AUSTIN
FAMILYMEDICINE
Optimal Health & Wellness

(512) 443-WELL
www.ausfp.com

CONSENT TO MEDICAL TREATMENT

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, medical or surgical treatment or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the patient's physician.

***Signature: _____ *Date: _____**

CANCELLATION POLICY

The undersigned understands that Austin Family Medicine Associates will charge a $40 or $80 No Show fee for any appointments not cancelled 24 hours in advance. (Working Days)

***Signature: _____ *Date: _____**

FINANCIAL ASSIGNMENT/AUTHORIZATION

I understand that as the primary carrier I am financially responsible for any balance not covered by my insurance including co-pay, deductible/co-insurance, and any services excluded by my policy. Our office will make every effort to work with the patient and insurance company according to the guidelines of that particular healthcare policy, however, any unpaid insurance charges that remain 120 days after date of treatment will be billed to you the patient. I also understand that it is the policy of Austin Family Medicine Associates to verify all insurance coverage. In the event my insurance is unable to be verified, I will assume responsibility for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. **Please be aware that our office collects co-pays, deductibles and coinsurance at the time services are rendered.**

Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to Austin Family Medicine Associates. A copy of this signature is valid as the original for one year.

***Signature: _____ *Date: _____**

ASSIGNMENT OF LEGAL RIGHTS

If payment is not received within 60 days after services are rendered, I irrevocably assign my legal rights so that Austin Family Medicine Associates may pursue collection of payment for all services provided.

***Signature: _____ *Date: _____**

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. (See binder in waiting room)

***Signature of patient or personal representative _____ *Date_____**

Printed Name:_____ DOB: _____ Chart #:_____

Austin Family Medicine Associates
500 N Capital of Texas Highway, Bldg. 6 Ste 125
Austin, Texas 78746
Phone: (512) 443-9355

Physician Assistant and Nurse Practitioner Consent

This facility has on staff a Physician Assistant and Nurse Practitioner to assist in the delivery of medical care.

A Physician Assistant and Nurse Practitioner are not doctors. A Physician Assistant is a graduate of a certified training program and is licensed by the state board. A Nurse Practitioner is a Registered Nurse who has received advanced education and training in the provision of health care. Under the supervision of a Physician, a Physician Assistant and Nurse Practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, a Physician Assistant and Nurse Practitioner may treat minor lacerations and other minor injuries. "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Physician Assistant and Nurse Practitioner may provide such medical services that are within his/her education, training and experience.

These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting in Surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

_____ _____
Name Date

_____ _____
Signature Witness (optional)

PATIENT INFORMATION SHEET

Please *print clearly* all information provided is required information.

***Patient Name: _____ *Date: _____**

***Address: _____ *Apt/Unit: _____**

***City: _____ *State: ____ *Zip: _____*Home #: _____ Cell #: _____**

***Email Address: _____**

***Date of Birth: _____ *Gender: _____ *Social Security Number: _____**

***Marital Status: _____ *Race: _____ *Language: _____**

***Patient Employer Name: _____ *Phone#_____**

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Emergency Contact Name: _____Relation: _____ Phone: _____

POLICY HOLDER'S INFORMATION (must complete all)

***Primary Insurance Comp: _____ *Phone Number: _____**

***Policy Holder Name: _____ *Date of Birth: _____**

***Relationship to Patient: _____*Policy ID #: _____ *Group #: _____**

***Secondary Insurance Comp: _____ *Phone Number: _____**

***Policy Holder Name: _____ *Date of Birth: _____**

***Relationship to Patient: _____*Policy ID #: _____ *Group #: _____**

Preferred Pharmacy Name & Phone# _____

How did you find us? Google____ Facebook___ Friend____ Insurance___ Other____

ROUTINE PHYSICAL EXAM/PAP POLICY

Recently, insurance companies have started to separate Annual routine Physical Exams and Pap smears as diagnostic services and any other issues as Therapeutic services. Patients have started to receive separate bills for Therapeutic services that were addressed during a routine Physical or Pap and charged them an additional copay, applied it towards a deductible, or deny any payment at all. Insurance companies state "preventative visits are for preventative services only. If an abnormality or a pre-existing problem is addressed in the process of performing the preventative evaluation and the problem is significant enough to require additional work then an additional office visit will be charged which can be an additional copay or applied to a deductible. You have the right to make another appointment at a later date to be evaluated for any pre-existing conditions or other concerns." To avoid more frustration and confusion, Austin Family Medicine Associates has implemented the following policy:

1. When a patient schedules a routine Physical or Pap, only Preventative issues will be addressed and only Diagnostic services will be ordered.
2. A Physical and Pap usually includes a review of medications and allergies, family history, past medical history and a thorough examination.
3. Typically this Diagnostics including blood test, an EKG, immunizations, and referral that are appropriate for that patient.
4. If a patient has additional issues to address or items arise during the course of an exam then a separate office visit will be scheduled to appropriately address those issues.
5. If time permits and any additional issues are addressed during a Physical or Pap, them an additional copay or deductible will be charged.

Thank you for your cooperation with our policies and if you have any questions, please discuss them with your healthcare provider or our staff.

_____

Patient Signature & Date

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____ Age: ____ Height: _____ Weight: _____ Sex: _____

Number of children: _____ Occupation: _____ Marital Status: _____

Your Medical History:

Drug Allergies: _____

Medications Currently Using:

Medication - _____ times per day ____ Medication - _____ times per day ____

Medication - _____ times per day ____ Medication - _____ times per day ____

Medication - _____ times per day ____ Medication - _____ times per day ____

Medication - _____ times per day ____ Medication - _____ times per day ____

Have you ever been told you have or diagnosed with: (circle)

Heart Trouble **Y N** **If (Y) when? _____**

Lung Problems **Y N** **If (Y) when? _____**

High Blood Pressure **Y N** **If (Y) when? _____**

Hepatitis **Y N** **If (Y) when? _____**

Fainting Spells **Y N** **If (Y) when? _____**

Nervousness/Anxiety **Y N** **If (Y) when? _____**

Bleeding Problems **Y N** **If (Y) when? _____**

Diabetes **Y N** **If (Y) when? _____**

HIV/AIDS **Y N** **If (Y) when? _____**

Dizziness **Y N** **If (Y) when? _____**

Cancer **Y N** **If (Y) when? _____**

Date of your last Tetanus shot? _____

Steroids or Cortisone in the last year? **Y N** When? _____

Do you take aspirin regularly? **Y N** ___ Number of tablets ___ times per day

Do you smoke? **Y N** How many ___ Cigarettes ___ Packs Per day _____ Years

Alcohol Consumption: ____None ____Rare ____ Moderate ____Regularly

Exercise: ____None ____Rare ____ Moderate ____Regularly

List any and all major surgeries, serious injuries, or other significant medical problems and approximate dates:

_____
_____
_____
_____

Family History:

Fathers Age: ___ Cause of death if deceased: _____ Age at death _____

Mothers Age: ___ Cause of death if deceased: _____Age at death _____

Number of Brothers_____ Sisters_____

Have any of your blood relatives had the following:

High Blood Pressure **Y** **N** which Relative(s) _____ Age at Diagnosis ____

Diabetes **Y** **N** which Relative(s) _____ Age at Diagnosis ____

Heart Trouble **Y** **N** which Relative(s) _____ Type _____

Cancer **Y** **N** which Relative(s) _____ Location _____

Sickle cell Disease or trait **Y** **N** which Relative(s) _____

Bleeding Problems **Y** **N** which Relative(s) _____ Type _____

Other Illness* **Y** **N** which Relative(s) _____ Type _____

Problems during surgery or Anesthesia **Y** **N** which Relative(s) _____ Type _____

*Explain in area below

Family/Personal Medical problems not listed above:

_____
_____
_____

ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Patient / Guardian Signature _____ Date _____

Account # _____

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HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

___ I DO NOT AUTHORIZE THE RELEASE OF MY RECORDS AT THIS TIME

___ I authorize Austin Family Medicine Associates to use and disclose the protected health information described below to _____ (individual seeking the information).

This authorization for release of information covers the period of healthcare from:

____ A. _____ To _____
____ B. All past, present and future periods

****

___ I authorize the release of my complete health record (including records relating to mental health, communicable diseases, HIV/Aids, and treatment of alcohol or drug abuse.

___ I authorize the release of my complete health records with the exception of the following:

___ Mental health records
___ Communicable Diseases including HIV/AIDS)
___ Alcohol and Drug Abuse treatment
___ Other: _____

****

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, any billing or claims payment, or other purpose as I may direct.

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Printed Name	Signature	Date