPAA PRIVACY POLICY

SCOPE

This policy applies to Morgan Family Medicine, and its subsidiaries, affiliates, and organizations that Morgan Family Medicine owns, manages, controls, or is otherwise affiliated with in its day-to-day operations.

PURPOSE

The purpose of this policy is to establish guidelines to comply with mandates to final rule HIPAA provisions enacted under the American Recovery and Reinvestment Act; HIPAA Administrative Simplification Privacy and Security Rule, to ensure that customers, visitors, employees, and business associates are knowledgeable of the procedures in place to protect the privacy, use, and disclosure of Protected Health Information (PHI) as well as to ensure that the most current information is available to all staff members/facilities.

Definitions

PHI—Individually identifiable Protected Health Information; data in motion, data at rest, date in use, data disposed including all forms, electronic, paper and oral. The facility will abide by the requirement for “minimum necessary” PHI to accomplish the intended purpose of the use or disclosure to perform their job functions.

POLICY

The company will provide and adhere to this Notice of Privacy Practice which describes how patient medical information (PHI) may be used and disclosed and how patients can obtain access to this information. This notice describes patient rights and certain obligations the company has regarding the use and disclosure of medical information.

The company and each of its facilitates is required by law to:

1. Assure that patient medical information is kept private and secure and to notify patients following a breach of unsecured PHI.

2. Give notice of the company’s legal duties and privacy practices in regards to patient medical information.

3. Follow the term of the notice.

PRIVACY PRACTICES

USE AND DISCLOSURE

The company’s clinic(s) is permitted to use and disclose patient medical information without obtaining authorization from patients in certain instances.

Treatment. The company' clinic(s) may use or disclose medical information to provide treatment, services, coordinate patient healthcare services, in consultation with other health care providers who are involved in a patient's care.

Payment. The company's clinic(s) may use or disclose medical information in order for the treatment and services rendered to be billed and to obtain payment from a patient's insurance company or a third party.

Health Care Operation. The company's clinic(s) may use or disclose medical information in performing business operations that allow us to improve the quality of care we provide and Business Associates who perform services on behalf of our facility and have agreed in writing to confidentiality.

Appointments and Follow-Up. The company's clinic(s) may use or disclose medical information to contact patients about reminders for upcoming medical services or follow-up that pertains to medications or treatments prescribed.

Treatment Alternatives. The company's clinic(s) may use or disclose medical information to inform patients about or recommend possible alternative treatment options that may be of interest to them.

Health-Related Benefits and Services. The company's clinic(s) may use or disclose medical information to inform patients of health-related benefits or services that may be of interest them.

Individuals Involved in Patient Care or Payment for Your Care. The company's clinic(s) may discuss, use, or disclose medical information about patients to a family member or close personal friend who is involved in the patient care or payment of the patient care as long as the patient has not specifically objected to it and we deem it reasonable that it is in patient best interest. This applies to the use and disclosure of medical information of the deceased as well.

Required By Law. The company's clinic(s) may use or disclose medical information when required or permitted by federal, state, or local law.

Avoid Harm. The company's clinic(s) may use or disclose medical information to law enforcement agencies in order to avoid a serious threat to the health, welfare, and safety of a person or the public.

Special Purposes. The company's clinic(s) may use or disclose medical information for the purpose of specifically approved Research, Childhood Immunization Programs, Immunization Records to Schools, Organ and Tissue Donation, Military and Veteran Authorities, Workman's Compensation Programs, Elder or Child Abuse or Neglect, Domestic Violence, Public Health Risk, Government Programs, National Security, Individual Risk of Disease Exposure, Health Care Oversight, Inmate Affairs, Coroner, Medical Examiners, and Funeral Directors. Medical information may be used for fundraising purposes only when the recipient is notified beforehand and given a clear opportunity to opt out of receiving further fundraising communications.

OTHER USES OF MEDICAL INFORMATION

Other uses of medical information not covered by this notice will require a written authorization. These uses may include the request for psychotherapy notes, activities in which payment is received such as marketing, or the sale of PHI. Patients may revoke that authorization, in writing, at any time, and we will no longer use or disclose that information for the reasons covered on the authorization. We cannot take back any information that was used prior to the written revocation. The facility will provide a formal authorization form for these situations.

PATIENT RIGHTS REGARDING MEDICAL INFORMATION

Patients have certain rights regarding their medical information. If patients wish to exercise these rights, they must submit the specific request in writing. The facility will provide a formal request form for these situations. The request will be reviewed and acted upon in a timely manner.

Right to Inspect and Copy. Patients have the right to inspect and request copies of paper and electronic medical information that may be used to make decisions about their care as well as billing information, except for psychotherapy notes, information for civil or criminal proceedings, and certain information governed by the Clinical Laboratory improvement Act. The facility may charge a fee for the cost of copying, mailing or transmitting records.

Right to Amend. If a patient feels that the medical information in the record is incorrect or incomplete, they may ask that it be amended. Patients must provide a reason that supports the request to amend. This does not apply to the deletion, erasure, removal, or otherwise destruction of any part of the medical record.

Right to Request Restrictions. Patients have the right to request a restriction on how their medical information is used or disclosed. If they self-pay for a service or procedure, the facility may not disclose information regarding the service or procedure to a health plan if a patient so requests, provided that the release is not necessary for their treatment. Patients also have to right to request a limitation on the information given to family and friends.

Right to an Accounting of Disclosures. Patients have the right to request a paper or electronic list of an "accounting of disclosures" of medical information for specific dates not longer than six (6) years and may not include dates prior April 14, 2003. The first 12-month period will be at no charge. The facility has the right to charge fees for additional months.

Right to Request Confidential Communication. Patients have the right to request and receive confidential communication concerning use and disclosure of their medical information, in a specific way (such as e-mail, phone, etc.) or location (such as home, work, cell, etc.) or to receive their electronic medical information.

Right to File a Complaint. Patients have the right to file a complaint with facility administration or directly with the Secretary of the Department of Health and Human Services regarding concerns pertaining to the use and disclosure of their medical information if they feel rights have been violated.

Right to a Paper Copy. This notice will be posted at the facility and on the facility website. Patients have the right to request a paper copy of this notice at any time.

CHANGES TO THIS NOTICE

The facility reserves the right to revise this notice and to make the revised notice effective for medical information we already have as well as medical information we receive in the future. Any changes to this notice will be posted at the facility and on the facility website.

TRAINING

The company will train all members of staff and management on the responsibilities of the Notice of Privacy Practices, including awareness and understanding of the HIPAA regulations, annually and on an ongoing basis.

Training will be documented, and training records will be kept for a minimum of five (5) years.

References

http://www.hhs.gov/ocr/privacy

Patient/Representative Signature: _________________________________

Date: ____________________

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