MEDICORP
My Family Doctor
www.myfamilydoctorhouston.com

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

WELCOME TO OUR PRACTICE!

Welcome to My Family Doctor! Our mission is to provide you and your loved-ones with the highest quality care through compassion, disease prevention, and a spirit of true partnership that puts you (the patient) at the center of everything we do.

For your convenience, we have several practice locations in Houston. Because our practice is fully-integrated, no matter which of our clinics or providers you visit, your primary care physician can closely monitor your health and medications, provide special instructions to your care team, and carefully review your progress notes and test results to ensure continuity of care and treatment. **For information regarding our hours and locations, including an interactive map of all our clinics, please visit us on the web at www.myfamilydoctorhouston.com.**

Here is some helpful information and answers to frequently asked questions. **We look forward to the opportunity to serve you and your family!**

1. Urgent same-day/walk-in appointments may require you to be treated by the provider on staff instead of your assigned primary care physician. Rest assured that all healthcare providers at My Family Doctor work collaboratively together and share insights and information to make sure you always receive excellent care.

2. Please bring all your medicines (in their bottles) with you to each visit. This includes any herbal remedies and over the counter medication you may take.

3. Please notify our staff if you stop taking a medication your physician has prescribed.

4. Please allow two weeks for normal labs and imaging reports to be reported via mail or the patient portal. If you do not hear from us after two weeks, please contact our office.

5. Please limit after-hours and weekend calls to urgent matters only. Remember that most of our clinics are open on weekends if you have a question or need to come in for a consultation.

6. Please allow 7-10 business days for your physician to sign or complete any forms you request to be reviewed, created, and/or signed, such as FMLA, Metro Lift, or Handicap Parking Applications. Please note that there may be an extra charge for completion of these forms.

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ACCESS OUR PATIENT PORTAL!

You can now easily communicate with your healthcare provider, schedule appointments, take control of your medical information, and more! Use this quick reference guide to get started.

GETTING STARTED

1. Let the receptionist know you would like to access your patient portal. We will then set up your account and give you a temporary password.
2. Check your email inbox to retrieve the patient portal link OR visit our website at www.myfamilydoctorhouston.com, click the "Patient Info" tab, then click the button to "Login" to the patient portal.
3. Your **username** is the email you provided at the front desk: _____
   And your temporary (case sensitive) **password** is: _____
4. Upon login, you will be prompted to set a new secure password.

QUICK LINK DEFINITIONS

CHART

- Visit summaries
- Medical history
- Current medications
- Immunization history
- Education materials
- Medication allergies
- Review your contact information

MESSAGES

- Create free-type messages based on:
  - » Appointments
  - » Billing
  - » Demographics
  - » General
  - » Login assistance
  - » Prescriptions

FORMS

- View forms assigned by your provider and staff that require your attention.
- View completed forms.
- View general practice forms.

PRESCRIPTIONS

- View your current medication prescriptions, and request refills with one click:

REQUEST REFILL

APPOINTMENTS

- View upcoming appointments and location.
- View previous appointments.
- Book new appointments

BOOK NOW

BILLING

- View ledger statements and balances.

For instructions on completing any of these tasks, please visit our website's "Patient Info" tab.

PATIENT REGISTRATION FORM

MEDICORP My Family Doctor

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable):
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Family Physician or Pediatrician:	Date of Birth:	Sex: ❑ Male ❑ Female	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Spanish ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Bosnian ☐ Russian ☐ Other

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Medicorp, PA d/b/a My Family Doctor ("Medicorp")'s payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Medicorp all money to which I am entitled for medical expenses related to the services performed from time to time by Medicorp, but not to exceed my indebtedness to Medicorp. I authorize Medicorp to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Medicorp by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Medicorp. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Medicorp's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party X_____ **DATE:** _____

Printed Name of Responsible Party _____

FINANCIAL POLICY

- Self-Pay. We offer competitive pricing for patients who do not have health insurance or whose insurance does not offer coverage for needed services. If you do not have insurance, you will be required to pay for all services prior to receiving treatment.
- Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we accept, payment in full is expected at each visit. If you are insured by a plan we accept but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your coverage or benefits.
- Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us comply with the law by paying your co-payment or deductible at each visit.
- Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of any claim.
- Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
- Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
- Payment plans. We are committed to caring for all members of the community, including those who are experiencing financial hardship. In special cases involving financial hardship or need, we may allow you to pay your account balance over time. In that event, you will be required to sign a promissory note in which you agree to make regular installment payments until your account balance is paid in full.

NARCOTICS POLICY

The treatment of chronic pain with narcotics has resulted in thousands of deaths, abuse, and diversion of narcotics into our schools and society. Texas is one of the states which has been most severely affected by this epidemic. After evaluating the new guidelines for dispensing narcotics for treatment of chronic pain, we have determined that, except in rare circumstances following the protocols set forth below, our facilities will not manage chronic pain with narcotics. My Family Doctor offers conservative, narcotic-free treatment of chronic pain associated with some medical conditions, including non-narcotic oral medications, physical therapy, splinting, exercise, heat and cold, etc. In the event of a legitimate need for narcotic therapy for the treatment of chronic pain, we recommend obtaining care from a facility that specifically treats chronic pain. Patients who elect to receive treatment from a pain-management facility will still be able to be treated for their other medical issues by My Family Doctor.

In rare circumstances where your physician determines that short-term treatment with opioid pain medications is clinically appropriate, you will be required to provide a full set of medical records from your previous physician and submit to a urine drug screen. We will also obtain a report from the State that shows which controlled substances, if any, have been prescribed for you in the past year. We require these items in order to make good decisions about your treatment. Please note that at least once per year, you will need to provide a urine sample. We will also obtain a report from the State, at least once yearly, that outlines the prescriptions you have received from pharmacies. As part of your opioid treatment plan, we will require that you sign a controlled substance agreement. Please read this agreement carefully, as it has useful and detailed information that is not discussed in this notice. To provide you with the best possible care, we will need to monitor your prescriptions. This will be done during scheduled office visits. Most patients will need to be seen at least once every one to three months. Your prescriptions will be written to last until your next visit. If you have a problem with your condition between office visits, you should schedule an office visit with us at that time. Please note that opioid prescription refills will not be given over the phone unless you have arranged this ahead of time with your doctor. Any medications that are lost or stolen will not be replaced. Additionally, you will be expected to use other medical treatments to improve your pain. It may not be possible to completely remove all of your pain. However, our goal in many cases is to return your functionality to an accepted level. Your health care team is able to provide the best treatment for you if we have good communication. You and your health care providers should be respectful of each other for treatment to continue.

CONSENT TO TREAT

I hereby authorize employees and agents of Medicorp, PA d/b/a My Family Doctor (including physicians, physician assistants, nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing by me. I understand that by not signing this consent, the patient / I will not be provided medical care except in the case of an emergency.

I UNDERSTAND AND AGREE TO ALL OF THE FORGOING POLICIES: _____ _____

SIGNATURE **DATE**

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing by me.

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN **DATE**

NEW PATIENT DEMOGRAPHICS FORM

Please complete all fields on this form; once completed, please <u>HAND</u> this form to the receptionist.

1) Name: _____ Date of Birth: _____

2) Pharmacy, address and phone: _____

_____

3) Please describe the reason for your visit and check the symptoms that you are experiencing now or you have experienced in the past 72 hours.

Reason for Visit: _____

_____

_____

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulder

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Poor appetite
- ☐ Stomach pain
- ☐ Vomiting

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

RESPIRATORY
- ☐ Chest congestion
- ☐ Dry/productive cough
- ☐ Nocturnal cough

EYE/EAR/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision flashes
- ☐ Vision halos

SKIN
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sore that won´t heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Last menstrual period:

_____

Pregnant: ☐ Yes ☐ No

Have you recently been to the hospital? ☐ No ☐ Yes (Reason: _____)

Are you seeing any specialists? ☐ No ☐ Yes (If yes, please provide their names and specialties below):

_____

_____

4) Of the following conditions, please check the ones that apply to your medical history.

Past Medical History

☐ AIDS
☐ Alcoholism
☐ Alzheimer´s
☐ Anemia
☐ Anorexia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Brain Inflammation
☐ Brain Trauma
☐ Cancer _____
☐ COPD
☐ Dementia
☐ Depression
☐ Drug/Meds Depend.
☐ Diabetes type I
☐ Diabetes type II
☐ Diabetes unknown type
☐ Diabetic Retinopathy
☐ Diabetic Neuropathy
☐ Deep Venous Thrombosis (DVT)
☐ Epilepsy
☐ Fatty Liver
☐ Fractures
☐ Gangrene
☐ High blood pressure
☐ High Cholesterol
☐ Heart attack
☐ Heart disease
☐ Hepatitis
☐ Herpes
☐ HIV Positive
☐ Joint Infection
☐ Kidney Stones
☐ Liver Disease
☐ Migraine Headaches
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Glaucoma
☐ Gonorrhea
☐ Gout
☐ Pacemaker
☐ Prostate Problem
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Sleep Apnea
☐ Sickle Cell Disease
☐ Spinal stenosis
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers of Skin
☐ Varicose Veins
☐ Venereal Disease
☐ Vertebrae Herniation
☐ Other:
_____
_____

Past Surgical History

☐ Amputation(s) of _____
☐ Arterio-Venous Fistula for Hemodialysis
☐ Bone Marrow Transplant
☐ Bypass Grafts (arteries/veins/heart)
☐ Colon or Stomach Segment Removal
☐ Heart Transplant
☐ Heart Valve Surgery
☐ Liver Transplant
☐ Prosthesis Implants of _____
☐ Appendectomy
☐ Back surgery
☐ Breast Biopsy
☐ Cataract Surgery
☐ Cesarean Section ____ time(s)
☐ Cholecystectomy
☐ Hysterectomy
☐ Mastectomy (breast removal, partial or complete)
☐ Tonsillectomy
☐ Other: _____

Health Habits

☐ Dieting
☐ Exercise
☐ Tobacco
☐ Binge Drinking
☐ Drugs _____

Family History

Please specify whether maternal/paternal or if immediate relative

☐ Asthma
☐ Cancer
☐ Diabetes
☐ High Blood Pressure
☐ Stroke
☐ Blood Clots
☐ Depression
☐ Heart attack
☐ Other: _____

5) Please write down all **allergies** that you have to food and medications and please describe the reaction.

1. _____
2. _____
3. _____

Patient Signature _____ Date: _____

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Information

- Effective Date of this Notice: **January 1, 2019**
- Privacy Officer:
  Spencer D. Solomon
  1315 St. Joseph Pkwy., Suite 1310
  Houston, TX 77002
  admin@mfdhouston.com