Family Medicine Associates of Conroe
Treating Your Family Like Ours

CONSENT TO TREATMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES & PROTOCOLS

First Name (as it appears on your insurance card)	MI	Last Name (as it appears on your insurance card)	Suffix	Date of Birth

Home Address (must be same as insurance card)	City, State	Zip	Gender

Cell Phone	Home Phone	Work Phone

Access to our healow Patient Portal? ▫Yes ▫No **E-mail Address:** **(needed to be web-enabled to our patient portal)**

User Name: _____

Race:	Ethnicity:	Language:
▫African ▫Caucasian ▫Asian ▫Other ▫Decline to specify	▫Hispanic/Latino ▫Non-Hispanic/Latino ▫Decline to specify	

Social Security Number	Emergency Contact (Name, Relation)	Emergency Contact #

Pharmacy Name	Pharmacy Address	Pharmacy Phone #

Responsible Party: ▫Self ▫Emergency Contact

▫Other Name:_____ Relation: _____ Phone#:_____ Social Security#: _____

Insurance Name	Insurance Type	Insurance Phone # (found on back of card)

Insurance Group #	Insurance Member ID #	Are you self-pay? ▫Yes ▫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

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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 FMAC, 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 and 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**

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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?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

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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:

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

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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

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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

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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:

- ☐ **Immunizations/vaccine chart**
- ☐ **Last mammogram report**
- ☐ **Last colonoscopy report**
- ☐ **Last EKG**
- ☐ **Last PAP smear report**
- ☐ **Most recent well-child visit**
- ☐ **Most recent 6 months of progress notes**
- ☐ **Most recent 6 months of laboratory results**
- ☐ **Last stress test or nuclear stress test report**
- ☐ **Last echocardiogram report**
- ☐ **Last bone density (DEXA) report**
- ☐ **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**