La Grange | Flatonia | Giddings
Family Health Centers

La Grange
O: (979) 968-8493

1253 N Von Minden
La Grange, TX 78945

Flatonia
O: (361) 865-3302
MAIN FAX LINE: 979-968-6388
230 W North Main
Flatonia, TX 78941

Giddings
O: (979)542-7400

598 Cactus St
Giddings, TX 78942

NEW PATIENT PACKET

Attached you will find the New Patient Packet that is required to become established with our practice. For your convenience, we now offer three locations:

La Grange	Flatonia	Giddings
979-968-8493	**361-865-3302**	**979-542-7400**
1253 N. Von Minden St	**230 W. North Main St.**	**598 Cactus St.**

Once the forms have been completed, please return your application in person to one of our clinics. You may also fax it to: 979-968-6388. In addition to the completed paperwork, we will need a copy of your current insurance cards (front and back) as well as your identification card. Please make sure all forms are signed and dated. Please allow our office up to 7 business days to process your application. Once your New Patient Packet has been approved, you will be contacted to schedule your first new patient appointment.

If you are needing more information or have concerns, please feel free to contact us.

Sincerely,

La Grange, Flatonia, & Giddings Family Health Center

PATIENT INFORMATION				
NAME:		DATE OF BIRTH:	☐ MALE ☐ FEMALE	
PREFERRED CONTACT: ☐ CELL ☐ HOME ☐ WORK	#:		#:	
EMAIL:	SSN:		DRIVERS LIC:	
ADDRESS:	CITY:		STATE:	ZIP CODE:
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	RACE: ☐ CAUCASIAN/WHITE ☐ AFRICAN AMERICAN/BLACK ☐ HISPANIC ☐ ASIAN ☐ OTHER			

GUARANTOR INFORMATION (SKIP IF THE PATIENT IS THE GUARANTOR)			
GUARANTOR NAME:		DATE OF BIRTH:	
MAILING ADDRESS:	CITY:	STATE:	ZIP:
RELATIONSHIP TO PATIENT:	SSN:		
CELL#:	HOME#:	ALT#:	

INSURANCE INFORMATION		
PRIMARY INSURANCE COMPANY:		
GROUP #:	POLICY #:	
POLICY HOLDER:	DATE OF BIRTH:	SSN:
SECONDARY INSURANCE COMPANY:		
GROUP #:	POLICY #:	
POLICY HOLDER:	DATE OF BIRTH:	SSN:

EMERGENCY CONTACT		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Family Health Center files insurance as a courtesy to our patients. It is the sole responsibility of the patient/guarantor to verify that the Provider and/or service they receive here are covered by their insurance/payor. Payment is due at the time services are rendered including any copay/coinsurance/deductible portions.

I, _____ (Self/Guardian/Guarantor) have read the following material; Office, Insurance, and Payment Policy and the Notice of Privacy Practices, presented to me by Family Health Center and I understand my responsibilities as the Patient/Guardian/Guarantor of this facility and that all of the information provided on this form is true and correct.

SIGNATURE: _____ Date: _____

PRINT NAME: _____ Relationship if not self: _____

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME:	DATE OF BIRTH:	TODAY'S DATE:

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Domestic Partner	□ MALE □ FEMALE

OCCUPTATION:	NUMBER OF CHILDREN:	NUMBER OF SEXUAL PARTNER:	CONTRACEPTIVE METHOD USE:

HEALTH HABITS:

TOBACCO	ALCOHOL	EXERCISE:	DIET
□ Do not use tobacco □ Cigarettes: ___ pks/day for ___ years □ Cigars/Pipe □ Dip/Chew □ Electronic Cig/Vape □ I would like to quit	□ Do not drink □ Beer: ___ bottles/day □ Wine: ___ drinks/day □ Alcohol: ___ drinks/day □ I would like to quit	□ Exercise Daily □ Exercise Regularly □ Rarely Exercise □ Never Exercise	□ Overweight □ Desired Weight □ Special Diet

SELF MEDICAL HISTORY: CHECK ALL THAT APPLY

ADHD		Depression		GERD		Alcoholism	
Anemia		High Cholesterol		Heart Disease		Osteoporosis	
Anxiety		Headaches/Migraines		Hepatitis/Liver Disease		Seizure Disorder	
Asthma		COPD		Hypertension		Stroke	
Diabetes		Bleeding Disorders		Tuberculosis		Thyroid Disease	
Cancer		What kind?		When?		Other:	

Have you been in the past 12 months or are you currently under the care of another healthcare professional? If yes, please list below:

FAMILY MEDICAL HISTORY: CHECK ALL THAT APPLY AND LIST FAMILY MEMBERS

M: Mother **MGM**: Maternal Grandmother **PGM**: Paternal Grandmother **PA**: Paternal Aunt **MA**: Maternal Aunt **S**: SIBLING
F: Father **MGF**: Maternal Grandfather **PGF**: Paternal Grandfather **PU**: Paternal Uncle **MU**: Maternal Uncle

ADHD		Asthma		Diabetes		Heart Disease	
Alcoholism		Depression		High Cholesterol		Seizure Disorder	
Alzheimer's Disease		Arthritis		Anxiety		Hypertension	
COPD		Cancer:		What Kind?		Other:	

ALLERGIES:

NAME OF MEDICATION/FOOD:	REACTION:

ALL MEDICATION(S) YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION:	DOSAGE OF MEDICATION:	DOCTOR THAT PRESCRIBED MED:
PHARMACY YOU ARE CURRENTLY USING:		

SURGERY HISTORY:		
DATE:	SURGERY/HOSPITALIZATION/MAJOR ILLNESS:	WHERE:

ANNUAL WELLNESS VISIT:		
Please provide the date of your last annual wellness visit:		

WOMEN ONLY:		
Number of Pregnancies:	Number of Miscarriages/Abortions:	Number of Live Children:
Date of last pap smear:	Result:	Date of last mammogram:
Perform breast self-exam? □ Yes □ No	Period: □ Regular □ Irregular	Menopausal? □ Yes □ No

Method of Birth Control: □ None □ Pills □ Condom □ Sponge □ Foam □ Norplant □ IUD □ Diaphragm □ Rhythm □ Tubal Ligation □ Vasectomy □ Other

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William Michael McBroom, M.D. Thomas O. Borgstedte, D.O. Wess J. Blackwell, M.D.

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AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: _____ Date of Birth: _____

MY HEALTHCARE INFORMATION

I hereby authorize the release of information as indicated:

_____ **I authorize** disclosure of healthcare information (related to my medical history, diagnosis, treatment or prognosis) to family member(s) or significant others.

_____

_____

_____ **I do not authorize** disclosure of any information regarding my healthcare. I understand that I will be considered a "NO INFORMATION PATIENT" and in the event of any emergency, the Clinic is unable to contact someone on my behalf.
*" Healthcare information" means information recorded in any form or medium that identifies the patient and relates to the patient's history, diagnosis, treatment or prognosis. It is commonly known as your "medical record".
This authorization is valid from this day forward, unless the patient informs us otherwise.

NOTE: Texas law authorized the release of healthcare information WITHOUT patient authorization in a number of situations, including disclosure to third party payers, such as insurance companies if the disclosure is to reimburse the hospital, other healthcare providers, or the patient for medical services or supplies.

_____ CONSENT: Treatment & Procedures - I give my consent to Family Health Center Doctors, Nurses, and Staff. I understand that I will have the opportunity to ask questions concerning my condition, treatment and or procedures.

_____ _____
Patient Signature Date

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PATIENT PORTAL AUTHORIZATION FORM

The La Grange/Giddings/Flatonia Family Health Clinic is offering this secure HIPAA complaint communication tool as a courtesy to our patients. It is an optional service and we reserve the right to suspend or terminate it at any time; we will alert you of any changes as promptly as possible. This form is intended to inform you of the facts and risks surrounding the sue of the web portal. By signing below, you confirm that you have read, understand and agree to comply with the procedures and guidelines for using the Patient Portal. You also agree not to hold the La Grange/Giddings/Flatonia Clinic or any of their staff liable for network infractions beyond their control, Privacy and Security.

Our website http://lgtxhealth.com has a secure tunnel connection with our clinic that uses Encryption to keep unauthorized person's from being able to access and read your health information or your communication with us. To help ensure that the tunnel remains secure, we need to have your current private email address and be informed if it ever changes. Always keep your portal User ID and Password secure so only you or someone authorized by you, can gain access to your patient information. If you think someone has learned your password, immediately log into your portal account and change it.

Your email address is confidential and protected information. With our best effort, we will protect this information, as we do your medical and other personal information. We will never purposefully share this information with any third party. All access to our internal network and electronic medical records (EMR) are password protected. Our staff is instructed to log off their workstations when not physical present. Additionally, in compliance with HIPAA guidelines, our EMR automatically logs the user out after a period of inactivity.

GUIDELINES FOR USING THE PORTAL SITE

◌ Send messages to the appropriate staff member regarding your healthcare and/or your account.
◌ View your health record and make requests to add, change, or update content, including medical history, demographic and insurance information.
◌ Print or save an electronic copy of your health summary.

PLEASE DO NOT USE THE PATIENT PROTAL FOR URGENT MESSAGES.

Our system will notify us when we have messages. We will normally respond to all messages within **24 hours** but no later than **2 business days**. After receipt, if you have not heard from us within 2 business days, please call the office at 979-968-8493 to check the status of your request. If for some reason the portal cannot be accessed, we will make every effort to inform and/or respond to you as soon as possible.

TO RECEIVE A USERNAME AND PASSWORD PLEASE SIGN BELOW AND RETURN TO OUR FRONT DESK.

Confidential email: _____

(The information and link for user access will go to this address: Please call us with changes)

Patient Name: _____ DOB: _____

Print name of Parent/Guardian requesting access for minor child: _____

Signature: _____ Date: _____

This consent is valid for 1 year from the date it is signed. Your access needs to be renewed yearly.

La Grange | Flatonia | Giddings
Family Health Centers

OFFICE, INSURANCE, & PAYMENT POLICY

Welcome to Family Health Center! In order to ensure quality and affordable healthcare, please read the following. If you have any questions regarding this information, please do not hesitate to ask one of our staff members.

◊ **OFFICE HOURS:** Our offices are open Monday through Friday from 8:00 am to 5:00 pm. Telephones are answered during this time. Due to high call volume, your call may be answered by our voicemail giving you instructions to leave a message for the appropriate person to assist you further. Although we do our best to call everyone back within the same day, please allow 24 hours for a call back. If you feel your situation is an emergency, please call 911 or proceed to the nearest emergency room.

INITIAL: _____

◊ **MISSED APPOINTMENTS**: Appointments must be canceled within 24 hours of the appointment time. For each no-show appointment a $50 fee will be assessed to that account. Future appointments will not be scheduled until fee is paid.

INITIAL: _____

◊ **PRESCRIPTIONS:** All prescription refill requests should be called in directly to your pharmacy. Your pharmacy will then contact our office if authorization is needed. Please allow 72 hours for processing all prescription refill requests. Prescription refills will not be called in, after hours or on the weekends, so please be sure that your refill request is called in prior to running out of medicine.

INITIAL: _____

◊ **ANNUAL WELLNESS VISITS:** We require our patients to be seen on a yearly basis to help provide the best care to you and your family. Scheduling these appointments are also a requirement from your insurance provider and we are required to comply to with your insurance guidelines. Please help us by scheduling your yearly visits.

INITIAL: _____

◊ **REFERRALS**: Referrals to other physicians and/or diagnostic facilities require at least 72 hours prior notification, if our office is not contacted within that time frame, the patient may have to reschedule or be held responsible for any and all charges incurred by the physician and/or diagnostic facility.

INITIAL: _____

◊ **MEDICAL RECORDS**: Medical Records requests can take up to 7 business days to process. Records requested by another physician or the patient's private insurance will be released without charge as a courtesy as long as a proper medical records release has been signed and dated by the patient and/or the patient's guardian. Records that are requested directly from the patient and/or the patient's guardian or a third party will be charged a $25.00 medical records fee. Additional charges may be applied determining the size of the record (more than 25 pages). Medical records requests that are signed and dated more than 180 days old will not be honored and an updated release must be presented.

INITIAL: _____

◊ **FORM COMPLETION:** There is a charge for the completion of forms that require a provider's attention and/or signature that are presented outside of a scheduled office visit. These forms include but are not limited to Indigent, Mail Order, Disability, and Accident/Injury forms. This charge cannot be billed to a patient's insurance and payment will be required upon completion and pick up of the requested forms. In some cases, an office visit may be required for the completion of a form. This will be determined by the Physician's medical staff upon review of these forms.

INITIAL: _____

◊ **PATIENT CODE OF CONDUCT: Family Health Centers is a private family practice and therefor reserves the right to refuse services to anyone. It is important that there is a proper and respectful communication between Patients, Providers, and Medical Staff to ensure quality medical care. If a patient, or a representative of the patient, presents**

with disrespectful, abusive, threatening or aggressive behaviors and/or language, Family Health Centers, has the right to refuse service and terminate the relationship with that patient and any other parties involved.

INITIAL: _____

◊ TERMINATION OF DOCTOR/PATIENT RELATIONSHIP: Unfortunately, there are times when a Provider must terminate his/her relationship with a patient if the Provider feels as though they are no longer able to care for that patient's medical needs. This termination of Doctor/Patient relationship can result from, but not limited to, failure to adhere to the Clinic Policy's set forth in this form, pharmaceutical abuse, failure to comply with medical direction, and failure to adhere to financial responsibility.

INITIAL: _____

◊ INSURANCE & PAYMENT POLICY:

Proof of Insurance: It is the patient's responsibility to provide proof of insurance at every visit. If the patient fails to provide proof of insurance at the time of service, that visit will be considered Private Pay and payments will be required at that time.

INITIAL: _____

Filling to Insurance: We file to all insurance as courtesy to our patients. It is the sole responsibility of the patient to verify that the provider they are seeing and the services they are requesting are a covered benefit under their plan.

INITIAL: _____

Co-Pay's and Co-Insurance: Co-Pay and Co-Insurances are required to be paid at every visit and prior to your appointment. Failure to pay your co-pay/co-insurance prior to your appointment could result in your appointment being rescheduled. Your insurance company requires us to collet your co-pay/co-insurance at the time of services. Failure to comply may constitute fraud under state and federal law, so please help us by paying your co-pay/co-insurance at every visit.

INITIAL: _____

Private Pay: If you do not have insurance, **payment is due at the time of services are rendered.** Partial payment cannot be accepted unless prior arrangements have been made with our billing department before the appointment.

INITIAL: _____

Third Party: We do not file to first party payors/billers (id; MVA'S, Injury/Accident policies, etc.). Payment is required at the time services are rendered and a receipt will be provided upon check-out for the patient to present to the third party.

INITIAL: _____

Workers Compensation: All work-related injuries are taken on a case-by-case basis depending on the physician current case load. We will obtain all necessary information to present to the Physician so that he/she may make a decision as to whether or not they are able to take your case. This information must be obtained prior to being seen.

INITIAL: _____

Account Balances: Balances that are over 120 days past due may result in the patient's account being "closed" and forward to a collection agency. If a patient's account is connected to a family account, future services could be interrupted until such balance is paid in full. Accounts must be in good standing for refills and appointments.

INITIAL: _____

A copy of this notice is available upon request

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CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

PHYSICIAN RELEASING RECORDS:

Name: _____

Address: _____

City, State, & ZIP: _____

Phone: _____

Fax: _____

PHYSICIAN/PERSON TO RECEIVE RECORDS:

Name: La Grange | Flatonia | Giddings Family Health Centers

Address: 1253 N Von Minden

City, State, & ZIP: La Grange, TX 78945

Phone: 979-968-8493

Fax: 979-968-6388

MEDICAL INFORMATION TO BE SENT:

____ **MEDICAL RECORD,** INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

____ **ENTIRE MEDICAL RECORD,** EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

____ **RECORD OF CARE FROM _____ TO _____,** INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

____ **RECORD OF CARE FROM _____ TO _____,** EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2. I authorize medical information to be released as indicated above. I understand this release is effective until _____ or 180 days after date of signature, but that I may revoke my consent at any time by providing written consent to the above-named party.

_____ _____
Patient or Patient's Legal Guardian Date

_____ _____
Witness Date