GrandMedical CLINIC

PLEASE BE READY TO PROVIDE AT THE FRONT DESK:

1. Your insurance card(s)
2. Your driver's license or ID
3. Visit copay

New Patient Information

Full Name:_____ DOB:_____/_____/_____ Sex: M F

Cell Phone:_____ Home Phone:_____

Address:_____ City:_____ ST:_____ Zip:_____

Employer Name:_____ Status: Full Time / Part Time

Marital Status: _____Ethinicity:_____ Student Status: Full time / Part Time

Email:_____

EMERGENCY CONTACT: Full Name:_____Relationship:_____Ph:_____

May we contact this person if unable to reach the patient? YES / NO

Insurance Information

PRIMARY INSURANCE:

Insurance Co. Name: _____Name on card:_____

Policy holder relation to patient: _____ Member ID #:_____Group #: _____

SECONDARY INSURANCE:

Insurance Co. Name: _____ Name on card:_____

Policy holder relation to patient: _____ Member ID #:_____Group #: _____

Your pharmacy information:

Pharmacy name:_____ Pharmacy phone: _____

Pharmacy address: _____

Consent for Treatment

As a consulting adult and/or legal guardian, I agree to permit the physicians and staff of Grand Medical Clinic to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I agree to permit the physician and staff at Grand Medical Clinic to perform necessary or appropriate medical care including physical examination, diagnosis, and treatment.

_____ _____ _____

Print name Patient/Guardian signature Date

Medical History

Medical history (diabetes, high blood sugar, cancer, allergies, surgery, family history, medications, immunizations, etc.)

Medications:_____ _____ _____ _____ _____ Self Medical History: _____ _____ _____ _____ _____	Allergies:_____ _____ Surgeries/Hospitalizations:_____ _____ _____ Family History: _____ ● Mother_____ _____ ● Father_____ _____

Social History

Do you smoke? Yes / No If yes, how many packs a day? _____ Years smoked? _____ Do you exercise? Yes / No If yes, how often? _____ Do you drink tea or coffee? Yes / No If yes, how often? _____ Do you drink alcohol? Yes / No If yes, how often? _____ Colonoscopy? Yes / No If yes, what year? _____	Mammogram? Yes / No If yes, what year? _____ Pap smear? Yes / No If yes, what year? _____ Bone density? Yes / No If yes, what year? _____ Flu shot? Yes / No If yes, what year?_____ Pneumonia shot? Yes / No If yes, what year? _____

Release of Information

I, _____ DOB:____/_____/____ , hereby give consent to Grand Medical Clinic and its staff to access any and all medical records necessary for continuum of care. I understand that I may refuse, in writing, the release of any and all records per right under HIPAA. I have been given a HIPAA information sheet and understand when, where and how the clinic may, in turn, release my information, unless I specify otherwise.

_____ _____

Patient's signature Date

I, _____ hereby give consent to the following people to discuss my records, and/or results, with the doctor and his staff if needed.

1._____ Relationship:_____Phone:_____

2._____ Relationship:_____Phone:_____

3._____ Relationship:_____Phone:_____

4._____ Relationship:_____Phone:_____

I understand that this authorization can be revoked, in writing, at any time and may apply to one or more of the above people.

_____ _____

Patient signature Date

Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. Late arrivals, cancellations, and "no shows" inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments.

Late arrivals

Failure to arrive within 15 minutes of your scheduled appointment time may result in a delay of services. While we will do our best to accomodate you, we may find it necessary to reschedule your appointment. These policies enable us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call Grand Medical Clinic promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in the need for treatment. If it is necessary to cancel your scheduled appointment, we acquire that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel appointments, please call 832-437-5218

_____ _____ _____

Signature of patient or personal representative Printed name of patient or personal representative Date

Financial Policy

Thank you for choosing Grand Medical Clinic as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part our professional relationship, it is important that you have an understanding of our financial policy. All patients must read and sign this form prior to receiving services.

- It is your responsibility to provide us with your most current insurance information.
- If you fail to provide accurate insurance information in a timely manner, your insurance company may decline the claim.
- If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is contact between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage of any kind will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of coverage. Please be aware that some of all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by you to contact your insurance company, we will file initial claim as courtesy. Payment, however, is due in full at the time of service.
- We charge what is usual and customary for our area. You are responsible for payment regardless any insurance companies' arbitrary determination of usual and customary rates.
- Co-payments, co-insurance, and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying in the full amount determined by your insurance company once they have paid claim- regardless of your estimation.
- It is your responsibility to provide us with your most current billing information.
- You must provide your most current billing address, all available telephone numbers, and any other important contact information. If your address or contact information changes, it is your responsibility to inform us of the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it your responsibility to contact our business office within days after receipt of the initial statement. You can call 832-437-5218 or our billing department 281-676-5111.
- Payment is in full due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency for further collection activity. You will be responsible to pay all collection cost incurred, including including attorney's fees and court cost if applicable.
- If you are unable to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $30.00 to your original balance. In addition, we may seek additional legal remedies provided to us under Texas law.
- We may charge you a "no show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- Failure to keep your account balance current may require us to cancel or reschedule your appointment.
- Full payment is due at the time of service. We accept cash, debit and credit cards.

I have read and understand this Financial Policy

_____	_____	_____
Signature of responsible party	Printed name	Date

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's

practice .These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students. Licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a signin sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation:

Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

Following is a statement of your rights with respect to your protected health information.
You have the right to Inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of responsible party _____ Printed name _____ Date _____

Physician/Patient Memorandum of Understanding

Thank you for choosing Cinco Family Medicine for your medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide YOU with high quality, personal medical care, which is responsive to your individual needs and values. In order for this goal to be achievable, it is important that we (the Physician and the Patient and/or the Patient's caregiver) each commit to satisfying certain responsibilities as follows:

Physician Responsibilities

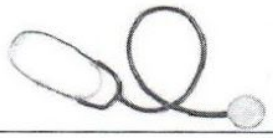
•I will listen effectively, provided YOU with explanations as to health care matters, and otherwise encourage a way of life of open, full and honest communication between us.
•I will provide YOU with information regarding the different treatment plan for YOUR acute or chronic condition to enable YOU to select the plan appreciate for YOU.
•I will provide convenient options (telephone, voice mail and email) for non-urgent communication between YOU and my practice team for scheduling office visits and follow-up visits and for obtaining test results and referrals.
•I will provide YOU telephone availability for urgent communication, 24 hours per day, and 7 days per week by myself or one of the other physicians in the office.
•As technology develops, every effort will be made to provide convenient options for nonurgent communications between YOU and I and/or my team, including post-hospital support, follow-up visits and consultations.
•I will coordinate a multidisciplinary approach to YOUR health care by referring YOU to other clinicians and health care institutions when appreciate.
• I will coordinate and integrate care provided by other health care professionals, other clinicians and health care institutions effectively so as to avoid duplication, delay and error.
• I will provide flexible and expanded office hours, schedule YOUR appointments within a reasonable time, and see YOU as closely as reasonable possible to YOUR scheduled appointment time.
•I will furnish YOU with test and treatment results promptly and correctly.
•I will provide YOU with information and recommendations regarding preventive care, maintaining wellness, self management directions and counseling.
• I will keep clinical information in a system that allows for ready search, retrieval and information transfer while protecting privacy and confidentiality, including participating in development and maintenance of standardized electronic health records and patient registries.
•My practice team will be trained in the responsibilities described above.

Your Responsibilities

•Communicate openly, fully, freely, and proactively with my Physician's staff.
•Be an active participant in the development with my Physician of a treatment plan for my or the parties acute or chronic condition, and follow agreed-upon treatment plan.
• Provide Physician with feedback regarding my or the patient's treatment plan.
•Appear on time for appointments, procedures and other medical tests at my Physician's office, and timely submit materials, samples and information as requested by Physician.
•Schedule and attend follow up appointments at intervals suggested by my Physician.
•Follow my Physician's and other health care professionals' recommendation with respect to maintenance or improvement of my or the Patient's health and wellness.
•Participate in developing and maintaining a comprehensive Patient health record by authorizing delivery and circulation of my or the patients clinical information to and from clinicians and health care institutions.

Please take the time to carefully read and understand each of our respective responsibilities. To show that you accept and agree with them sign your name below. Thank you once again.

Patient signature _____ Signature of caregiver/guardian _____ Date _____



Grand Medical Clinic

2840 COMMERCIAL CENTER BLVD STE 104
KATY TX 774946406
Ph: 832-437-5218 Fax:832-437-7294

Sexual History

Name: **Gender:** **Date:**

Had sex in the last 12 months (vaginal, oral, or anal)?

- [ ] Yes
- [ ] No

with

- [ ] Men only
- [ ] Women only
- [ ] Both Men and Women

Use protection?

- [ ] Yes
- [ ] No

How often?

- [ ] All of the time
- [ ] Most of the time
- [ ] 90%
- [ ] 80%
- [ ] Half the time
- [ ] Some of the time
- [ ] 70%
- [ ] 60%
- [ ] 20%
- [ ] 10%
- [ ] 0%

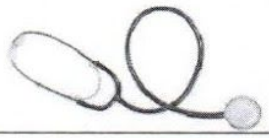
Prevention Strategies discussed:

- [ ] Abstinence
- [ ] Condoms
- [ ] Other

Have you ever had an STD?

- [ ] Yes
- [ ] No

LMP:



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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Total Score: _____

Interpretation

☐ Minimal Depression

☐ Mild Depression

☐ Moderate Depression

☐ Moderately severe depression

☐ Severe Depression

Interpretation of Total Score for Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression