ROSEWOOD FAMILY PHYSICIANS

2405 S. Gessner, Suite B, Houston, TX 77063; Phone: 713-266-7673; Fax: 713-866-4744

TODAY'S DATE _____ **PLEASE PRINT**

PATIENT INFORMATION

IF PATIENT IS A MINOR, COMPLETE PARENT/LEGAL GUARDIAN FORM

LAST NAME _____ **DATE OF BIRTH_____/_____/_____**

FIRST NAME_____MI_____ **SEX: M F (circle one)**

ADDRESS _____ **SOCIAL SECURITY_____/_____/_____**

_____ **EMPLOYER NAME _____**

CITY_____ **EMP STATUS: FULL PART RETIRED SELF**

STATE_____ **STUDENT STATUS: FULL PART**

HM PHONE_____CELL_____ **MARITAL STATUS: S M D W**

WK PHONE_____EXT_____ **SPOUSE NAME_____**

EMAIL_____

EMERGENCY CONTACT_____ **RELATIONSHIP_____**

HM PHONE_____ **WK_____ EXISTING PATIENT: Y N**

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE NAME_____INSURANCE PHONE#_____

MEMBER ID#_____GROUP#_____

POLICY HOLDER/SUBSCRIBER_____ _____ _____
(LAST) (FIRST) (MI)

RELATION TO PATIENT: SELF SPOUSE PARENT/GUARDIAN OTHER

IF DIFFERENT FROM ABOVE: **EMPLOYER NAME _____**

SOCIAL SECURITY_____/_____/_____ **DATE OF BIRTH_____/_____/_____**

SECONDARY INSURANCE:

INSURANCE NAME_____ **INSURANCE PHONE#_____**

MEMBER ID#_____ **GROUP#_____**

POLICY HOLDER/SUBSCRIBER_____ _____ _____
(LAST) (FIRST) (MI)

RELATION TO PATIENT: SELF SPOUSE PARENT/GUARDIAN OTHER

IF DIFFERENT FROM ABOVE: **EMPLOYER NAME _____**

SOCIAL SECURITY_____/_____/_____ **DATE OF BIRTH_____/_____/_____**

I have read, understand and agree to abide by the policies states on the reverse side of the form.

_____ _____ _____
Patient's name (PRINT) **Patient/Responsible Party Signature** **Date**

AUTHORIZATION AND CONSENT

I hereby authorize the physicians and staff of Rosewood Family Physicians to release any information acquired in the course of my treatment to my insurance company or third party payer as required for claims field, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include HIV virus, Acquired Immune Deficiency Syndrome (AIDS) and mental health.

I authorize direct payment to be made to the physicians of Rosewood Family Physicians for any and all medical and surgical services rendered. I understand that if any services or charges are not covered, or if Rosewood Family Physicians is unable to verify eligibility that I am responsible for all charges incurred for services rendered.

_____ _____ _____
Patient's name (PRINT) **Patient/Responsible Party Signature** **Date**

NAME_____ DOB_____/_____/_____ TODAY'S DATE: _____/_____/_____

INFORMATION FOR YOUR PHSYICIAN

PLEASE ANSWER THE FOLLOWING QUESTIONS PRIOR TO YOUR FIRST EXAMINATION. IT WILL HELP YOUR PHYSICIAN TO KNOW ABOUT YOU AND YOUR FAMILY HISTORY.

EDUCATION_____OCCUPATION_____

HAVE YOU TRAVELED OR LIVED OUTSIDE THE US AND CANADA? _____NO_____YES WHERE?_____

PLEASE IDENTIFY ANY SIGNIFICANT MEDICAL HISTORY FOR THE FOLLOWING FAMILY MEMBERS.

ALIVE DECEASED PRESENT HEALTH OR CAUSE OF DEATH

FATHER_____

_____

MOTHER_____

_____

BROTHER(S) _____

_____

SISTER(S) _____

_____

CHILDREN_____

_____

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES: _____DIABETES _____CANCER _____BLEEDING TENDENCY

_____KIDNEY DISEASE _____TB _____HEARD DISEASE _____STROKE _____HIGH BLOOD PRESSURE _____DEPRESSION/ANXIETY

_____ALLERGIES _____OTHER: _____

CHECK ANY ILLESS OR CONDITIONS YOU HAVE HAD: _____DIABETES _____GLAUCOMA _____HEART DISEASE _____VEIN TROUBLE

_____SEXUALLY TRANSMITTED DISEASE _____CANCER_____ASTHMA_____JAUNDICE_____BLEEDING TENDENCIES_____PNEUMONIA

_____TB_____KIDNEY DISEASE_____RHEUMATIC FEVER_____DEPRESSION/ANXIETY_____STOMACH ULVERS_____HYPERTENTION

OTHER: _____

LIST OTHER ILLNESSED NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPIALIZED_____

_____

_____

HAVE YOU HAD ANY SERIOUS INJURIES, BROKEN BONES, ETC.? _____NO_____YES LIST_____

_____

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICATION OR OTHER SUBSTANCES? _____NO_____YES LIST_____

_____

DO YOU USE TOBACOO NOW? _____NO_____YES TYPE AND AMOUNT_____HOW LONG_____

EVER USED_____ HOW LONG_____

DO YOU USE ALCOHOLIC BEVERAGES NOW? _____NO_____YES TYPE AND DAILY AMOUNT_____HOW LONG_____

DO YOU DRINK COFFEE_____NO_____YES WEEKLY AMOUNT_____HOW LONG_____

DATE OF LAST IMMUNIZATION (FOR CHILDREN, PLEASE PROVIDE IMMUNIZATION RECORDS): INFLUENZA_____HEPATITIS A_____

HEPITITIS B_____ TETANUS_____ PNEUMONIA_____ OTHER_____

PREVIOUS OPERATIONS (DATES, HOSPITALS AND NAME OF SURGEON)_____

_____

_____

DENTAL (LIST ANY PROBLEMS YOU HAVE NOW)_____

MEDICATIONS (NAME OR OTHERWISE IDENTIFY CURRENT OR RECENTLY USED MEDICINES)_____

_____

LAST MENSTRAL PERIOD_____ LAST MAMMOGRAM_____ LAST PAP SMEAR_____

MENSES ARE: _____REGULAR_____IRREGULAR NUMBER OF: _____PREGNANCIES_____MISCARRIAGES_____ABORTIONS

ORAL CONTRACEPTIVES? _____NO_____YES OTHER FORMS OF CONTRACEPTION?_____

HAVE YOU RECEIVED A BLOOD TRANSFUSION? _____NO_____YES DATE: _____

HEIGHT_____WEIGHT_____HOW LONG HAVE YOU BEEN AT THIS WEIGHT? _____

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?_____

_____

WHAT ARE YOUR MAIN SYMPTOMS? _____

_____

PREVIEWED BY PHYSICIAN_____ DATE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the Rosewood Family
(Patient Name)
Physicians Notice of Privacy Practices.

_____
Patient Name (PRINT)

_____
Patient Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices; however, acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited the acknowledgement

( ) An emergency situation prevented us from obtaining the acknowledgement

( ) Other: _____

_____

_____

Office, Financial and HIPAA Policies Acknowledgement

Welcome to Rosewood Family Physicians. Rosewood Family Physicians' main goal is to provide the best quality of care for their patients. The doctors of Rosewood Family Physicians will not perform any services that they do not feel are reasonable or necessary for your well being. We will strive to make your visits to our office as comfortable as possible. Please read and sign these policies prior to your treatment so that you will have better understanding of our office policies.

Payment in full is due at the time services are rendered. For your convenience, we accept cash, check and credit cards (MasterCard and Visa). All non-cash transactions and/or services that are to be filed to insurance require a legal form of picture identification (driver's license, state identification card, or passport) to be scanned into our computer system and your social security number. Rosewood Family Physicians will file your claim to those insurance companies for this geographical area.

There is a $30.00 charge on all returned checks. We do not accept post-dated checks. It is our policy to report past due balances over 120 days to the credit bureau unless special arrangements have been made through the billing office.

Insurance Contracts obligate your physician to collect any and all copay, deductible, or co-insurance amounts from you. As a courtesy, this office attempts to verify your insurance benefits prior to any services you may receive but the information we receive is not a guarantee of payment. You are ultimately responsible for knowing your plan benefits and requirements; therefore, are responsible for any and all copays, deductibles, co-insurance and non-covered services as identified on the explanation of benefits we receive from your insurance plan.

It is your responsibility to notify Rosewood Family Physicians of any change in insurance coverage. To facilitate this process, it is required at every visit that patients complete and sign the sign-in form. This helps to ensure that our office updates your information at every visit. Failure to provide this office with current insurance information at the time of service may result in you being held responsible for the full amount of the charges due to the claims filing deadlines required by your insurance which is typically 90 days or less.

Many insurance plans require prior-authorizations for certain tests, referrals, ER visit and/or treatment. These must be obtained prior to treatment. Without the proper authorization, your insurance may refuse to pay. You will be responsible for all charges. It is the patient's responsibility to obtain referrals at office visits and provide them to the specialist's office. Our office is not responsible for faxing referrals to the specialist's office.

Minors (Children under the age of 18) must be accompanied by an adult. The accompanying parent or guardian must assume financial responsibility.

For your convenience and safety, prescriptions are issued during office hours only. Due to HIPAA guidelines and to protect your confidentiality, we no longer refill medications by phone or fax. If you take medication for a chronic condition, you are required to see the physician on a regular basis. It is your responsibility to plan ahead so that you do not run out of your medication.

You may be assessed a $25.00 no-show fee for any appointment not cancelled at least 24 hours before appointment.

If you have lab tests or x-rays, the normal results of these will be phoned/ mailed to you within 7 business days. Please allow 10 days from the date your tests were performed to phone our office for results.
There are times when the phone/ mail notice may ask you to make an appointment. Please do not be alarmed. This typically means that the provider wants to speak to you in person for clarification or educational reasons. As a professional courtesy, we will fax or mail copies of medical records to other physicians with a signed authorization to release. Medical records are available to patients with a signed authorization to release health information and a charge of $25.00. Medical records requested by insurance companies or attorneys must be requested by those entities.