PATIENT INFORMATION FORM

Patient Information

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Age: _____ SSN: _____ Sex: ____ Male ____Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Preferred # ___Home __ Work ___ Cell

Patient's Spouse Information (or if patient is a Minor, enter Father's Info below)

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Age: _____ SSN: _____ Sex: ____ Male ____Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Preferred # ___Home __ Work ___ Cell

(or if patient is a Minor, enter Mother's Info below)

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Age: _____ SSN: _____ Sex: ____ Male ____Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Preferred # ___Home __ Work ___ Cell

Primary Insurance Information

Insurance Policy Holder's Name:_____ Date of Birth:_____ SSN:_____

Insurance Company:_____ Relationship to Patient:___Self ___Spouse ____Child (dependent)

Insurance Address:_____ City:_____ State:_____ Zip:_____

Insurance Phone:_____ ID#:_____ Grp Name:_____Grp#:_____

Emergency Contact (Not residing in same household)

First Name: _____ M.I. _____ Last Name: _____

Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Authorization for Medical Treatment: I authorize Texas Family Wellness Clinic to perform medical treatment and/or diagnostic testing as recommended. Assignment of Benefits: I authorize payment of medical insurance benefits directly to Texas Family Wellness Clinic. I acknowledge that I am financially responsible for co-pays, deductibles, or non-covered services that may apply.

Patient's Signature: _____ Date: _____

(Or Guardian, if patient is a minor)

TEXAS FAMILY WELLNESS CLINIC

Allergy Questionnaire

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____

Do you believe you have allergies? _____ yes / _____ no

If so, what do you think you are allergic to? _____

If given the opportunity, would you like to have allergy testing done? _____ yes / _____ no

Have you ever had any of the following problems or symptoms? (check all that apply)

- ❑ Hives or swelling, how often? _____
- ❑ Breathing problems, weezing, or coughing? _____
- ❑ Have you been diagnosed with asthma? _____ at what age? _____
- ❑ Do you have any indoor pets? _____ if yes, how many & what type? _____
- ❑ Skin Problems, eczema or other rashes? _____
- ❑ Sinus trouble, hay fever? _____
- ❑ Runny, stuffy, itchy nose, how often? _____
- ❑ Sneezing often? _____
- ❑ Headaches, migraines, dizziness? _____ how often? _____
- ❑ Ear pain or pressure? _____
- ❑ Itching in the ears/throat, how often? _____
- ❑ Watery or itchy eyes? _____
- ❑ Frequent sinus or throat infections, how often? _____
- ❑ Food reactions? Which foods & describe _____
- ❑ Drug reactions? Which drugs & describe _____
- ❑ Insect reactions? Which insects & describe _____

Have you ever taken any medication for the above symptoms? ____ Yes _____ No

If yes, which medications have you tried & if/how they worked for you to relieve symptoms

_____

When is the last time you took any of the above mentioned medications? _____

Have you ever had an allergy skin test? _____ allergy shots? _____ did they work? _____

If yes, date _____ Physician's Name _____

Do you suffer from uncontrolled asthma or reduced lung function? ____ Yes ____ No

Have you had a severe allergic reaction or anaphylaxis reaction? ____ Yes ____ No

Have you ever been hospitalized due to uncontrolled allergies? ____ Yes ____ No

Do you suffer from any cardiovascular disease? ____ Yes ____ No

Do you take any beta blockers to treat your heart disease? ____ Yes ____ No

TEXAS FAMILY WELLNESS CLINIC

Clinic Policies & Patient Agreement

Our mission at Texas Family Wellness Clinic (TFWC) focuses on achieving and maintaining optimal health through lifestyle modifications. These include appropriate nutrition, exercise, hydration, rest, and stress reduction. We will offer medicinal treatment when necessary to manage disease. We feel that lifestyle modifications will limit the need for medication and will help you to achieve the best health possible.

Below you will find our office policies that you must read and sign before seeing any of our providers. All forms must be completed before your appointment.

Appointments

Please arrive on time for your appointment. Late arrivals will not be seen and will be rescheduled for a different date or time. Same day appointments are available, but must be made by phone or online. Please schedule your appointments as far in advance as possible. If you need to reschedule or cancel your appointment please let us know at least 24 hours before your appointment. All no show, cancelled, or re-scheduled office appointments with less than a 24-hour notice will be charged a $50.00 administrative fee. Payments of this balance will be required prior to scheduling any further appointments. Failure to pay may jeopardize the doctor / patient relationship.

Requests for any paperwork to be completed by a provider will require its own separate office visit. Depending on the amount of time needed to complete the paperwork, that may be the only thing covered during that visit. Please let the front office clerks know about the paperwork when scheduling the appointment. Our team may be able to accommodate you prior to the visit or get the process started if we have the paperwork prior to the scheduled appointment.

A problem visit consists of evaluating a presenting disease, condition, illness, injury, symptom, sign, findings or complaint. Keep your appointment to a minimum of three problems or concerns, so that the provider can spend the appropriate amount of time on each complaint. If you have more than three problems or reasons (i.e. medication refill) to see the provider, please schedule another appointment to discuss those issues at another time. A physical exam visit or an “Annual Wellness Exam” is a visit that consists of a comprehensive preventative and maintenance exam and does <u>not</u> include problems or other concerns/reasons. The provider may decide to do a complete physical exam and a problem visit on the same date of service. Your insurance may require you to pay an additional co-pay, co-insurance, or deductible to cover the 2nd encounter/visit. You will be responsible to pay this at the time of service.

Bring all of your medications with you to each visit. If you cannot bring the actual bottle of medicine, you’ll need to bring a list that includes the name of the medicine, dose amount, instructions, amount left in the bottle, and number of refills still available. If we will be doing any lab work at your visit, be sure to know if it requires that you fast for the test.

Payments & Insurance

Please bring a photo ID to each visit, along with any insurance cards to verify your coverage.

All fees for services rendered must be paid at the time of service. For patients on insurance plans, we will make a reasonable attempt to determine insurance benefits. All co-pays, co-insurance, or deductibles are due at the time of service. We will then bill your insurance carrier according to our billing agreement. For services rendered to minor patients, the adult accompanying the patient and/ or parent or guardian with custody will be responsible for payment at the time of service. For surgical procedures, a deposit is required to be paid prior to the procedure.

We have made arrangements with most insurance carriers to accept assignment of benefits. We will bill your insurance carrier on your behalf according to the following agreements. I hereby authorize and direct my insurance carrier(s), including Medicare, to issue payment directly to Texas Family Wellness Clinic/Dr. Ron Guevara, D.O. for medical services rendered to me or my dependents and authorize Texas Family Wellness Clinic to:

- Release any information necessary to insurance carriers regarding my illness and treatments,
- Process insurance claims generated in the course of exam or treatment,
- Allow a photocopy of my signature to be used to process insurance claims, and
- Determine insurance eligibility.

Patients will be asked to provide insurance cards, social security number, and driver's license prior to service and are responsible for informing the office of any changes in their insurance carrier, eligibility, and for any amount not covered or paid by your insurance. Delinquent accounts greater than 60 days will be assessed an administrative fee and may be turned over to a collection agency, unless financial arrangements for payments are made and are on time as agreed by both parties.

Minors & Medical Power Of Attorney

Minor patients (patients under 18 years of age) must be accompanied with a parent or legal guardian during their visit. If a parent or legal guardian cannot be present, written authorization from a parent or legal guardian must be presented to TFWC prior to the visit. Our staff will receive the document, contact the parent or legal guardian to confirm & scan the document received into the file. Once this process has been completed, it will not be required again at any other visit thereafter.

If you are the caretaker of a disabled or elderly patient and have documentation proving that you have the power to make medical decisions with a Medical Power of Attorney, please bring these documents with you for our staff to document in the patient's electronic chart. Our team will then communicate with you directly, rather than the patient moving forward. We will initiate a discussion to understand your specific situation on when to include the patient in medical discussions and decisions and when not to, depending on their cognitive situation.

Communication

At Texas Family Wellness Clinic, we value your health and your trust in us for your family's wellness. Please know that we are taking steps to provide the most cutting-edge strategies to keep in touch with you to navigate through the process of becoming a new patient, updating your medical chart each time there is a visit, confirming your appointment, educating you on healthy lifestyle tips, and motivating you to make the right choices to benefit your long-term health. With that being said, it is imperative that you provide us with

your current cell phone number and email address. Our team will be sending you as much or as little information that you would like. When you provide us with your cell phone number and email address, we will send you interactive texts/emails to confirm/cancel your appointment, update your insurance info or verify it's correct, complete your introduction for the provider by answering a review of systems survey, sign documents, such as policies/procedures, HIPPA forms prior to your visit from the leisure of your own home or on the go via email and text message the day before your appointment ~ before you even arrive to the clinic. Please note that these steps are in place to provide you with a shorter wait time in our lobby and more time with the provider to discuss your concerns. Your patient portal is another vital tool that will be used by our team to update you on any developments concerning your medical records, appointments, lab results, and much more. Please do not hesitate to ask our staff about these tools and how to get them set-up on your electronic devices or how to utilize them to your advantage. Signing up for our monthly newsletter and following us on Facebook is another critical way to learn about our services, advice from the providers on your health regarding a wide variety of topics, and instructions/tutorials on how to use the interactive tools we offer to communicate with our team outside of a visit or before the visit.

Courtesy

Out of respect for other patients, staff, and providers we ask that you quietly use your cell phone device or tablet during your visit & put your device(s) on silent. If you need to take a call or make a call, we ask that you step outside in the parking lot to do so. Spectrum customers are welcome to use the spectrum guest hotspot for free up to 30 minutes.

If you are exhibiting signs of COVID-19, Influenza and/or any symptoms such as fever, sneezing, and/or coughing please wait in your vehicle and call the office to let us know you have arrived for your visit. We will then instruct you to come in by having a staff member escort you directly back to an exam room.

Privacy Policy

All medical records and other individually identifiable health and billing information used or disclosed by us in any form will be kept properly confidential according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Reasons for Termination of Physician - Patient Relationship.

If you do not comply with our policies or if one of our providers feels that we are not able to treat or serve you, TFWC may terminate our relationship with you for any reason.

By signing, I acknowledge that I have read the clinic policies & I understand the clinic policies above.

_____	____/_____/____
Patient's Name (Please Print)	Patient's DOB
_____	_____
Patient's Signature	Date
(Or Guardian, if patient is a minor)	

TEXAS FAMILY
WELLNESS CLINIC

Patient Authorization for Use & Disclosure of Protected Health Information (PHI)

I authorize Texas Family Wellness Clinic (TFWC) to use and disclose protected health information (PHI) about me to continue medical treatment, payment, and health operation (TPO).

With this authorization, TFWC may call my home, or other designated location and leave a message on a voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any and all calls pertaining to my medical care, including laboratory results among others.

With this authorization, TFWC, may mail to my home address or other designated location items to assist the practice in carrying out TPO, such as appointment reminder cards, patient billing statements, referral appointments and any and all information pertaining to my medical care as marked confidential.

With this authorization, TFWC, may email to the email address provided or other designated location items to assist the practice in carrying out TPO, such as appointment reminder cards, patient billing statements, referral appointments and any and all information pertaining to my medical care as marked confidential.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to refuse to sign this authorization. If I do not sign this consent, TFWC, may decline to provide treatment to me. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 15406 Northwest Blvd., Ste. B, Robstown, Texas 78380.

By signing this authorization form, I am consenting to TFWC's use and disclosure of my PHI to carry out TPO.

_____ ____/_____/____

Patient's Name (Please Print) Patient's DOB

_____ _____

Patient's Signature Date

(Or Guardian, if patient is a minor)

TEXAS FAMILY WELLNESS CLINIC

Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists.

The information may be used for diagnosis, therapy, and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio & video
- Output data from medical devices & sound & audio files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient information and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain in his/her location while obtaining test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to -

- In rare cases, information transmitted may not be sufficient (e.i. Poor resolution of images) to allow for appropriate medical decision making by the provider.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocols could fail, causing a breach in privacy of personal medical information
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgement errors

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
- I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform my provider of electronic interactions regarding my care that I have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to the use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Texas Family Wellness Clinic to use telemedicine in the course of my diagnosis and treatment.

_____ ____/_____/____

Patient's Name (Please Print) Patient's DOB

_____ _____

Patient's Signature Date

(Or Guardian, if patient is a minor)

TEXAS FAMILY WELLNESS CLINIC

Patient Medication Agreement

The following conditions must be agreed upon prior to treatment at Texas Family Wellness Clinic (TFWC) for any condition that requires the utilization of medications.

- I understand that TFWC only addresses pain of an acute nature and does not participate in the long term management of pain (greater than 30 days).
- As a patient, I can expect to be referred to the appropriate specialist to address the root causative factors and to a pain management specialist for the management of my chronic pain medication needs.
- I understand that failure to establish a timely doctor/patient relationship with the appropriate specialist or pain management specialist may result in a gap in care and may result in my being without medication.
- I will not use illegal substances, street drugs, abuse alcohol or take controlled medications prescribed for other people.
- I will not be involved in the sale, illegal possession, diversion or transport of controlled substances like narcotics, sleeping pills, “nerve pills”, or stimulants.
- I will not share my medications.
- I agree to submit to drug screening tests as required by my healthcare provider.
- I agree to obtain all prescriptions for controlled substances from TFWC until I have been appropriately established with a pain management specialist at which time I will only receive medications from my pain management provider. I will not attempt to obtain any controlled medication from any other healthcare provider.
- I will take medications only as they are prescribed.
- I agree to communicate fully, without misrepresentation, the need for and the effect of any controlled medicines prescribed.
- I agree to follow-up with my healthcare provider as required for the management for the condition for which I obtain controlled medication for. No prescriptions will be given over the phone or after hours. IF there is a need to change any controlled medication prescription, a new, non-urgent appointment must be obtained.
- I agree TFWC has the right to communicate with other healthcare providers and pharmacists regarding my care as deemed necessary.
- I will safeguard my controlled medications. I understand NO ALLOWANCES will be made for lost/stolen prescriptions or medications.
- I understand that an office visit is required for the renewal of prescriptions of medication in which all refills have been utilized.
- I agree that I will use my medications at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- I understand that as long as I keep my follow-up appointments, my long-term medications will be prescribed to last until the next follow-up visit.
- I understand this mode of treatment will be stopped if any of the following occur: 1.) I give away, sell or misuse my medications or other people’s medications, or illegal substances. 2.) I am non-compliant with any of the terms of this agreement. 3.) I disrespect or harass clinic personnel.

_____ ____/_____/____

Patient’s Name (Please Print) Patient’s DOB

_____ _____

Patient’s Signature Date

(Or Guardian, if patient is a minor)

TEXAS FAMILY WELLNESS CLINIC

LAB POLICY NOTIFICATION

At Texas Family Wellness Clinic we strive to provide the best quality of care to our patients. We have hired a Phlebotomist to be on-hand for our patients' convenience. If you choose to use our services, please schedule an appointment with our Lab in addition to your office visit with the provider to take care of any lab work. Our staff will assist you with scheduling your Lab Visit either before or after your doctor's visit, whichever is appropriate for your personal circumstances and in respect to the doctor's request.

This notification is to inform you that although your labs may be drawn in our office, we DO NOT bill your insurance for the labs that are drawn (except for finger stick A1C, Lipid tests, and certain urine tests). Most all labs that are drawn in our office are billed by your preferred lab company on your behalf to your insurance.

Please be aware if your preferred lab company of choice is not covered by your insurance policy, you will need to work that out with the lab and your insurance. We are not responsible for checking if your lab work is covered under your insurance policy and which lab company is their prefered lab partner.

If you receive a bill from the lab company, you will need to call their billing department to address your questions/concerns.

If you have any other billing questions/concerns, you may call Texas Family Wellness Clinic at (361) 933-1188 and ask for Amie Guevara, Office Administrator.

*Below please choose **one lab company** you prefer to use and/or your insurance's preferred lab partner.*

- ❑ CPL
- ❑ Quest
- ❑ LabCorp

Patient's Name: _____
(Please Print)

Patient's Signature: _____ Date: _____

PATIENT CONTACT CONSENT FORM

At Texas Family Wellness Clinic we strive to offer top-notch patient care. We want to offer our patients with the latest technology and resources in order to have immediate access to their medical information and connect with our staff.

These resources include eMessenger "Texts", FREE Patient Portal, Healow App for any smart device, and our monthly FeelGood Newsletter. Some of the features provided include, but are not limited to - access to view medical records and lab results, the ability to update your contact information, update insurance, update medication list, communicate with various staff with requests and questions. As an established patient you'll be able to schedule appointments, confirm appointments, sign consent forms, check-in prior to arriving at the appointment "contactless check-in", virtual telemedicine visits, and pay your account balance and co-pays for future visits online/on your phone.

Once you've provided us with your email address, you will receive an email to set-up your Patient Portal to set your password. This portal can be accessed from a computer. Once your Patient Portal is set-up, you'll be able to download the Healow App for free from your phone's app store for FREE. This is the SAME log-in as your Patient Portal. The Healow App is basically a phone version of your computer Patient Portal. Both of these resources can be used to accomplish all of the features stated above.

Our TFWC FeelGood Newsletter will be sent via email once a month to patients that ask to receive it. The newsletter will have information on a variety of topics to keep you motivated, tips on how to get the most out of our services & your doctor's visits. We'll even provide you with Dr. G Approved products, recipes, and a whole lot more!

Please select below which resources you'd like to utilize & please provide us with your email & cell phone number. If you do not have a cell phone or email, please write "DO NOT HAVE" and sign the form.

- ❏ eMessenger "Texts" (Appt. Reminders/Confirm Appt./Contactless Check-in)
- ❏ Patient Portal
- ❏ FeelGood Newsletter

Patient's Name: _____ DOB: ____/____/____

Cell # _____ Email: _____

By signing below, I understand that I am giving Texas Family Wellness Clinic permission to email me and text me about the services & resources stated above.

X_____

Patient's Signature

TEXAS FAMILY WELLNESS CLINIC

MEDICAL RECORD REQUEST

Date Requested: ___/____/____

Requesting Medical Records from: _____

Phone #: _____ Fax #: _____

Please forward the following:

___ Last 5 Progress Notes
___ Most Recent Labs
___ Imaging
___ Cardiac Test Results

Patient's Name: _____

Address: _____

_____

Date of Birth: ____/____/_____

Patient's Signature: _____

Forward all records to -
Texas Family Wellness Clinic
% Ron Guevara, D.O.
15406 Northwest Blvd., Ste. B
Robstown, TX 78380

SECURE EMR/MEDICAL RECORDS FAX LINE: 800-990-5305
We also accept records via eClinicalWorks with P2P