Fritch Medical Clinic

700 W. Broadway Fritch, TX. 79036
(806) 857-2311 Fax (806) 857.9362

PATIENT INFORMATION

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Race _____ Ethnicity: _____ Sex: Female / Male Marital Status: S M W D

Mailing Address _____ City _____ State_____ Zip_____

Physical Address_____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Patient Employer_____ Phone # _____ Occupation _____

Emergency Contact Name_____ Emergency Contact Phone # _____

Personal Physician_____ Referred by Dr. _____ Dental Provider: Dr._____

RESPONSIBLE PARTY / BILLING INFORMATION ☐ *Same as PATIENT information*

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Sex: Female / Male Relation to Patient:_____

Mailing Address _____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Employer_____ Phone # _____ Occupation_____

INSURANCE INFORMATION Do you have Insurance? [ ] Yes [ ] No Is this an on the job injury? [ ] Yes [ ] No Date of injury? _____

*You must provide our office with a current Insurance card.

1) Insurance Carrier Name_____ 2) Insurance Carrier Name_____

INSURED / POLICY HOLDER INFORMATION ☐ *Same as PATIENT information* ☐ *Same as RESPONSIBLE PARTY information*

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Sex: Female / Male Relation to Patient:_____

Mailing Address _____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Employer_____ Phone # _____ Occupation_____

AUTHORIZATIONS AND ACKNOWLEDGEMENT

Do you have an advanced directive? [ ] Yes [ ] No If so we will need a copy for your file. Copy provided [ ] Yes [ ] No

Do you have a Durable Power of Attorney for Healthcare? [ ] Yes [ ] No If so we will need a copy for your file. Copy provided [ ] Yes [ ] No

Is Fritch Medical Clinic you Medical Home? [ ] Yes [ ] No

The medical home also known as the patient-centered medical home (PCMH), is a team based health care delivery model led by a physician that provides comprehensive and continuou medical care to patients with the goal of obtaining maximized health outcomes. It is "an approach to providing comprehensive primary care for children, youth and adults

I voluntarily request that Fritch Medical Clinic and such assistants as they may deem necessary, manage/treat my condition and I hereby release Fritch Medical Clinic, Golden Plains Community Hospital and any other participating health care providers from any and all liability. The duration of this consent is identified and continues until revoked in writing.

BENEFITS TO PHYSICIAN: I hereby authorize the release of information relating to all claims for referral and benefits submitted on behalf of myself and/or dependents I hereby authorize payments directly to Golden Plains Community Hospital and/or the health care provider of the medical and/or surgical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicated that I have read the above and grant the request of authorizations.

X_____ _____ _____

Signature of Patient or legal guardian Printed Name Date

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PATIENT HISTORY FORM

NAME: _____ Date ___/___/___

D.O.B. ___/___/___ Age _____ PREFERRED PHARMACY: _____

A. REVIEW OF SYSTEMS

YES	NO	GENERAL
		1. Unexplained weight loss more than 10 lbs. in the past year?
		2. Night sweats
CARDIO-RESPIRATORY		
YES	NO	
		3. Hypertension (high blood pressure)
		5. Chest Pain
		6. Blood Clots
		7. Swelling of legs or feet
		9. Shortness of breath
GASTROINTESTINAL		
YES	NO	
		11. Constipation
		12. Diarrhea
		13. Blood in stools
		14. Liver Problems
		15. Gallbladder Problems
		16. Trouble Swallowing
MUSCULOSKELETAL		
YES	NO	
		22. Swollen or painful joints / Where? _____
		23. Osteoporosis
		24. Gout
SKIN		
YES	NO	
		25. Acne
		26. Rash
NEUROLOGICAL		
YES	NO	
		27. Headache
		28. Seizures
		29. Dizziness
PHYCHOLOGICAL		
YES	NO	
		30. Depression / Anxiety
		31. Bipolar Disorder
YES	NO	ENDOCRINE
		30. Thyroid problems
		31. Diabetes
YES	NO	PREVENTATIVE
		32. Colonoscopy after age 50? Date: _____
		33. Mammogram after age 40? Date _____
HEMATOLOGICAL / LYMPHATIC		
YES	NO	
		34. Anemia
		35. Blood clotting disorder

ALLERGY *(please list)*

1.
2.
3.
4.

B. Obstetrical History

(please list ALL pregnancies in order, including miscarriages, premature births, stillbirths, ectopic (tubal) and abortions

Year	M / F	Wt.	Type of Delivery	Length of pregnancy	Problems	Age

GYN HISTORY (Check ALL that apply)

Age of first Period? _____ Last Menstrual period? _____

Cycle length every _____ days Lasting _____ days

Periods are: ☐Regular ☐Irregular ☐Painful ☐not bothersome

Flow is: ☐Light ☐Light to moderate ☐Moderate to heavy ☐Very Heavy

Date of last PAP Smear _____ ☐Normal ☐ Abnormal

METHOD OF BIRTH CONTROL

☐	Condoms	☐	Pills	☐	Patch	☐	Vaginal Ring
☐	Tubal	☐	Essure	☐	IUD	☐	Other
☐	Partner with Vasectomy			☐	Natural family planning		

SEXUAL HISTORY

YES	NO	
		Are you sexually active?
		Virginal?
		New partners?

Number of lifetime partners? _____

Sexual preference?

☐	Heterosexual (Opposite sex)	☐	Same Sex	☐	Bi-sexual

MEDICATION LIST

1.
2.
3.
4.
5.

HOSPITALIZATION AND SURGERIES

Year	Reason

COMMENTS:

CONTINUED NEXT PAGE

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PATIENT HISTORY FORM (CONT'D)

NAME: _____ Date ____/____/____

D.O.B. ____/____/____ Age _____ PREFERRED PHARMACY: _____

C. FAMILY HISTORY			
Are you adopted? ☐Yes ☐ No			
Have your biological (parents, brothers, sister) had any of the following?			
YES	NO	Diagnosis	Relative
		Heart disease/ heart attack/stroke before age 50	
		High blood cholesterol	
		Genetic problems	
		Cancer What Type?	
		Diabetes	
		Osteoporosis	
		Blood Clots	

ALCOHOL HISTORY: ☐Current ☐ Former *Type* _____ ☐ None

Per Day #_____ Years Used_____ Years Quit_____

SMOKING HISTORY: ☐Current ☐ Former *Type* _____ ☐ None

Per Day #_____ Years Used_____ Years Quit_____

EXPOSURE TO SECOND HAND SMOKE ☐ YES ☐ NO

☐ In the home ☐ Other:

DRUG USE: ☐Current ☐ Former *Type* _____ ☐ None

Per Day #_____ Years Used_____ Years Quit_____

EDUCATION	High School / College	Year

IMMUNIZATIONS (Check the ones you have received)	Does not receive	Verified by :	Year
☐ Flu Vaccine		☐Verbal ☐Record ☐Immtrac	
☐ Pneumococcal		☐Verbal ☐Record ☐Immtrac	
☐ Varicella (chicken pox)		☐Verbal ☐Record ☐Immtrac	
☐ Zostavax (shingles)		☐Verbal ☐Record ☐Immtrac	
☐ T-dap		☐Verbal ☐Record ☐Immtrac	
☐ Other		☐Verbal ☐Record ☐Immtrac	
☐ Other		☐Verbal ☐Record ☐Immtrac	

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ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that **Golden Plains Community Hospital** provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient

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Permission to Disclose Information
To those involved in my care

Patient Name: _____ DOB: _____

I hereby allow FRITCH MEDICAL CLINIC to disclose the following information to the people listed below.

(Please give full name)	NAME	Phone Number
☐ Spouse:	_____	_____
☐ Family friend(s):	_____	_____
☐ Children:	_____	_____
☐ Others:	_____	_____
	_____	_____

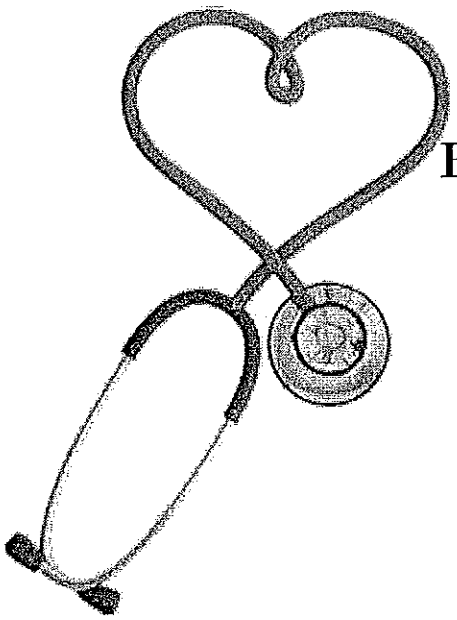
In the following forms of communications

- ☐ Home voice messaging system
- ☐ Work voice messaging system
- ☐ Cellular phone
- ☐ Cellular voice messaging system
- ☐ Other: _____
- ☐ All of the above

• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department. Revocation will not apply to information that has already been disclosed in response to this authorization.

_____ _____
Patient / Guardian Signature Date:

_____ _____
Witness Date:



FRITCH MEDICAL CLINIC

Dean Cates, FNP-BC.

700 Broadway Fritch, TX. 79036

(806) 857-2311 Fax: (806) 857-9362

Narcotics Policy

Fritch Medical Clinic is committed to providing high quality medical care to our patients. Due to a recent change in Federal Laws we are unable to prescribe opiod medication (Hydrocodone, Oxycodone, Morphine, etc.) Prescription for Tramadol or Tylenol #3 can be dispensed on a case by case basis. The need for stronger pain medication will necessitate a referral to a pain management specialist. If is decided between the patient and the provider that Tramadol or Tylenol #3 are medically necessary, we ask that you obtain prescriptions for these medication through Fritch Medical Clinic **only**. This is for your safety. If patient is found to be receiving medications from other providers, the patient will no longer be able to receive prescriptions for these medications through Fritch Medical Clinic.

In addition, as part of the pain management process we may request a urine drug test at any time. Our goal is to get you pain to a manageable level.

Thank you for your understanding and cooperation.

My signature indicated that I have read and understand the above Narcotics Policy.

X _____ _____

Signature of patient or legal guardian — Date

X _____ _____

Witness — Date

No narcotics are maintained on the clinic premises.

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Welcome to our practice!

We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for a select group of major PPO and HMO networks. However due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. Therefore it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information contacting your insurance plan or reviewing your provider list before an appointment. You will be responsible for payment in full for services rendered by a physician if he/she is not in your plan.

YOU MUST PRESENT A VALID ID CARD AND INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

REFERRALS

It is *your* responsibility to obtain from your primary care physician referrals required by your insurance company to see a specialist, as well as to track the number of your visits and keep your referrals current. Without a current referral at the time of the visit, your appointment will have to be rescheduled.

CO-PAYMENTS

We are required to collect your co-payment at the time of service. If the co-pay amount is not listed on your card, or you have a standard traditional plan, we will collect the percentage of the services rendered that is applicable to your plan.

NON-MANAGED CARE

For non-managed care of traditional plans, we will file a claim as a courtesy. However, the contract with your insurance company is between you and this company. We are nc a party to that contract. You are ultimately responsible for your bill, regardless of any non-payment by the insurance carrier. If within 45 days payment is not relieved by your insurance company, payment will be due by you, regardless of the status of your claim.

DEDUCTIBLE

If you have a deductible, and it is likely that the services rendered will go toward your deductible, payment in full must be made at the time of service. Unless other arrangement have been made with our office

PRECERTIFICATION OF HOSPITAL ADMISSION OR SPECIAL SERVICES

Pre-certification of hospital admissions and other special services is an area in which we strive to help. With the exception of some HMO plans, it is ultimately the patient's responsibility to inform this office when pre-certification is a requirement of your plan. Due to the varying policy provisions of all the different plans, it is impossible for us to kno each patient's specific plan provisions. If you fail to disclose pre-certification requirements PRIOR to services being rendered, you will be responsible for payment of all related fees in full.

FOR ALL SERVICES PROVIDED OUTSIDE OF OUR OFFICE, YOU MUST BE AWARE OF; AND INFORM US, WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN. THIS INCLUDES X-RAY, LABORATORY, DIAGNOSTIC, AND REHABILITATION FACILITIES.

SECONDARY INSURANCE

We will file secondary insurance as a courtesy for you. Please keep in mind that payment of your account is ultimately your responsibility, and we will look to you for payment c your account if we are unsuccessful in obtaining reimbursement by your insurance.

RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in the minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings in the minor child, that person will be required to pay for services rendered and they will be provided a receipt. It is not th policy of our office to become involved in medical bill disputes resulting from divorce, etc.

LIABILITY OR AUTO ACCIDENT CLAIMS

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to file your claim.

PAYMENT PLANS

We understand that from time to time unexpected circumstances may arise which make paying for medical care difficult. With this understanding, we provide payment plans to assist you in the management of your account. Please notify us if you need this service.

NSF CHECKS

Once a check is returned for NSF, we will accept only cash or money orders for future visits.

NON-PAYMENT OF ACCOUNTS / NON-COMPLIANCE

Accounts for which we are unable to collect, the balance will be discharged. Our physicians / providers reserve the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood, and agrees to the policy of this office.

X _____ _____

Signature of patient or legal guardian — Date

PATIENT NAME: _____ Date of birth ____/____/____

FRITCH MEDICAL CLINIC
P.O. BOX 1570
FRITCH, TX 79036
(806)-857-2311

Prescription Refill Policy

Fritch Medical Clinic will only consider refilling prescriptions that have been originally prescribed by the clinic staff.

Please contact your pharmacy for refill requests.

Refill requests are accepted Monday through Thursday 8:00am—4:00 pm only.

Our office is closed for all major holidays. Please plan accordingly.

Please allow at least 48 hours for your prescription request to be filled.

PRESCRIPTIONS WILL NOT BE REFILLED ON WEEKENDS.

I have read and understood Fritch Medical Clinic prescription refill policy, and I agree to abide by its terms. I also understand that Fritch Medical Clinic may amend these policies at any time.

_____
Print name of the patient

_____ _____
Signature of patient or responsible party if a minor Date