NEW PATIENT INFORMATION

Name as it appears on your insurance card:

Name(First):_____ Middle Initial:___ Name(Last):_____

Date of Birth:____/____ /_____ Sex:_____ SSN: _____-_____-_____

Address:_____

City:_____ State: _____ Zip:_____

Phone:_____ Email:_____

How did you hear about us?_____

INSURANCE INFORMATION:

Do you have health insurance? YES / NO

Primary Insurance Carrier:_____

Member ID #: _____ Group #:_____

Name of Insurer(policy holder):_____ DOB: _____

Patient Pharmacy Name: _____ Number: _____

Address:_____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone: _____

Name: _____ Phone: _____

May we leave personal medical information on your cell phone or voicemail? YES / NO

May we email you regarding yo YES / NO

FINANCIAL POLICY

In order to reduce any confusion and or misunderstanding between our patients and the practice, MedComplete has adopted the following financial policy. 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. If you have any questions or concerns about the policy, please discuss them with our office manager.

As a patient of MedComplete, I hereby understand and agree to the following:
Please initial each paragraph

_____ MedComplete will make arrangements with my insurance company and will submit an insurance claim for services rendered. Any copayments will be collected on the date of service. I agree to have my insurance company pay MedComplete directly and any deductible, co-insurance or unapproved procedures will be invoiced to the address I have listed above. I understand that if my insurance company does not pay MedComplete, I am responsible to provide MedComplete payment in full and that if I receive an invoice from MedComplete payment is due immediately upon receipt of that invoice.

_____ I am financially responsible for all charges concerning my care and treatment. Full payment is due at the time services are rendered including services such as cosmetic consultations and procedures. As a courtesy, MedComplete may forgo requiring my complete payment at the time of services. For my convenience, MedComplete will accept Visa, MasterCard, American Express, Discover, Care Credit and check or cash as forms of payment.

_____ I understand and agree that if I have insurance coverage with a plan that **DOES NOT** have a prior agreement with MedComplete, complete payment for my care and treatment is due at the time of service.

_____ All health plans are not the same and do not cover the same services. I understand and agree that in the event my health plan determines a service is "not covered" I am responsible for the complete payment of the service.

*Returned checks are subject to a $35 fee.

I have read and understand the financial policy of MedComplete and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of patient or Responsible party:_____

Please Print Name of Patient:_ _____

Date:_____

PROVIDER VISIT CANCELLATION/NO-SHOW POLICY

Provider visits: cancel or reschedule at least 24 hours before your appointment. After a one-time courtesy waiver, eligible late cancellations and no-shows are charged a $30 administrative fee to the card authorized in Tebra. The fee is not billed to insurance. Medicaid and other prohibited payer categories are exempt. Online requests remain pending until the required Tebra authorization is complete.

MEDICAL RECORDS REQUEST

There will be a $25 to $27.50 fee based on Texas Medical Board Rule 165.2 (tmb.state.tx.us) for every medical record request. Please allow 7-10 business days to process medical record requests.

DISABILITY/FMLA FORMS

There will be a $10-$25 fee (depending on how extensive the paperwork is) for completion of all disability/fmla forms. These forms require physician review so please allow 7-10 business days for completion.

AFTER HOURS CALLS

Your physician is on call after-hours and on weekends for serious medical problems. In the event of an emergency call 911. For routine medical questions or minor problems, please call during regular business hours.

PATIENT RESPONSIBILITY

I understand that when/if my physician has ordered any laboratory tests or radiological procedures it is my first responsibility to follow through and have the ordered test performed. Thes companies we refer you to are in no way affiliated with MedComplete and will send their own separate claims to the insurance company you have provided. It is imperative that we have constant communication with you in order to review results.

As we stated above, the primary goal of our practice is to provide the finest medical care and services to the people in our community.

I have read, understood and agreed to abide by the policy set forth. I also acknowledge that I have received a copy of the MedComplete Privacy policy.

Patient Signature:_____

Printed Patient Name: _____

Date:_____

Pharmacy Name:_____ _____

HIPAA COMPLIANCE PATIENT CONSENT FORM/NOTICE OF PRIVACY

I give MedComplete my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review MedComplete's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that MedComplete has the right to change their privacy practices and that I may obtain any revised notices at the MedComplete office.

I understand that I have the right to request a restriction of how my protected health information is used, however I also understand that MedComplete is not required to agree to the request. If MedComplete agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient signature:_____ Date: _____

May we discuss your medical condition with any member of your family? ☐YES ☐NO

If YES, please name the members allowed:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name(First):_____ Name(Last):_____

Reason for today's visit:_____

MEDICAL HISTORY

Have you ever had any of the following conditions?

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Glaucoma
- ☐ Depression
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ GERD
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/AID'S
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Myocardial Infarction
- ☐ Peptic Ulcer Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Ulcerative Colitis
- ☐ NONE OF THE ABOVE

SURGICAL HISTORY

Have you ever had any of the following surgeries?

- ☐ Adrenal Gland Surgery
- ☐ Appendectomy
- ☐ Bariatric Surgery
- ☐ Bladder Surgery
- ☐ Breast Surgery
- ☐ Cesarean Section
- ☐ Cholecystectomy
- ☐ Colon Surgery
- ☐ Coronary Artery Bypass Graft
- ☐ Esophagus Surgery
- ☐ Hemorrhoid Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Kidney Surgery
- ☐ Neck Surgery
- ☐ Prostate Surgery
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Stomach Surgery
- ☐ Thyroid Surgery
- ☐ NONE OF THE ABOVE

List other past medical proble _____ _____ _____ _____ _____ _____

List your prescribed medications and over-the-counter drug:

Drug:_____ Dose/Frequency:_____
Drug:_____ Dose/Frequency:_____
Drug:_____ Dose/Frequency:_____
Drug:_____ Dose/Frequency:_____
Drug:_____ Dose/Frequency:_____
Drug:_____ Dose/Frequency:_____
Drug:_____ Dose/Frequency:_____
Drug:_____ Dose/Frequency:_____

☐ I take no medications, vitamins or any other over-the-counter drugs.

ALLERGIES

Name:_____ Reaction you had:_____
Name:_____ Reaction you had:_____
Name:_____ Reaction you had:_____

☐ I have no known drug/food allergies

FAMILY HISTORY

Has anyone in your family had any of the following conditions?

☐ Anemia
☐ Blood Clots
☐ Cancer Heart Disease
☐ High Blood Pressure
☐ Stroke
☐ Bleeding Problems
☐ Hepatitis
☐ Anesthesia Reaction
☐ Other _____

SOCIAL HISTORY

Do you drink alcohol?..... ☐Y ☐N
Do you use tobacco?..... ☐Y ☐N
Do you use illegal drugs?..... ☐Y ☐N

What is your occupation? _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

WOMEN

Number of pregnancies_____ Number of deliveries_____ Vaginal_____
C-Section_____ Miscarriages_____ Abortions_____

CANCER HEALTH HABITS

WOMEN:			MEN:		
BREAST:	Monthly Exam	☐YES ☐No	PROSTATE:	Yearly Prostate Exam	☐YES ☐No
	Yearly Physician Exam	☐YES ☐No		Yearly PSA (blood)	☐YES ☐No
	Last Mammogram	Date:	COLON:	Last Colonoscopy	☐YES ☐No
OBGYN:	Yearly OBGYN Exam	☐YES ☐No		Yearly Rectal Exam	☐YES ☐No
	Yearly Pap Smear exam	☐YES ☐No		Yearly Stool Test	☐YES ☐No

REVIEW OF SYSTEMS

Do you currently have any of the following symptoms or conditions:

GENERAL:

- ☐ Weight Loss (_____lbs)
- ☐ Loss of appetite
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fainting Spells
- ☐ N/A

EYES:

- ☐ Eye disease or injury
- ☐ Wear glasses or contacts
- ☐ Blurred vision or double vision
- ☐ N/A

BREAST:

- ☐ Breast lump
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ N/A

EARS, NOSE, THROAT, MOUTH:

- ☐ Hearing loss
- ☐ Earache/infection
- ☐ Ringing in the ears
- ☐ Nose bleeds
- ☐ Bleeding gums
- ☐ Mouth Sores
- ☐ Runny nose/cold
- ☐ Sinus problems
- ☐ Neck stiffness
- ☐ Enlarged neck gland/masses
- ☐ N/A

RESPIRATORY:

- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma

- ☐ ıitis
- ☐ ıonia

GYNECOLOGIC:

- ☐ Irregular periods, last period_____
- ☐ Abnormal vaginal discharge
- ☐ N/A

DIGESTIVE:

- ☐ Difficulty swallowing
- ☐ Early satiety
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody stool
- ☐ Dark tarry stool
- ☐ Abdominal pain
- ☐ Painful bowel movements
- ☐ Poor control of bowel movements
- ☐ N/A

CARDIOVASCULAR:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Sinus problems
- ☐ Heart Valve Problems
- ☐ Heart valve problems
- ☐ Calf pain with walking
- ☐ Leg swelling
- ☐ N/A

PSYCHIATRIC:

- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings

ENDOCRINE:

- ☐ Heat or cold intolerance
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Excessive sweating
- ☐ N/A

NEUROLOGICAL:

- ☐ Frequent headaches
- ☐ Migraines
- ☐ Weakness
- ☐ Seizures
- ☐ Stroke
- ☐ Paralysis
- ☐ Decreased sensation
- ☐ Difficulty with speech
- ☐ Dizziness
- ☐ N/A

SKIN:

- ☐ Rash
- ☐ Skin infection
- ☐ Ulcers/sores
- ☐ Yellowing of the skin
- ☐ Eczema, psoriasis, other
- ☐ Pyoderma gangrenosum, erythema nodosum
- ☐ N/A

- ☐ Panic attacks
- ☐ Suicide thoughts or attempts
- ☐ N/A

ALLERGIC, IMMUNOLOGIC:

- ☐ HIV
- ☐ Hepatitis
- ☐ Immunodeficiency
- ☐ Antibiotics for dental
- ☐ N/A

MUSCULOSKELETAL:

- ☐ Joint pain
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Leg pain
- ☐ Broken bones
- ☐ N/A

URINARY:

- ☐ Burning with urination
- ☐ Weak urine stream
- ☐ Blood in urine
- ☐ Gas or stool in urine
- ☐ Poor control (leakage)
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Testicular mass
- ☐ Up at night to urinate
- ☐ N/A

HEMATOLOGIC, LYMPHATIC:

- ☐ Prior blood transfusion
- ☐ Easy bleeding or bruising
- ☐ Low red blood cell count
- ☐ Low white blood cell count
- ☐ Prolonged bleeding
- ☐ Swollen glands
- ☐ Blood clots
- ☐ Use of blood thinners
- ☐ Swollen Lymph Nodes
- ☐ N/A

Pharmacy Name:_____ Phone #:_____

CONNECT WITH US

MEDCOMPLETE

GOOGLE REVIEW

SCAN QR CODE ABOVE