



CONSENT TO TREATMENT AND ACKNOWLEDGEMENT OF OFFICE POLICIES & PROTOCOLS

First Name <small>(as it appears on your insurance card)</small>	MI	Last Name <small>(as it appears on your insurance card)</small>	Suffix	Date of Birth
Home Address	City, State		Zip	Gender
Race:	Ethnicity:		Language:	
E-mail Address: <small>(needed in order to be web-enabled to our patient portal)</small>				
Social Security Number	Emergency Contact (Name)		Relation	Emergency Contact #
Responsible Party <input type="checkbox"/> Self <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Other Name: _____ Relation: _____ Phone#: _____ Social Security#: _____				
Pharmacy Name	Pharmacy Address		Pharmacy Phone #	
Insurance Name	Insurance Phone #		Are you self-pay?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

CONSENT FOR TREATMENT:

I give consent for my treatment including examinations and the use of diagnostic and therapeutic remedies and medical equipment, that may be provided or prescribed by a physician, midlevel provider (nurse practitioner or physician's assistant), and/or staff of Family Medicine Associates of Conroe, PLLC (FMAC). I may revoke this consent, in writing, at any time, provided that the treatment has not already occurred. I am encouraged to see the first available provider to minimize a delay in diagnosis, lapse in treatment, or delay in immunization or other preventive testing which might cause me unnecessary or unforeseen harm. I have read, understand, and agree to the Notice of Privacy Practices for Family Medicine Associates of Conroe.

ACCESS TO MY HEALTH INFORMATION:

I give consent for FMAC to access my protected health information by contacting hospitals, pharmacies, labs, healthcare providers, insurance companies, and healthcare-related prescription and immunization databases. I authorize FMAC to contact me and those I designate below with protected health information and without restriction, including lab and test results, by phone, text, mail, and e-mail. I am aware that my test results will routinely be posted to my online portal. Not using my portal may delay my getting important information about my health, including critical lab results, educational materials, and visit summaries. I am aware that this office sends prescriptions electronically. I will notify FMAC when my contact information changes, including phone numbers, e-mail addresses, and mailing addresses, to minimize potential harm that may be caused to me when I cannot reach me with abnormal or critical results.

Please allow these people to have access to my health information, accept test results, and take messages for me:

NAME: _____ RELATIONSHIP (circle): spouse parent child friend other
 NAME: _____ RELATIONSHIP (circle): spouse parent child friend other

FINANCIAL AGREEMENT:

I agree to pay all deductibles, co-pays, account balances, procedure deductibles, and all other fees in-full at the time of service. I direct my insurance carrier to pay FMAC directly on my behalf. However, when my account has a balance for any reason, including charges not covered or not paid for by insurance or Medicare, I remain responsible for the charges and will be billed by mail or electronically for the balance in full, including a monthly billing service fee of \$5. If FMAC does not receive payment for the full balance within 30 days, a late administration fee of up to 20% of my unpaid balance (\$25 minimum) plus the \$5 billing service fee will be added to the previous balance. Balances that remain outstanding for 60 days or more may be turned over to a collection agency. Billing fees and office fees are subject to changes based on postal rates and office costs.

ADMINISTRATIVE SERVICES & FEES NOT COVERED BY INSURANCE OR MEDICARE:

- **SAME DAY CANCELLATIONS:** Appointments must be canceled **PRIOR TO 9 AM** to avoid a \$50 administrative fee charged for same-day cancellations.
- **NO SHOWS:** Patients who miss an appointment without notifying our office prior to the appointment will be charged a \$50/75/100 administrative fee for their 1st/2nd/3rd missed appointments. Individuals who leave the office after checking in for an appointment but without being seen by the provider will be charged the fee for a missed appointment.
- **INSUFFICIENT FUNDS:** \$50 administration fee for checks written with insufficient funds.
- **PHONE CONSULTATIONS:** Phone consultations outside of an office visit, including weekend and evening calls to the answering service to speak to the provider on-call, will be billed as fee-for-service at a rate of \$45 per 15-minute increment as fee-for-service and will not be billed to insurance.
- **OFFICE FEES:** Fees for photocopying (\$3 minimum), mailing (\$5 minimum), and completion of forms outside of an office visit (\$25 minimum) are due at the time of service. Administrative fees are subject to change.

OFFICE BEHAVIOR, CELL PHONE USE, AND NO SMOKING POLICY:

Talking on cell phones is not allowed in the clinic. Please keep cell phones turned off or on a silent mode. Recording or videoing a FMA employee is prohibited. Profanity, vulgarity, rudeness, yelling, or threats of any kind—in person or with office staff over the phone—will not be tolerated. Anyone violating these policies on the day of an appointment may be asked to leave the building (will be charged an administrative fee as a missed appointment) and/or may be asked to find another family medicine home for their medical care. FMA operates a smoke-free and tobacco-free campus. I will be responsible for cleaning fees (\$50 minimum) if I cause property damage or leave a mess behind, including trash or tobacco-related/smoking-related debris.

CONSENT FOR DRUG TESTING AND CONTROLLED SUBSTANCE POLICY:

As a patient of FMA, I consent to random drug testing, either by blood or urine. I agree to use one pharmacy for controlled substance prescriptions (such as pain medications, narcotic cough suppressants, anxiety medications, muscle relaxers, stimulants for sleep apnea or attention deficit, and appetite suppressants). I agree to not use marijuana, other illegal drugs, or take another individual's prescriptions while I am taking a controlled substance. I will not sell or share any of my prescribed medications to anyone. Violations of any one of these policies will make me ineligible to receive future prescriptions for controlled substances from FMA providers.

APPOINTMENT TYPES USED IN OUR OFFICE:

- (1) **ANNUAL WELLNESS VISIT FOR ADULTS:** All patients of FMA are encouraged to schedule an annual wellness visit. Neglecting to schedule an annual wellness visit may delay addressing potential risk factors that I may have for developing cancer, heart disease, stroke, and can put off significant screening tests and immunizations that may help me live a longer and healthier life.
- (2) **SICK (ACUTE) APPOINTMENTS** will be scheduled to evaluate a new symptom or a chronic problem that is getting worse. Routine health concerns and refills are not handled during sick/acute appointments.
- (3) **FOLLOW-UP (REFILL) APPOINTMENTS** are scheduled to monitor the progress of previously identified health concerns and to write prescription refills. New/acute health concerns are not handled during sick/acute appointments.
- (4) **WELL-CHILD VISITS** are scheduled to review growth, update immunizations, and monitor developmental milestones.
- (5) **PROCEDURE APPOINTMENTS** are scheduled for knee, hip, or shoulder injections; skin biopsies; cyst removals; ingrown toenail removals; muscle spasm injections; elbow injections; wart removals; abscess treatment; IUD management; newborn circumcision; screening treadmill stress tests; home sleep studies; cryotherapy (liquid nitrogen) treatments for common skin cancers and benign skin lesions; dementia/memory evaluations; cosmetic procedures. Refills & acute health concerns are not handled during procedure appointments.
- (6) **SMART WEIGHT LOSS APPOINTMENTS** are scheduled with our Wellness Coach.

I HAVE READ THIS 2-PAGE DOCUMENT AND AGREE TO THE TERMS.

YOUR SIGNATURE

TODAY'S DATE

Family Medicine Associates of Conroe, PLLC
2236 N Loop 336 West
Conroe, TX 77304
Phone: 936.441.2003 Fax: 936.494.4023

Medical History

Date _____

Name _____ Age _____ Birthdate _____
 Address _____ Sex Male Female
 _____ Home Phone _____
 _____ Work Phone _____
 Social Sec _____ Email _____
 Occupation _____ Emergency Contact _____
 Emergency Phone _____

Single Married Divorced Widowed Separated

If married, spouse's name _____

Children's names and ages _____

Pharmacy (Name, Phone#, Address) _____

2nd Pharmacy (Mail Orders) _____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name Dose Drug Name Dose Drug Name Dose

Allergies to Medications, X-Ray Dyes, or Other Substances Yes _____ No _____

(If yes, please list name of medicine and type of reaction)

List previous hospitalizations/ surgeries/ serious injuries **Year?**

Medical History

Name _____

Date _____

Past Medical History and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Unexplained weight | <input type="checkbox"/> Low back problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Persistent cough | gain/loss | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> T.B. | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Chest pain/chest tightness | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Venereal diseases |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Colitis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Nausea | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Head or neck radiation | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Leakage of urine | <input type="checkbox"/> Impotence or |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Difficulty urinating | Erectile dysfunction |

Gynecologic and Obstetric History

Age at Onset of Periods _____ Frequency _____ Length of Period _____

Age at Onset of Menopause _____

Pregnancies _____ Births _____ Miscarriages _____

Prolonged or Abnormal bleeding _____ No _____ Yes, Explain _____

Leakage of Urine _____ No _____ Yes, Explain _____

Pelvic Pain _____ No _____ Yes, Explain _____

Abnormal Discharge _____ No _____ Yes, Explain _____

History of Abnormal Pap Smear _____ No _____ Yes, Explain _____

Please List and Supply the Dates

Immunizations history - have you had:

Shingles Vaccine No Yes When? _____

Pneumovax Vaccine No Yes When? _____

Flu Vaccine No Yes When? _____

Tetanus Shot No Yes When? _____

When was your last:

Pap smear _____ Breast exam _____ Colon Cancer Test _____

Mammogram _____ Cholesterol Check _____ Prostate Exam _____

Medical History

Name _____

Date _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members	Age
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other _____	_____	_____

Prevention

- Do you exercise regularly? Yes No How many days a week? _____
- Do you smoke? No Yes How many per day? _____
- Do you drink alcoholic beverages? No Yes How much per week? _____
- Do you drink caffeinated beverages? No Yes How many cups a day? _____
- Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? No Yes Explain: _____
- Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? No Yes
- Do you ever feel afraid of your partner? No Yes N/A
- Do you have a 'living will'? Yes No

This information is for use by your physician as part of your confidential medical records.

Family Medicine Associates of Conroe, PLLC
Gregg M. Hallbauer, DO, MCG, FAAFP
Board Certified Family Physician
2236 N Loop 336 West
Conroe, TX 77304
Phone: 936.441.2003 Fax: 936.494.4023



HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize use or disclosure of my protected health information as described below to Dr. Gregg M. Hallbauer and partners to continue my medical care.

PATIENT NAME: _____ DATE OF BIRTH: _____

PLEASE REQUEST RECORDS FROM: _____

I REQUEST MY PRIVATE HEALTH RECORDS BE MAILED OR FAXED TO:

Family Medicine Associates of Conroe
2236 N Loop 336 West
Conroe, TX 77304
Fax#: 936.494.4023

A CHECK IN THIS BOX INDICATES THAT THIS INFORMATION IS NEEDED URGENTLY AND THAT I AM AUTHORIZING AND REQUESTING THAT IT TO BE FAXED TO DR. GREGG HALLBAUER AT 936-494-4023 AS SOON AS POSSIBLE.

DESCRIPTION OF INFORMATION I REQUEST TO BE RELEASED:

- | | |
|---|---|
| <input type="checkbox"/> Immunizations/vaccine chart | <input type="checkbox"/> Most recent 6 months of progress notes |
| <input type="checkbox"/> Last mammogram report | <input type="checkbox"/> Most recent 6 months of laboratory results |
| <input type="checkbox"/> Last colonoscopy report | <input type="checkbox"/> Last stress test or nuclear stress test report |
| <input type="checkbox"/> Last EKG | <input type="checkbox"/> Last echocardiogram report |
| <input type="checkbox"/> Last PAP smear report | <input type="checkbox"/> Last bone density (DEXA) report |
| <input type="checkbox"/> Most recent well-child visit | <input type="checkbox"/> Last MRI report |

Other: _____

I understand that the information disclosed may be subject to re-disclosure by the persons receiving it and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Family Medicine Associates of Conroe in writing of my desire to withdraw it. However, I understand that any action already taken in advance of this authorization cannot be reversed and that my revocation will not affect those actions. I also understand that the medical provider to whom this authorization is furnished may not condition his/her treatment of me on whether or not I sign the authorization. This authorization will expire in 1 year unless otherwise noted by me on this form.

SIGNATURE OF PATIENT

DATE

DATE OF BIRTH OR SSN#

SIGNATURE OF GUARDIAN
(if applicable)

DATE

GUARDIAN'S AUTHORITY
TO SIGN ON PATIENT'S BEHALF