FOSSIL CREEK FAMILY MEDICAL CENTER

David Simonak, D.O., Ryan Simonak, D.O., & Brady Simonak, D.O.
7510 North Beach Street
Fort Worth, TX 76137
Phone: 817-498-1818Fax: 817-581-3761

COMPLETE THIS PAGE, GIVE TO THE RECEPTIONIST, THEN COMPLETE REMAINING PAGES.

PATIENT INFORMATION (Please print clearly)
New ( ) Update ( )

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Date: _____

Patient's Name: _____ Spouse: _____

Address: _____ Apt#: _____ City: _____

State: _____ ZIP Code: _____ Email_____

Would you like to be web-enabled for easy access to your records, through our secure Patient Portal? Y N

Phone: (H)_____ (W)_____ (C)_____

Date of Birth: _____ Age: _____ SSN: _____

Marital Status (Circle One): M S W D Sex: M F Driver's Lic#: _____ State: _____

Circle One: Caucasian African American Asian Hispanic Native America Other _____

Patients between the ages of 19 to 25: Student? Yes _____ No _____ Full Time _____ Part Time _____

_____ Patient is a minor (under 18) _____ Patient is over 18 (Responsible for Self)

Full Name of Person Responsible for Account

Name: _____ Relationship:_____

D.O.B._____ Phone#_____ Driver's License #: _____ SSN: _____

Address (If Different than Patient): _____

Please list all patients that you are financially responsible for:_____

_____

Insured Information

Name: _____ Relationship:_____

D.O.B._____ Phone#_____ Driver's License #: _____ SSN: _____

Address (If Different than Patient): _____

Employer Name: _____ Employer Phone # _____

Employer Address: _____

- Primary Insurance Name: _____

  ID # _____ Group #: _____

- Secondary Insurance Name: _____

  ID# _____ Group#:_____

Subscriber's Name: _____ D.O.B.: _____ Relationship:_____

Are You Allergic To Any Medications, please list: _____

_____

Emergency Contact (other than your spouse / child / relative living with you):

Name: _____

Phone: _____ Relationship: _____

Who Referred You To This Offfice? (If phone book, Please list which one. Example: SBC, Transwestern, etc.)

_____

Please List Your Current Pharmacy:

_____

Pharmacy Name Phone

_____

Address Pharmacy #

I verify all the information provided above to be correct. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and clinic to release any information needed to process insurance claims or in treatment of my care. I also authorize my insurance claim to be paid directly to the clinic.

_____

Signature of Patient / Parent/ Guardian Printed Name Date

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COMPREHENSIVE HISTORY

Name: _____ M / F D.O.B.:_____ AGE:_____ DATE:_____

Ethnic Origin: _____ Marital Status: S M W D Occupation:_____

All Medications / Herbs / Supplements Taken Regularly

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

Allergies / Reaction

_____
_____
_____
_____
_____
_____
_____
_____

Year of Last Immunization

Hepatitis _____
Dtap _____
MMR _____
Polio _____
Tetanus _____
Flu _____
Pneumonia _____

Screening Tests

Please list if you've had any of the following in the last 5 years, include the year

	Year(s)				
Cholesterol	_____	_____	_____	_____	_____
PAP	_____	_____	_____	_____	_____
Mammo	_____	_____	_____	_____	_____
PSA/PAP	_____	_____	_____	_____	_____
Hemoccult	_____	_____	_____	_____	_____
Colonoscopy	_____	_____	_____	_____	_____

Hospital Admissions

Year	Illness	Surgery	Fractures
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		

Personal Information

Tobacco Use: Y N
Years Smoking: _____
Interested in Quitting: Y N

Exercise: Y N
Type: _____
Amt of Time / Wk: _____

Diet: Do You Eat Breakfast: Y N
Do You Eat Meat: Y N
Servings of Fruit / Vegetables per Day: _____

Alcohol: _____ oz / wk
Coffee/Tea/Soda: _____oz / day

Wt Gain ____ lbs past year
Wt Loss ____ lbs past year

Sleep: Difficulty Falling Asleep: Y N
Frequent Wakenings: Y N
Snoring: Y N

Are you Sexually Active? Y N
Birth Control Method: _____
Sexual Problems? _____
_____
_____
_____

Females: Onset of Periods (Age) _____
Cycle: _____ days
Duration of Flow: _____days
Spotting Between Periods: Y N
Menstrual Problems:_____
_____

Please complete page 2

NAME:_____ DOB:_____

Family History

Please circle & mark if your grandparents (G), parents (P), or siblings (S) have suffered:

Heart Disease ___ Diabetes ___ Stroke ___ Kidney Disease ___ Cancer ___ Epilepsy ___ Osteoporosis ___

Migraines ___ Thyroid Disease ___ Emphysema ___ Tuberculosis ___ Anemia ___ High Cholesterol ___

Arthritis ___ Gout ___ Glaucoma ___ Mental Illness ___ Allergies ___ Asthma ___ Alcoholism/Addictions ___

Personal Medical History - Mark "C" for current problems. Check box for past problem

- ❑ Decreased Hearing
- ❑ Ringing in Ears
- ❑ Ear Infections – Frequent
- ❑ Dizzy Spells
- ❑ Fainting Spells
- ❑ Failing Vision
- ❑ Double/Blurred Vision
- ❑ Eye Pain
- ❑ Eye Infections – Frequent
- ❑ Nosebleeds – Recurrent
- ❑ Sinus Infections – Recurrent
- ❑ Sore Throat
- ❑ Strep Throat – Recurrent
- ❑ Allergies
- ❑ Hoarseness – Prolonged
- ❑ Pneumonia
- ❑ Chronic Cough/Bronchitis
- ❑ Congestion – Chronic
- ❑ Wheezing/ Asthma
- ❑ Shortness of Breath at Rest w/normal activity w/exertion
- ❑ Chest Pain
- ❑ High Blood Pressure
- ❑ Heart Murmur
- ❑ Palpitations
- ❑ Irregular Pulse
- ❑ Swollen Ankles/Feet
- ❑ Leg Pain w/Walking
- ❑ Loss of Appetite
- ❑ Difficulty Swallowing
- ❑ Indigestion/Heartburn
- ❑ Nausea/Vomiting – Persistent
- ❑ Ulcers
- ❑ Abdominal Pain
- ❑ Change in Bowel Habits
- ❑ Diarrhea
- ❑ Constipation
- ❑ Diverticulosis
- ❑ Bloody Stools
- ❑ Hemorrhoids
- ❑ Gallbladder Problems
- ❑ Jaundice/Hepatitis
- ❑ Hernia
- ❑ Bladder Infections
- ❑ Painful Urination
- ❑ Blood in Urine
- ❑ Nighttime Urination
- ❑ Kidney Stones
- ❑ Venereal Disease
- ❑ Positive HIV
- ❑ Urethral Discharge
- ❑ Seizures
- ❑ Stroke
- ❑ Tremor
- ❑ Muscle Weakness
- ❑ Numbness/Tingling
- ❑ Headaches – Frequent
- ❑ Back Pain – Recurrent
- ❑ Gout
- ❑ Foot Pain
- ❑ Rash
- ❑ Change in Mole
- ❑ Hives
- ❑ Psoriasis
- ❑ Eczema
- ❑ Depression
- ❑ Memory Loss
- ❑ Moodiness – Excessive
- ❑ Phobias
- ❑ Mental Illness
- ❑ Sleeping Difficulty
- ❑ Daytime Sleepiness
- ❑ Snoring
- ❑ Anemia
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Measles
- ❑ Rheumatic Fever
- ❑ Mumps
- ❑ Polio
- ❑ Scarlet Fever
- ❑ Tuberculosis

Reviewed/ Updated

Date:	Updates
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Quality Personalized Family Health Care
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Non-Parental Authorization for Consent to Treat a Minor

I, _____, parent/legal guardian of the child(ren) listed below, do hereby give my authorization and consent for the below named adult(s) to consent for the medical or surgical treatment of my child(ren). I hereby authorize and grant that the below named adult(s) has/have permission from the parents or legal guardian to obtain medical treatment, or sign for surgical procedures, deemed necessary for the health and well-being of my child(ren).

_____	_____	_____
Signature	Relationship to child(ren)	Date

Child(ren) _____ _____

_____ _____

_____ _____

Authorized Person(s)

_____	_____
Name	Relationship to Child(ren)
_____	_____
Name	Relationship to Child(ren)
_____	_____
Name	Relationship to Child(ren)
_____	_____
Name	Relationship to Child(ren)

I understand that while this authorization may be rescinded at any time, it is my responsibility to communicate any changes to this consent,
in writing, to Fossil Creek Family Medical Center.

This authorization expires one year after the date it is signed and must be renewed yearly.

11.2017

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Fossil Creek Family Medical Center, P.A. is a fee for service facility and the following applies regarding payment:

- Payment is due at the time of service
- If you owe an additional balance after your insurance processes your claim, payment is due within 30 days, unless you make other arrangements.
- We do not accept credit card payments for less than $10.00. Please pay by cash or check.
- If you have authorized another adult to bring your child to our facility, that adult is expected to pay any amount due at the time of service. (It is not our policy to bill parents.)
- If a dependent 18 years of age, or older, is seen by our office without another adult present, they are expected to pay for their services at the time of service. (It is not our policy to bill the parents.)
- If you are divorced, or separated, and you bring your child in, you are responsible for payment and then getting reimbursed by your ex, if they are responsible for payment.
- There is a charge for requesting a copy of your medical records. Payment is expected prior to the record being given to the requesting party. (We will send them to another doctor for your treatment at no charge.)
- There is a charge for the time and effort involved in researching information in your records to complete forms such as disability, FMLA papers, etc. Payment for these is expected prior to the form being released.
- There is a charge for typing letters for any reason. Payment is expected prior to the letter being released.
- There is a return check charge for any check that does not clear the bank, for any reason. (Unresolved returned checks will be referred to the District Attorney for handling.)
- Should you accrue a balance, and payment is not paid within a timely manner, your account will be sent to a collection agency. We will make an effort to notify you prior to being sent for collections. Should your account be sent to a collection agency, you will be responsible for the fees due to the collection agency. These will be added to the balance due, to be paid by you, even if you make payment to our facility, as we are still responsible for issuing payment to the agency.
- Texas is Community Property State; if your spouse owes a balance, you will be liable as well.
- If you would like to give us authorization to charge a credit card for any unpaid balance/balance due, please notify the front office. We will send a receipt for any balance charged.
- A $25 fee will be charged to patients who do not call 24 hours in advance to advise that they will not be able to make their scheduled appointment. This fee will be billed to the patient, as it is NOT COVERED by insurance. The fee must be paid prior to your next appointment. We also reserve the right to terminate patients from the practice who incur multiple "no shows" during a 12-month period.

I have read and agree to abide by the payment policies listed above.

_____ / _____ _____

Patient (Responsible Party) Signature / Printed Name Date

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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.

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at, or get a copy of, health information about you that we use to make decisions about you. There will be a charge of $28.00 for providing a copy of your health information. You have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add missing information.

You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes, except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Office Manager
7510 N. Beach Street
Fort Worth, TX 76137
Phone: 817-498-1818

Please complete Privacy Acknowledgement and Releases on the following pages.

PRIVACY POLICY

This is to acknowledge I have read and am aware of Fossil Creek Family Medical Center's policy on disclosure of my health information.

_____ I would like a copy of the disclosure of information policies.

Copy provided by _____ Date _____

_____ I do not choose to obtain a copy of the disclosure of information policies at this time.

_____ _____

Signature and Relationship if not Patient Printed Name Date

RELEASE FORM

Due to the Privacy Law, we need you to list the people that you approve to have access to the following healthcare information when we contact you: (If we may speak with anyone in your household, please note by writing "Anyone" in the appropriate blank, if only self, please indicate such.)

Appointment Scheduling: _____

Billing: _____

Lab Results/Test Results: _____

Prescripton/Medications _____

I authorize Fossil Creek Family Medical Center to provide healthcare information concerning me to the following people, should they contact our office. A "code" word is provided for each person to enable our staff to verify the person contacting them is the person they claim to be. If there is not anyone who might contact us about your private information, please indicate "no one".

Name	Code Word
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRIVACY RELEASE & ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

Authorization to Mail Postcards

_____ (Initial) I authorize Fossil Creek Family Medical Center, P.A. to mail appointment reminder cards and test results cards to the address that I currently have on file at this office.

Authorization to Leave Messages

_____ (Initial) I authorize Fossil Creek Family Medical Center, P.A. to leave messages regarding my medical condition, such as lab reports, medications, and appointment reminders on my home answering machine.

Authorization to be Contacted at Employment

_____(Initial) I authorize Fossil Creek Family Medical Center, P.A. to contact me and/or leave a message at my place of employment if they are unable to contact me at my home number for any of the reasons listed above. Current Work Phone #: _____

All above authorizations will remain in effect unless written notice is given to Fossil Creek Family Medical Center, P.A. to the contrary.

_____

Signature (Patient / Parent /Guardian) Printed Name Date

Authorization for Care

_____(Initial) I grant permission for Fossil Creek Family Medical Center, P.A. to render such care that my physician / practitioner may deem necessary in my diagnosis and treatment. Such care may include medical treatment and minor surgical procedures. I also agree, to the best of my ability, to abide by the care recommended by my provider / practitioner.

Authorization for Release of Information

_____(Initial) I authorize Fossil Creek Family Medical Center, P.A. to release necessary information 1) to other physicians for continuing professional care; 2) to any insurance company or third party payor for the propose of processing a claim; 3) otherwise as allowed by law. I release Fossil Creek Family Medical Center, P.A. from any liability for the release of this information and understand this release includes any and all blood and related test, including HIV, HIB, and other diseases. This authorization is irrevocable and is not limited in time.

Financial Responsibility

_____(Initial) I understand that insurance coverage is not a guarantee of payment, and I agree

I am ultimately responsible for payment of services rendered at Fossil Creek Family Medical Center, P.A. I will honor the clinic's payment policy. If I cannot pay in full at the time of service, Fossil Creek Family Medical Center, P.A. can ask others about my credit worthiness. I agree to pay all expenses related to collections, whether by collection agency or by an attorney.

Medicare / Insurance Assignment

_____(Initial) I certify the information I gave in applying for payment of Medicare / Insurance benefits is correct. I irrevocably assign and transfer to Fossil Creek Family Medical Center, P.A. all insurance benefits covering all services provided by an employee / provider of Fossil Creek Family Medical Center, P.A. I understand it is my responsibility to comply with all referral and pre-certification requirements. I acknowledge I am responsible for payment of any insurance deductibles, co-payments, and co-insurance at the time of service.

Signature (Patient / Parent /Guardian) Printed Name Date