



**Woodlands Family & Community  
Medicine**  
17521 St. Luke's Way, Suite 190  
The Woodlands, Texas. 77384  
Phone: (936) 447-9483 Fax: (936) 231-8200



**PATIENT INFORMATION**

NAME: \_\_\_\_\_ SEX: [M] [F]  
ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ SS#: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_ MARITAL STATUS: [ ] MARRIED [ ] SINGLE  
EMAIL ADDRESS: \_\_\_\_\_

**EMERGENCY CONTACT**

(PLEASE LIST RELATION)

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
PREFERRED PHARMACY: NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**RESPONSIBLE PARTY** (COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN THE INSURED OR PATIENT)

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_ SS#: \_\_\_\_\_

**PRIMARY INSURANCE**

NAME OF INSURED: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ ID: \_\_\_\_\_  
INSURANCE PHONE: \_\_\_\_\_ GROUP: \_\_\_\_\_  
INSURED DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_

**SECONDARY INSURANCE (IF APPLICABLE)**

NAME OF INSURED: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ ID: \_\_\_\_\_  
INSURANCE PHONE: \_\_\_\_\_ GROUP: \_\_\_\_\_  
INSURED DATE OF BIRTH: \_\_\_\_\_

I UNDERSTAND THAT THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. I UNDERSTAND THAT IF ALL OF THE ABOVE INFORMATION IS NOT COMPLETED, A CLAIM MAY NOT BE ABLE TO BE FILED TO MY INSURANCE COMPANY; THEREFORE, MAKING ME FULLY RESPONSIBLE FOR ANY CHARGES INCURRED.

PATIENT/RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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## Conditions of Services

PATIENT \_\_\_\_\_ DOB \_\_\_\_\_ ACCT# \_\_\_\_\_

### Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize Woodlands Family and Community Medicine ("WFCM") to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third-party payor, including but not limited to, my health insurance carrier, Medicare, and any other payor or agency.

I also hereby authorize payment of insurance benefits under the terms of my policy directly to WFCM for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

### Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by WFCM, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered. Failure to pay any outstanding debt may be considered cause for dismissal from Woodlands Family & Community Medicine.

X \_\_\_\_\_  
Patient / Guarantor Signature Date

### Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do here by consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatment or examination at WFCM.

X \_\_\_\_\_  
Patient / Guarantor Signature Date

### Consent to Medical Treatment by a Physician Assistant/Nurse Practitioner

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services from a physician assistant/nurse practitioner. I fully understand that a physician assistant/nurse practitioner IS NOT A PHYSICIAN. I further acknowledge that the general medical services provided to me by a physician assistant/nurse practitioner are the responsibility of the physician providing the services at WFCM both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients.

X \_\_\_\_\_  
Patient / Guarantor Signature Date

### Release of Patient Healthcare Information

I hereby authorize WFCM to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to healthcare providers, to facilitate reimbursement by a health benefit plan or personnel of another healthcare entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

X \_\_\_\_\_  
Patient / Guarantor Signature Date

Do you have an advanced directive (living will)? \_\_\_\_YES \_\_\_\_NO

If yes, bring a copy to our office for our files.

If no, and you would like information on an advanced directive, please speak with your physician.

The above authorizations are valid unless you specify otherwise or revoke them in writing.

## Patient History Form

**Patient name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Medications

Please list all medications that you're currently taking, prescription and nonprescription, and their dosage:

#### Medication

#### Dose

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

#### Allergies

Are you allergic to any medications?

YES       NO

If yes, please list the name of the medication the type of reaction:

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to any foods?

YES       NO

If yes, please list: \_\_\_\_\_

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### Past Medical History

Please indicate if you have ever experienced any of the following conditions:

- |  |   |
|--|---|
| <input type="checkbox"/> Alcohol dependence        | <input type="checkbox"/> Headache                 |
| <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Heart attack             |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> High blood pressure      |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> High cholesterol         |
| <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Irregular heartbeat      |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Insomnia                 |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Blood clots               | <input type="checkbox"/> Hepatitis                |
| <input type="checkbox"/> Broken bones              | <input type="checkbox"/> Kidney stones            |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Liver disease            |
| Type: _____  | <input type="checkbox"/> Low blood pressure       |
| <input type="checkbox"/> Chronic blood thinner use | <input type="checkbox"/> Migraines                |
| <input type="checkbox"/> Chronic bronchitis        | <input type="checkbox"/> Osteoporosis             |
| <input type="checkbox"/> Chronic sinusitis         | <input type="checkbox"/> Palpitations             |
| <input type="checkbox"/> Congestive heart failure  | <input type="checkbox"/> Seizure/epilepsy         |
| <input type="checkbox"/> COPD/emphysema            | <input type="checkbox"/> Sleep apnea              |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Stomach ulcer            |
| <input type="checkbox"/> Diabetes type I           | <input type="checkbox"/> Stroke or TIA            |
| <input type="checkbox"/> Diabetes type II          | <input type="checkbox"/> Thyroid disease          |
| <input type="checkbox"/> Esophageal reflux         | <input type="checkbox"/> Tinnitus                 |
| <input type="checkbox"/> Gallbladder stones        | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Gout                      | <input type="checkbox"/> Other: _____             |

**Surgical History**

Please check all that apply and the date of the procedure:

	Date		Date
<input type="checkbox"/> Angioplasty	___/___/___	<input type="checkbox"/> Gastric bypass	___/___/___
<input type="checkbox"/> Angioplasty with stent	___/___/___	<input type="checkbox"/> Hernia repair	___/___/___
<input type="checkbox"/> Appendectomy	___/___/___	<input type="checkbox"/> Hip replacement	___/___/___
<input type="checkbox"/> Back surgery	___/___/___	<input type="checkbox"/> Knee replacement	___/___/___
<input type="checkbox"/> Carpal tunnel release	___/___/___	<input type="checkbox"/> Liver biopsy	___/___/___
<input type="checkbox"/> Cataract extraction	___/___/___	<input type="checkbox"/> Pacemaker	___/___/___
<input type="checkbox"/> Colon surgery	___/___/___	<input type="checkbox"/> Thyroidectomy	___/___/___
<input type="checkbox"/> Coronary artery bypass graft	___/___/___	<input type="checkbox"/> Tonsillectomy	___/___/___
<input type="checkbox"/> Gallbladder	___/___/___	<input type="checkbox"/> Other: _____	___/___/___

**Female Surgical History**

Please check all that apply:

	Date
<input type="checkbox"/> Breast implants	___/___/___
<input type="checkbox"/> Bilateral tubal ligation	___/___/___
<input type="checkbox"/> Breast biopsy	___/___/___
<input type="checkbox"/> Cesarean section	___/___/___
<input type="checkbox"/> D&C	___/___/___
<input type="checkbox"/> Breast reduction	___/___/___
<input type="checkbox"/> TAH/BSO (total abdominal hysterectomy)	___/___/___
<input type="checkbox"/> Vaginal hysterectomy	___/___/___
<input type="checkbox"/> Other: _____	___/___/___

**Male Surgical History**

Please check all that apply:

	Date
<input type="checkbox"/> Prostate biopsy	___/___/___
<input type="checkbox"/> TURP (transurethral resection of the prostate)	___/___/___
<input type="checkbox"/> Vasectomy	___/___/___
<input type="checkbox"/> Other: _____	___/___/___

**Family History**

Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death.

Adopted

	Mother	Father	Sibling(s)	Children	Grandparents	Cause of death
<input type="checkbox"/> Alcoholism						
<input type="checkbox"/> Alzheimer's						
<input type="checkbox"/> Heart disease						
<input type="checkbox"/> Cancer Type: _____						
<input type="checkbox"/> Depression						
<input type="checkbox"/> Diabetes						
<input type="checkbox"/> High blood pressure						
<input type="checkbox"/> High cholesterol						
<input type="checkbox"/> Kidney disease						
<input type="checkbox"/> Osteoporosis						
<input type="checkbox"/> Stroke						
<input type="checkbox"/> Seizures						

**Social History**

Type of employment \_\_\_\_\_ Previous work, if retired \_\_\_\_\_

Marital Status       Married     Single       Divorced     Widowed

Do you currently use tobacco?    Yes       No      If yes, how many packs per day? \_\_\_\_\_

Have you previously smoked?    Yes       No      If yes, how many packs per day? \_\_\_\_\_

Other tobacco units per day (dip, cigars, etc.)?

Units per day? \_\_\_\_\_ Years used? \_\_\_\_\_ Year quit? \_\_\_\_\_

Do you drink caffeine?    Yes       No      Type? \_\_\_\_\_ Amount Daily? \_\_\_\_\_

Do you drink alcohol?    Yes       No       Daily       Weekly       Monthly      Amount: \_\_\_\_\_

Religious preference (optional) \_\_\_\_\_

**Immunizations**

Are your immunizations current?    Yes       No

Do you have copies of your immunization records?    Yes       No

**Pharmacy Information**

Do you have a preferred pharmacy?    Yes       No

Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Health Maintenance**

Last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

Last Well Woman Exam: \_\_\_\_\_ Results: \_\_\_\_\_

Colonoscopy: \_\_\_\_\_ Results: \_\_\_\_\_

Last lab drawn: \_\_\_\_\_ Results: \_\_\_\_\_

Flu shot: \_\_\_\_\_

Pneumonia shot: \_\_\_\_\_

Tetanus shot: \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

Are you interested in any cosmetic products or procedures to decrease aging of the skin (wrinkles, fine lines, age spots, melasma, acne etc.)?       Yes     No

## HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

RECORDS ON (PATIENT NAME) \_\_\_\_\_ (DOB) \_\_\_\_\_

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

RECORDS MAILED FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following person or class of persons may receive disclosure of protected health information about me:

RECORDS MAILED TO: Woodlands Family Medicine  
Brent Allmon M.D.  
17521 St. Luke's Way Suite # 190  
Conroe, TX 77384  
P:936-447-9483 Fx:936-231-8200

Specific description of information to be released (must include date(s) of service):

Labs, EKG, All tests, All Dr. Notes, Shot records.

The information to be released will be used for the purpose described below:

Continuing Care

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke or withdraw this authorization by notifying \_\_\_\_\_ in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed; and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on \_\_\_\_\_, or 1 (one) year after the date of said authorization.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.**

\_\_\_\_\_  
Signature of Individual                      Date of Signature                      Date of Birth or SS Number

--OR, if applicable--

\_\_\_\_\_  
Signature of Guardian                      Date of Signature                      Description of Guardian's  
Personal Representative's  
Authority to Act for the  
Individual

A copy of this completed, signed and dated form must be given to the individual or person signing on the individual's behalf.



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**PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)**

I, \_\_\_\_\_, give my authorization to release my protected health information including, but not limited to, results of my laboratory tests, x-ray and other test results to the following designated representative(s):

Patient Initials

\_\_\_\_\_ My Spouse (Name) \_\_\_\_\_

\_\_\_\_\_ My Child (Name) \_\_\_\_\_

\_\_\_\_\_ Other (Name) \_\_\_\_\_

\_\_\_\_\_ Personal Representative \_\_\_\_\_

\_\_\_\_\_ May be left on my voice mail at home.

\_\_\_\_\_ May be left on my voice mail at work.

\_\_\_\_\_ May be left on my cell phone.

\_\_\_\_\_ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, the clinic must receive the revocation in writing. The revocation must include: 1) the patient's name, address, and date of birth, 2) the patient's desire to revoke the authorization, and 3) the date of the revocation and the patient's signature. All revocations must be sent in writing to the attention of Dr. Allmon or Dr. Kerschenbaum at 17521 St. Luke's Way, Suite 190, The Woodlands, Texas, 77384 and will not be considered effective until received by the clinic.



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**Acknowledgment of Review of Privacy Practices**

I, the undersigned, have reviewed the WFCM privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the privacy practices.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Representative

\_\_\_\_\_  
Capacity of Representative

(Parent, Guardian, Trustee, Executor, Power of Attorney)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code





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## **POLICY REGARDING MISSED APPOINTMENTS**

**Effective Jan. 1, 2014**

(posted July 16, 2013)

We are dedicated to helping our patients and appreciate those who value this dedication of time, energy and service. We receive many calls from patients who wish to be seen on the same day. Our schedule is often full. Last minute cancellations and no-shows adversely affect other patients.

**Therefore, effective Jan. 1, 2014:**

- **All no-show/missed appointments will result in a fee of \$50.**
- **The same \$50 fee will also apply to patients who do not give us at least a 24-hour cancellation notice.**

Your understanding and cooperation is appreciated.

Dr. Brent Allmon, M.D.

Dr. Joel Kerschenbaum, M.D.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

# Prescription Refill Policy

Effective 9/10/12, revised 3/15/13

Currently, our office receives a large-volume of calls and faxes daily for medication refill requests. Our office can no longer safely manage this volume of phone and fax requests. As of September 10, 2012, we have a new prescription refill policy. We understand that this is a change for both you and us. We hope to work together to ensure safe, efficient and high-quality medical care. Thank you for being our valued patient!

It is typically my practice to give prescriptions with refills for 6 months at a time to coincide with six-month followup appointments for monitoring. It is very important to request your prescriptions during your routine office visits. In order to ensure that you do not run out of your medications, please make sure to schedule a followup appointment at the end of each visit. If office visits are scheduled and kept on a regular basis, prescriptions are refilled at these visits, and pharmacies follow instructions on prescriptions given, then requests for refills outside of office visits should rarely occur.

As of September 10, 2012, requests made for prescription refills made outside of an office visit may be subject to a fee:

1. \$15.00 may be charged for 1-3 prescription refills that or not requested during an office visit
2. \$25.00 may be charged for 4+ prescription refills that are not requested during an office visit.

To request a refill, please leave a detailed message on our refill request voicemail. **Please allow 2 business days for refill requests to be completed.**

Ways to reduce unnecessary refill requests and medication errors:

1. We do require office visits on a regular basis for all of our patients taking prescription medication. The interval for followup will vary depending on the type of medication you are prescribed. Please be sure you have enough medication to last until your next scheduled visit.
2. Before you come to your regular appointment, you should look over your medications, diabetic supplies, inhalers etc. to determine if you need to request any new prescriptions at your appointment.
3. Please bring all of your prescription bottles with you to your appointment. This is important to make sure that you're taking the correct medications in the correct dosages. We will take the time to carefully review your medications and write for refills at your office visit.
4. It is your responsibility to schedule a followup appointment before you run out of your medication. We recommend you schedule your next visit before you leave our office.
5. If you are changing pharmacies, you can usually have your new pharmacy request prescriptions be transferred from your old pharmacy.

**“Auto-Renewal”, “Auto-Fax”, “Readyfill” etc.**

Most of the requests for refills that we receive are generated automatically from the pharmacy without the patient's knowledge. "Auto-renewal" or "Auto-Fax" programs with most pharmacies are at fault for most of these requests. ***As of March 15, 2013, we will no longer respond to refill requests that are faxed from the pharmacy. If you are in need of a refill we expect you to contact us directly and leave a detailed message on our Refill Request Voicemail.***

Reasoning:

From my research, the main benefit for "auto renewal" is for the pharmacy. This generates a constant stream of cash flow for pharmacies and often does not benefit the patient. It is my experience that when we receive "Auto-renewal" refill requests from the pharmacy, the patient usually still has medication and is not actually in need of refill. In many cases, the pharmacy is requesting a refill on behalf of the patient without their knowledge and may be billing insurance for the medication regardless of whether the prescription was picked up by the patient. Refilling prescriptions without a patient's approval raises the possibility of insurance fraud, state officials say. According to the *L.A. Times*, one national pharmacy chain is under federal investigation for this very reason.

“Auto Renewal” also increases chance for medication errors. Consider this common example:

“In the past few weeks we heard from a patient utilizing the automatic refill system who picked up three prescriptions but later called the pharmacy to report he had picked up a blood pressure pill called Norvasc, which his doctor had previously discontinued. Fortunately, he hadn't yet taken any. In another case a patient's Cardizem, a heart medication, was increased from 240 mg to 360 mg. The elderly gentleman purchased the new prescription for diltiazem 360 mg but also received the diltiazem 240 mg prescription that had been filled earlier through the automatic refill program. After receiving a call from the confused patient, the pharmacist contacted the patient's doctor to determine which strength the patient should be receiving. Had the patient accidentally taken both strengths of Cardizem, it could have caused serious heart or blood pressure complications.”

Acknowledgement of Receipt:

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



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***FINANCIAL POLICY***

*We require all patients to pay at time of service. You will be charged at every visit for any outstanding deductible, co-insurance or co-pay due, as well as any fees for services not covered by your insurance plan.*

<b>Your Plan</b>	<b>What You Do</b>	<b>What We Do</b>
<b>Medicare</b>	Pay your deductible (\$147 for 2014) and co-insurance (20% of the allowable.) If you request any services that Medicare does not cover, you agree in writing to pay our regular fee for those services.	We will file Medicare for you.
<b>Medicare + Secondary Insurance</b>	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
<b>Commercial Insurance</b>	Pay your deductible, co-insurance or co-pay at time of service.	We will file your insurance for you.
<b>Insurance we are not contracted with</b>	Pay the visit in full at time of service.	We will provide a receipt for your services for you to file with your insurance for reimbursement.
<b>Health Savings Account (HSA)</b>	Your HSA credit card may be used	We will file your insurance and if the amount due is not paid, you may use your HSA.

***Additional Charges:***

- No Show/Cancellation < 24hrs: \$50
- Completion of Forms: \$25 to \$50, based on time
- Out of office prescription refills: \$15 to \$25
- Prior Authorization for medication (if required by your insurance): \$25