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

Today's Date_____ **email completed forms to info@conroefamilyphysicians.com**

Patient's Name: _____ DOB_____

Birth Sex: ☐Male ☐ Female Gender:_____

Parents/Guardians (if minor)_____

Address_____ City _____ State ___Zip _____

Primary phone:_____Cell: _____ Work:_____

DL#_____SSN_____

Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian ☐ Asian ☐ Black or African-American ☐ White ☐ Other_____☐ Declined

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

How did you find out about our office?_____

EMERGENCY CONTACT INFORMATION:

Name_____Relationship_____ Phone _____

RESPONSIBLE PARTY/GUARANTOR

Who is responsible for the account? □Self □ Other _____
Address/City/State/Zip (if different from above)_____
Relationship to patient_____DOB_____
Primary Phone_____Work/Cell_____

PRIMARY INSURANCE _____
Policy #_____
Group # _____
Telephone #_____
Policy Holder _____
Policy Holder's DOB _____
Relationship to Pt_____

SECONDARY INSURANCE _____
Policy #_____
Group # _____
Telephone #_____
Policy Holder _____
Policy Holder's DOB _____
Relationship to Pt_____

Authorization and Release

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payments of benefits be made to Louetta Family Medicine. I acknowledge that I am financially responsible for payment of services not covered by insurance.

☐ **CHECK HERE IF YOU DO NOT HAVE MEDICAL INSURANCE AND WILL PAY AMOUNT IN FULL**

Parent/Guardian's Name _____

Signature _____**Today's Date**_____

Patient Name: _____DOB:_____

LOUETTA FAMILY MEDICINE

RELEASE OF INFORMATION/HEALTH DISCLOSURE CONSENT

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I,_____, DOB_____, will allow Louetta Family Medicine to disclose information to the following person(s) about my health if I am not available.

	NAME	RELATIONSHIP	PHONE
1.			
2.			
3.			
4.			

Parent/Guardian's Name _____

Signature _____**Today's Date**_____

PATIENT PORTAL

Would you like access to our secure, electronic patient portal? You can save time and communicate better with our office by providing a unique e-mail address. Please note, patients cannot share e-mail accounts and must provide a separate e-mail for each portal access.

E-mail: _____

Patient Name: _____DOB:_____

LOUETTA FAMILY MEDICINE

PRESCRIPTION HISTORY CONSENT

The purpose of this consent is for permission to obtain your medication history. Patient medication history is a list of prescription medicines that our providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illnesses properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history may not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements and/or herbal remedies that patients take on their own may not be included.

By signing this consent form you are giving your healthcare provider permission to collect information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Louetta Family Medicine, unless revoked by me in writing. I certify that I have read this form or it has been read to me.

Parent/Guardian's Name _____

Signature _____**Today's Date**_____

PREFERRED PHARMACY

☐ Local pharmacy:_____

Address or phone#:_____

☐ Mail order pharmacy:_____

Patient Name: _____DOB:_____

LOUETTA FAMILY MEDICINE

Office and Financial Policies

Welcome and thank you for choosing Louetta Family Medicine for your medical care.

Initials:_____**Insurance**: The patient is responsible for knowing their insurance benefits including their deductible and out-of-pocket expenses. Copays, deductibles and the patient's financial portion including any outstanding balances will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. We file your insurance claim on your behalf. **We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits.** You are responsible for timely payments on your account.

Initials:_____**Cancellations/No Show Fee:** Please call our office at least 24 hours in advance if you are unable to keep a scheduled appointment. You will be charged a No Show Fee of $50 if the new patient appointment is canceled with less than 24 hours' notice, or a $25 no show fee for subsequent visits.

Initials:_____**Late Arrivals:** We do our best to reduce patient wait time, but when a patient arrives late, it is impossible to stay on schedule. If you arrive 15 minutes or more after your scheduled appointment time, you will be charged as no-show and will need to reschedule your appointment.

Initials:_____**PCP Assignment:** Patients with an HMO policy need to choose one of our physicians as their PCP to be seen at Louetta Family Medicine. Please note that it may take 24 hours to update your PCP with your insurance company. You may be asked to reschedule if the insurance still lists another physician as a PCP.

Initials:_____**Patient Balances:** Please be prepared to pay for the current visit as well as any past balances on your account. Copays, deductible, out-of-pocket expenses and non-covered services must be paid at the time of service. For your convenience we accept cash, check and credit cards.

Initials:_____**Dishonored Checks:** A $30 Return check fee will be assessed on all dishonored checks. If you have dishonored checks on file, check payment will no longer be a payment option for you, but we will gladly accept cash or credit card payments at your future visits.

Initials:_____**Collections:** You will receive 3 statements from our office for balances owed before it gets referred to collections. Please make payment arrangements, if necessary, to keep your account current. If your address changes, it is your responsibility to inform Louetta Family Medicine to update our records. When your account is in collections, you may not be seen until the account is paid in full.

Initials:_____**Prescriptions**: It is the patient's responsibility to make an appointment for prescription refills prior to running out of medications. All patients must be evaluated before refilling any chronic medications. Controlled substances will not be filled after hours or outside of an office visit unless there is a written agreement between physician and patient.

Initials:_____**Financial Policy**: Any out-of-pocket expense for the patient such as co-pays, deductibles, or co-insurances must be paid at the time of the clinic visit, including services that are not covered under the patient's benefit plan.

I have read, understand and agree to the above Office/Financial policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing by signing this statement.

Parent/Guardian's Name _____

Signature _____**Today's Date**_____

rev 5/2023

Patient Name: _____DOB:_____

LOUETTA FAMILY MEDICINE

Health Insurance Portability and Accountability Act (HIPAA)

A. Inspection and copies of protected health information – you may inspect and / or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that a request for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: The information is psychotherapy notes; the information reveals the identity of a person who provided information under a promise of confidentiality; the information is subject to the Clinical Laboratory Improvements Amendments of 1988; the information has been compiled in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for review of our decision to deny access. Texas law requires us to be ready to provide copies or a narrative report within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based-fee.

B. Amendments of Medical Information – you may request an amendment of your medical information in the designated records set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons: The information was not created by this practice or physicians in this practice; the information is not part of the designated records set; the information is not available for inspection because of an appropriate denial; the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical records. If we refuse to allow an amendment to be made and tell others that we now have the correct information.

C. Accounting of Certain Disclosures – HIPAA privacy regulations permit you to request, and us to provide, and accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by our or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12- month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits – We may contact you by (telephone, mail or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints – If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filling a complaint with us or the government.

F. Our Promise to you – We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of your privacy practices with respect to protected health information, and to abide by the terms of notice of privacy practices in effect.

G. Questions and Contact Person for Requests - If you have any question or want to make a request pursuant to rights described above, please contact our office at 832 698 4291.

I acknowledge that I have been given an opportunity to review Louetta Family Medicine Notice of Privacy Policies and have been provided a copy if I desire one.

Parent/Guardian's Name _____

Signature _____**Today's Date**_____

Patient Name: _____DOB:_____

LOUETTA FAMILY MEDICINE

Authorization To Treat a Minor

Please complete this form if you will allow an adult other than parents or guardians to bring your child to our clinic in your absence.

I, _____ give the following adult person(s) authorization to consent for medical evaluation and treatment of my child as named above.

- ☐ Only for evaluation
- ☐ For all treatment including immunizations, injections 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 if I am not able to accompany them to the clinic.

Adult must present ID at the time of visit for proper identification

_____

Parent/Guardian's Name _____

Signature _____**Today's Date**_____

Patient Name: _____DOB:_____

LOUETTA FAMILY MEDICINE

Pediatric Medical History - Birth through age 4

Parent or Guardian:_____

Previous medical care – Dr. _____

Last Well Exam: _____ Last Vision Exam: _____ Last Dental Exam: _____

Reason for today's visit _____

Medications:

Please list all the medications currently taken. Include all prescribed and over the counter medications, such as vitamins, supplements and inhalers.

NAME	DOSE/STRENGTH	FREQUENCY TAKEN	REASON FOR MED
1.			
2.			
3.			

Pregnancy/Birth history

Provider of prenatal care Dr._____

Location of delivery _____

Any complications: ▢ No ▢ Yes_____

Pregnancy issues: ▢ Smoking ▢ Alcohol ▢ Drugs

▢ Medications _____

Type of delivery? ▢ Vaginal ▢ C-section (reason for c-section _____)

Birth weight: _____ Birth length: _____

Gestation: ▢ Full-term ▢ Premature _____weeks

▢ Single pregnancy ▢ Multiple (twin/triplet/etc)

Breech position? ▢ Yes ▢ No

Feeding: ▢ Breast ▢ Bottle ▢ Both

Passed hearing test? ▢ Yes ▢ No ▢ Unknown

Did your baby receive the Hepatitis B vaccine in the hospital? ▢ Yes ▢ No ▢ Unknown

Patient Name: _____DOB:_____

LOUETTA FAMILY MEDICINE

Pediatric Medical History– Birth through age 4 (page 2)

Past Medical History:

Immunizations up to date? ▢ Yes ▢ No ▢ Unknown

Please MARK (X) if your child has had these problems in the past or currently has:

▢ ADHD/ADD	▢ Diabetes	▢ Learning disability
▢ Allergies/hay fever	▢ Down Syndrome	▢ Lung problems
▢ Anemia	▢ Ear infections	▢ Pneumonia
▢ Asthma/Wheezing	▢ Eczema	▢ Reflux
▢ Autism	▢ Headaches	▢ Seizures
▢ Birth defects	▢ Hearing problems	▢ Skin infections
▢ Bleeding tendency	▢ Heart murmur	▢ Sleep problems
▢ Blood transfusion	▢ Heart problems	▢ Thyroid problems
▢ Cancer (type)	▢ Jaundice	▢ Urinary infections
▢ Developmental delay	▢ Joint problems	▢ Vision problems

Other_____

ALLERGIES ▢ **Check here if NONE**

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

Agent/Substance **Reaction**

1. _____
2. _____

SURGICAL HISTORY ▢ **Check here if NONE**

Date (Month/Yr) **Surgery** **Hospital/Doctor**

1. _____
2. _____

HOSPITALIZATIONS ▢ **Check here if NONE**

Date (Month/Yr) **Reason** **Hospital**

1._____
2._____

Patient Name: _____DOB:_____

LOUETTA FAMILY MEDICINE

Pediatric Medical History– Birth through age 4 (page 3)

FAMILY MEDICAL HISTORY

HTN = hypertension

Father	▢Alive ▢Unknown ▢Deceased at age ___	▢Diabetes ▢Stroke	▢HTN ▢Cancer	▢Heart disease ▢Mental Illness	▢High cholesterol ▢Other
Mother	▢Alive ▢Unknown ▢Deceased at age ___	▢Diabetes ▢Stroke	▢HTN ▢Cancer	▢Heart disease ▢Mental Illness	▢High cholesterol ▢Other
Paternal Grandfather	▢Alive ▢Unknown ▢Deceased at age ___	▢Diabetes ▢Stroke	▢HTN ▢Cancer	▢Heart disease ▢Mental Illness	▢High cholesterol ▢Other
Paternal Grandmother	▢Alive ▢Unknown ▢Deceased at age ___	▢Diabetes ▢Stroke	▢HTN ▢Cancer	▢Heart disease ▢Mental Illness	▢High cholesterol ▢Other
Maternal Grandfather	▢Alive ▢Unknown ▢Deceased at age ___	▢Diabetes ▢Stroke	▢HTN ▢Cancer	▢Heart disease ▢Mental Illness	▢High cholesterol ▢Other
Maternal Grandmother	▢Alive ▢Unknown ▢Deceased at age ___	▢Diabetes ▢Stroke	▢HTN ▢Cancer	▢Heart disease ▢Mental Illness	▢High cholesterol ▢Other
Siblings	▢Alive ▢Unknown ▢Deceased at age ___	▢Diabetes ▢Stroke	▢HTN ▢Cancer	▢Heart disease ▢Mental Illness	▢High cholesterol ▢Other
Other					

Social History

Parent #1 Name/occupation:_____

Parent #2 Name/occupation:_____

Home Smoke Detector Use: ▢ Yes ▢ No

Housing: ▢ House ▢ Apartment ▢ Other _____

Living with: _____

At home are there: ▢Smokers ▢Guns ▢Swimming pool

Home built before 1960? ▢ Yes ▢ No

Parents work with lead? ▢ Yes ▢ No

Pets:_____

Siblings (First name/birth year/sex) _____

Developmental History

Any developmental issues? ▢ No ▢ Yes_____

Issues with the following? ▢ Speech ▢ Motor ▢ Behavior

Parent/Guardian's Name _____

Signature _____**Today's Date**_____