



TEXAS FAMILY HEALTHCARE

Board Certified in Family Medicine

7777 Forest Lane, Suite A-222

Dallas, Texas 75230

Phone: 972-566-7970

Fax: 972-566-5983

Please provide us with a daytime phone number, so we can inform you about any **test results** you are expecting. If you would like a copy of you labs, please inform the caller at that time.

Home: _____

Work: _____ Ext. _____

Cell or Alternate #: _____

May we leave a voicemail/recorded message at this number yes or no _____

Print Name: _____

Signature: _____

Date: _____

NOTE: If phone contact cannot be made a letter will be sent, please check the accuracy of all information.

BRUCE B. HENRY, M.D., BRADLEY J MUSSER MD, RACHNA PATEL, PA-C EMILY ZHU, PA-C, ANN FONTANA PA-C, ANDREA BEAVERS PA-C

PATIENT PROFILE

Patient Information

Last Name: _____ MI: _____ First: _____

Sex: M F

Date of Birth: _____

Address: _____

City/State: _____

Zip Code: _____

Home Phone: _____

Cell/Other Phone: _____

Work Phone: _____ EX _____

TX DL#: _____

Social Security#: _____

Marital Status: Married Single Other

Patient Employment

Employed Retired Other

Employer: _____

Address: _____

City/State/Zip: _____

Occupation: _____

Insured Party

Same as Patient

Relationship to Patient: _____

Name: _____

Address: _____

City/State/Zip: _____

Social Security #: _____

Date of Birth: _____

TX DL#: _____

Referring Physician: _____

Emergency Contacts

Insured Employment

Employed Retired Other

Employer: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Occupation: _____

Primary Insurance Carrier

Same as Patient Same as Insured Other

Name of Carrier: _____

Insured's ID#: _____

Insured's SS#: _____

Policy#: _____

Group #: _____

Pharmacy Information: We must have one Pharmacy on file.

Local Pharmacy: Name Address & Phone Number

1. _____

Name of Mail-order Company: _____

Information of form is correct:

Signature: _____

HEALTH QUESTIONNAIRE

HOSPITALIZATIONS <i>IF YOU HAVE BEEN IN A HOSPITAL OVERNIGHT-STATE THE YEAR-ILLNESS/SURGERIES (PLEASE START WITH THE MOST RECENT EVENT)</i>	
YEAR	ILLNESSES

YEAR	SURGERIES

LIST ALL MEDICATIONS YOU TAKE: PRESCRIPTION, OVER THE COUNTER, & HERBAL					
MEDICATION	DOSE	TIMES/DAY	MEDICATION	DOSE	TIMES/DAY
1.			12.		
2.			13.		
3.			14.		
4.			15.		
5.			16.		
6.			17.		
7.			18.		
8.			19.		
9.			20.		
10.			21.		
11.			22.		

DRUG INTOLERANCE & ALLERGIES:	
DRUG	REACTION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	



Dear Patients:

We are upgrading our computer system to better serve you, our patient, more efficiently. In order to enter you information into our system, we must have your email address as well as your birth date.

Please list your birth date and email address below:

Date of Birth: _____

Email Address: _____

Patient Name: _____

By giving us your email it will automatically enroll you in our patient portal.

Thank you for your cooperation in advance.

Texas Family Healthcare



Informea Consent Agreement for Controlled Substance Medication Management

The purpose of this agreement is to give you information about your responsibility in the proper use of these medications; and the role you will play in your treatment. The overall goal of treatment is to provide the best quality of life possible given the reality of your clinical condition.

Please initial the following:

____ 1) I understand that the daily use of controlled substances may lead to physical dependence, tolerance and/ or addiction.

- **Psychological Dependence** is a feeling of well-being produced by the long term use of some medications. Absence of the medication may produce feelings of anxiety, irritability, depression or cravings.
- **Tolerance** is a physical state resulting from regular use of the drug in which an increased dose is needed to produce the same effect. Tolerance does not always occur with controlled substance treatment and does not alone indicate addiction.
- **Addiction** is the lack of control over drug use, including taking drugs more often than prescribed. Genetic, psychological and environmental factors may influence the addiction. Signs of addiction or misuse may result in a referral to be evaluated for substance abuse, as well as discontinuation of the controlled substance as decided by the provider.

____ 2) I understand that taking higher doses than prescribed by my provider may result in a drug overdose.

____ 3) I have received a handout and / or had a discussion with the provider, pharmacist, or clinic support staff about the effect of the medication, and have been given the opportunity to ask questions about my condition and treatment. The risks and hazard of treatment and no treatment have been explained.

____ 4) I will tell my providers about all medications and substances I take so that they will understand the potential interaction with my other medications.

____ 5) If I have a history of alcohol or drug misuse/addiction, I must tell the provider immediately as such history since the treatment with controlled substances may increase the possibility of a relapse. Starting or continuing a program for recovery may be suggested or required.

____ 6) I understand that there is no guarantee of a cure with these medications. I acknowledge receipt of the agreement portion of this document. I have been given a signed copy of this document.

____ 7) I will not illegally sell or distribute my prescription to anyone. Any illegal use or distribution will not be tolerated and will result in patient termination from the practice at any visit.

____ 8) Per DEA guidelines and regulations we may require you to perform a random urine screen our office.

I hereby give my voluntary consent to participate in the controlled substance medication management program.

Signature _____

Date _____



June 8, 2015

Controlled Substance Policy Addendum

Recent changes in the law under the Drug Enforcement Administration (DEA) require strict control and supervision of controlled substances such as hydrocodone, Adderall, Vyvanse, etc. Since we prescribe these medications, we have put new policies in place to follow the DEA requirements:

- ✓ Controlled substance agreement: every **year**
- ✓ Urine drug screen: every **6 months** and/or randomly as determined by your provider
- ✓ AssessMD testing: every **6 months** or as determined by your provider
- ✓ Appointments: every **3 months** or as determined by your provider
- ✓ Prescriptions: **30 day** supply only. No postdating, mailing prescriptions, etc.
- ✓ Refills: **2** maximum. Register on portal or call to request meds at least **72 hours** before you need a refill. You must pick these up in person and sign for them at the front desk.
- ✓ Only **1** pharmacy on file

Any violation of these policies will be considered noncompliance with treatment and a provider may refuse to continue prescribing controlled substances to a patient. If you have any other questions, please ask your provider.

Patient signature/date

Provider signature/date



Authorizations and Consents

Consent to Treat: I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize all medical treatments considered necessary or advised in the judgment of the physician employed by Texas Family Healthcare.

Consent for Use and Disclosure of Protected Health Information: I hereby give my consent for Texas Family Healthcare to use and disclose protected health information about me to carry out treatment, payment, and health care operations.

With this consent, Texas Family Healthcare may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Texas Family Healthcare may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders and patient statements as long as they are marked "Personal and Confidential".

By signing this form I am consenting to allow Texas Family Healthcare to use and disclose my protected health information.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Texas Family Healthcare may decline to provide treatment to me.

I have read the authorizations, consents, and agreements and I accept the terms as described above.

Signature of Patient or Legal Guardian

Date

Print Patient's Name

Print Name of Legal Guardian (if applicable)



Financial Policy

Welcome to Texas Family Healthcare, P.A. In order for our staff to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

We ask that you present your insurance card at each visit.

If you have a change of address, telephone numbers or employer, please notify the receptionist.

We will collect your deductible, co-payment, or charge for non-covered service at your time of visit. If you have a balance after an insurance payment from a previous service we will also ask for that payment.

If we do not participate with your insurance company or we cannot verify your coverage, you will be expected to make payment in full at time of service.

We will submit you claims and assist you in any way we reasonably can to help get your claim paid.

Your insurance benefit is a contract between you, your employer, and the insurance company. We are not party to that contract. It is very important that you understand the provisions of your policy; we cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

If your insurance denies the charges or if your account becomes delinquent we reserve the right to refer your account to a collection agency and report it to the credit bureau.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at 972-566-7970.

I have read and have a full understanding of the financial policy of Texas Family Healthcare, P.A.

Signature of Patient or Legal Guardian

Date

Print Patient's Name

Print Name of Legal Guardian (if applicable)



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your Privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Texas Family Healthcare, PA (hereinafter referred to as “the Practice”), privacy is one of our highest priorities.

Keeping Your Information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to Meet Your Needs through Information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping Information Accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate, or not current, please call or write us at the telephone numbers or addresses listed below. WE take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How-and-Why Information is shared

We limit who receives information and what type of information is shared.

- Sharing Information Within the Practice

We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- Sharing Information With Companies That Work For Us

To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- Other

Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

“The Practice” does not share any customer information with third-party marketers who offer their products and services to our patients.

Count On Our Commitment to Your Privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us-whether it's at our office, over the phone or through the Internet.

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Revised June 8, 2015

RE: Test result reporting (blood work, ultrasounds, MRI, CT, etc.) Frequently Asked Questions (FAQs)

Q: How long does it take for test results to come back?

A: 5-7 business days. Your provider reviews them once they arrive in our inbox.

Q: How will I find out about my test results?

A: We will send test results either by MAIL or by PORTAL. Please let us know your preference. If abnormal, we will also call you to make a follow up appointment. This allows your provider to explain the results to you, answer your questions, and work with you on an appropriate treatment plan.

Q: Why can I not receive test results over the phone?

A: To ensure patient confidentiality, privacy, and consistency.

Q: How do I start using the portal?

A: Pre-register, pre-register, pre-register! At checkout, ask for a temporary username/temporary password and register within 7 days after your appointment. You CANNOT pre-register on your cell phone or tablet. There is no site or URL with which to log in.

Q: How do I know if I have received a lab result or message on the portal?

A: You will receive an email if we send you something through the portal. Please remember to check your spam folder.

Thank you,

Texas Family Healthcare, P.A.

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