Louetta Family Medicine

5834 Louetta Road, Suite F

Spring, TX 77379

P: 832-698-4291 F: 832-698-4297

PATIENT'S NAME_____ DATE OF BIRTH_____ SEX M F

ADDRESS_____ HOME PHONE_____

CITY_____ STATE____ ZIP_____ WORK PHONE_____

SOCIAL SECURITY # _____ CELL PHONE_____

DRIVER LICENSE _____ EMAIL _____

PATIENT EMPLOYER _____

PRIMARY INSURANCE_____

POLICY HOLDER NAME / DATE OF BIRTH _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

PERSON TO NOTIFY IN CASE OF EMERGENCY _____

RELATIONSHIP_____ PHONE # _____

HOW DID YOU HEAR ABOUT US? _____

We ask that all patients show their insurance card with identification card and allow us to make a copy for our records.

I hereby authorize LOUETTA FAMILY MEDICINE, P.A. to furnish information to insurance carriers concerning my illness and treatments. I hereby assign LOUETTA FAMILY MEDICINE, P.A. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. Furthermore, I give consent to be treated by the physician/staff at LOUETTA FAMILY MEDICINE, P.A.

Signature:_____ **DATE:**_____

To Our Valued Patients: Our goal is to provide quality medical services for our patients. We will strive to direct your care and your need for specialist consults, lab work, and other test according to your managed care guidelines. However, our office deals with many different plans, and it is the patient's responsibility to make sure that all facilities and specialists that we recommend you to are on our health care plan. Please verify their participation **BEFORE** services rendered to receive network benefits from your insurance company.

Due to updated guidelines per Insurance plans

Please choose one of the following:

Race:

- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Native Hawaiian or other Pacific
- ❑ Black or African American
- ❑ White
- ❑ Hispanic
- ❑ Other Race
- ❑ Other Pacific Islander
- ❑ Unreported/Refused to Report

Ethnicity:

- ❑ Hispanic or Latino
- ❑ Not Hispanic
- ❑ Refused to Report

Language:

- ❑ English
- ❑ Other
- ❑ Indian
- ❑ Spanish
- ❑ Russian

How would you like appointment reminders?

- ❑ Voice Mail
- ❑ Text Message

Preferred Phone Number _____

Preferred time to call: Morning Afternoon Evening

Would you like to have access to our Patient Portal (Informational Website) if YES please provide email: _____

_____

Patient's Signature Date

Office & Financial Policies

We are committed to providing you with the highest quality medical care in an efficient, timely, and cost-effect manner. We provide you with our policies in advance to prevent any misunderstandings or frustration at the time of your visit. PLEASE INITIAL EACH SLOT ACCORDINGLY.

_____INSURANCE: **you are responsible** for knowing your insurance benefits and if you have a deductible or co-pay plan. **HMO policies must have one of our doctors designated as their physician prior to being seen.** If this change is not done prior to the appointment you may be asked to reschedule or pay out of pocket for the visit. We will not become involved in disputes between you and your insurance company regarding your coverage/policy benefits. **You are responsible** for timely payment on your account. **Bring your insurance card to every appointment.** Without your card we are unable to file for your visit and you will be responsible for the cost of the visit.

_____CAR ACCIDENTS: we do not bill or deal with third party payers (i.e. car insurance companies). **If you wish to be seen you will be unable to use your insurance and will be responsible for cash price of visit.**

_____CHECK-IN: **please arrive 15 minutes before your scheduled time** to ensure all paperwork is completed prior to seeing the physician. **It is your responsibility** to notify the office of any demographic changes or pharmacy changes that need to be done to your account. **Please be prepared to pay for your current visit as well as any past balances** you may owe. This includes co-pays, deductibles, percentages, or fees for non-covered services. For your convenience we take cash, check, or credit cards.

_____DISHONORED CHECKS: a $30.00 service fee will be assessed on all dishonored checks. The full amount of the check plus the service fee must be paid by cash or credit card. If payment is not received within 10-15 business days your information will be filed with Montgomery County Hot Check Division. We will be unable to see you until payment is made in full. After 2 occurrences we will no longer be able to accept checks.

_____LATE ARRIVALS: **We do our best to keep to our schedule.** When you arrive late it is impossible to stay on schedule and can disrupt other scheduled appointments. **If you arrive 15 minutes late or more you may be asked to reschedule** so that other patients scheduled appointments are not interrupted. **This will also be marked as a "no show" on your account.**

_____NO SHOWS: **it is your responsibility to know your appointment time.** If you are unable to make it to your scheduled appointment it is your responsibility to inform us at least 24 hours prior to the scheduled time. **There is a $25 "no show fee"** that will be applied to your account and due prior to being seen again. **Once you have had 3 no shows in a one year's time frame you will be dismissed from the practice** and will be responsible for finding a new primary care physician.

_____MEDICATIONS: You will be given enough medication at your office visit to last you until you are due back for a follow up/medication review. **Please keep up with when you are due back for your follow up** to decrease the chances of lapsing in treatment. **It is your responsibility to request refills from your pharmacy.** We recommend contacting them 5 days prior to running out of your medications. **All controlled substances require an office visit. THEY WILL NOT** be prescribed or refilled over the phone.

I have read, understand, and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patients Name: _____ DOB: _____

Signature: _____ Date: _____

Louetta Family Medicine
Pediatric Medical Questionnaire - BIRTH TO AGE 5

Patient Name:_____ Date of Birth:_____Today's Date:_____
Previous medical care – Dr. _____ Last Well Exam: _____
Reason for today's visit _____
Date Began (if applicable) _____

Pregnancy/Birth history ○ Full-term ○ Premature _____weeks
Type of delivery? ○ Vaginal ○ C-section (reason for c-section _____)
Birth weight: _____ Birth length: _____ ○ Single pregnancy ○ Multiple (twin/triplet/etc)
Pregnancy issues: ○ Smoking ○ Alcohol ○ Drugs ○ Medications _____
Breech position? ○ Yes ○ No Birth Complications? ○ No ○ Yes_____
Did baby receive the Hepatitis B vaccine in the hospital? ○ Yes ○ No ○ Unknown
Passed hearing test? ○ Yes ○ No ○ Unknown
Past Medical History: Immunizations up to date? ○ Yes ○ No ○ Unknown
Hospitalizations (when-where-why) _____
Serious injuries or ER visit (when-what) _____

Please MARK (X) if your child has had these problems in the past
○Asthma/Wheezing ○Allergies/hay fever ○Ear infections ○Pneumonia ○Lung problems
○Heart problems ○Heart murmur ○Thyroid problems
○Bleeding tendency ○Anemia ○Blood transfusion
○Jaundice ○Diabetes ○Reflux ○Urinary infections
○Joint problems ○Developmental delay ○Learning disability ○Autism ○Down Syndrome
○Headaches ○Seizures ○Hearing problems ○Vision problems ○Sleep problems ○ADHD/ADD
○Eczema ○Skin infections ○Cancer ○ Birth defects
Other:_____

Past Surgical History: (please indicate year) ○ Appendix ○ Bone surgery ○ Ear tubes
○Tonsils/Adenoid ○ Circumcision Other:_____

Medications: list all prescription and over-the-counter medications or supplements

Name	Dosage	Frequency	Indication/Use

Allergies to Medication/Food/Other (PLEASE DESCRIBE REACTION – i.e. rash, nausea, etc)

_____

Pharmacy (location/phone): _____

Pediatric Medical Questionnaire – BIRTH TO AGE 5 (page 2)

Family Medical History Please mark if any blood relatives have the following:
○Asthma ○Allergies ○Anemia ○High blood pressure ○Heart disease ○High cholesterol ○Diabetes
○Seizures ○Migraines ○Thyroid problems ○Liver problems ○Kidney problems ○Mental retardation
○Birth defects ○Genetic disease ○Sudden infant death ○Tuberculosis ○Psychiatric illness
○Substance Abuse ○Cancer ○ADHD ○Autism ○Other
Please explain any marks:_____
_____

Social History Parents ○ Married ○ Separated ○ Divorced
Mother _____ Age ____ Occupation _____Lives with child? ○Yes ○No
Father _____ Age ____ Occupation _____Lives with child? ○Yes ○No
Siblings (First name/age/sex) _____
Other people living in household: _____
Child care: ○Home ○Daycare ○Nanny ○Family members Other:_____
At home are there: ○Smokers ○Pets ○Guns ○Swimming pool ○Smoke detectors
Home built before 1960? ○ Yes ○ No Parents work with lead? ○ Yes ○ No

Feeding and Nutrition
Current nutrition: ○Breastfeeding ○Formula ○Table Food ○Cow Milk (Whole/2%/1%/skim/other?)
If breastfeeding/formula, amount? _____ minutes/ounces every ___ hours

Developmental History At what age did your child sit alone? _____ Walk alone? _____
Did your child say any words by 15 months old? ○Yes ○No
At what age was your child potty trained during the day? _____
Compared to other children his/her age, is your child ○advanced ○same ○behind

REVIEW OF SYSTEMS: Mark (x) if your child *CURRENTLY* has any of the following:
○Fever ○Weight loss ○Swollen glands
○Red/pink eye ○Eye drainage ○Vision problems ○Ear drainage ○Runny nose ○Nasal congestion
○Snoring ○ Allergies/sneezing ○Hearing problems ○Thrush
○Sore throat ○Cough ○Stop breathing ○Turning blue ○Wheezing
○Diarrhea ○Vomiting ○Constipation ○Food intolerances ○Loss of appetite
○Headaches ○Seizures ○Fainting ○ Behavior problems
○Birthmark ○Diaper rash ○Itching ○Rash ○Jaundice/yellow skin or eyes
○Pain with urination ○Blood in urine ○Scrotal swelling ○Vaginal discharge
○Joint pain ○Problems walking ○Easy bruising ○Easy bleeding

OFFICE USE ONLY: Wt_____ Ht_____ HC_____ HR_____ T_____ O2_____ BP_____

Health Disclosure Information

I, _____ will allow Louetta Family Medicine to disclose information to the following person(s) about my health, If I am not available. I also will allow them to bring my minor children in my absence.

Acknowledgement of review of Notice of Privacy Practices

I can be offered a copy to review of Louetta Family Medicine, P.A.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. Please ask for your copy at time of check in if desired.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient or Personal Representative Date

Authorization To Treat a Minor

I, _____ give the following person(s)
Parent/Legal Guardia

consent for medical evaluation and treatment of my child _____, DOB

_____.

☐ Only for evaluation

☐ For all treatment including biopsies and procedures

Name _____ Relationship_____ DOB_____

Name _____ Relationship _____ DOB_____

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB_____

I understand that my signed consent is required to allow treatment of my child without personally being present and give permission to the above person to consent to any and all medical treatment.

Accompanying adult must present ID at the time of visit for proper identification

_____

Signature of Parent/Legal Guardian Date

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth / / *Children under 18 years only.

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator: _____
Printed Name

_____ _____
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac – Please enter client information in ImmTrac and affirm that consent has been granted. DO NOT fax to ImmTrac. Retain this form in your client's record.

Louetta Family Medicine
5834 Louetta Road, Suite F
Spring, TX 77379
Tel 832-698-4291
Fax 832-698-4297

Medical Records Release Authorization Form

Patient Name: _____ DOB: _____

Release my protected health information to the following person(s)/entity:

From:_____ To: Louetta Family Medicine

Phone: _____ Phone: 832-698-4291

Fax: _____ Fax: 832-698-4297

The health information you may release subject to this authorization is as follows:

_____ All medical records _____Lab _____Radiology _____Consult notes

_____ From Service date: _____ to _____

Your initials are required to release the following information:
HIV/AIDS Test Results/Treatment ____ Drug, Alcohol, or Substance Abuse Records ____
Genetic Information (including Genetic Test Results) ____
Mental Health Records (excluding psychotherapy notes) ____

The purpose for this release of information is for patient care and treatment. This authorization shall be in force and effective for 30 DAYS from the date below. By signing this form, I authorize you to use and disclose the protected health information. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Louetta Family Medicine at the address above. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

_____ _____

Signature of Patient or Personal Representative Witness

_____

Date