Muenster Family Medical Clinic, LLC
Confidential Patient Information Sheet

Date: ____/____/____

First Name:_____Last Name:_____ DOB___/___/_____
Street Address:_____Mailing Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Gender: Male_____Female:_____ SS#_____
Email Address:_____
Circle One: Married-Single-Partnered-Widowed
Name of partner/spouse/significant other:_____

Patient Employed by:_____
Business Address;_____
Business Phone:_____
Name of Spouse/responsible party:_____Phone#_____

Do you have health insurance: Yes/No

In case of emergency who should we notify:
Name:_____
Relationship:_____
Phone:_____

Preferred Pharmacy:_____ **How did you hear about us?**_____

Assignment of insurance benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, hereby authorize my insurance company to pay and hereby assign directly to Muenster Family Medical Clinic LLC all benefits, if any , otherwise payable to me for his/her services as described on the attached forms, I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Muenster Family Medical Clinic will be credited to my account in accordance with the above said assignment. I also release all insurance/Medicare payments to go directly to Muenster Family Medical Clinic, LLC.

Authorized signature of subscriber _____**Date:** _____

Consent to be evaluated and treated by a Nurse Practitioner

I understand that Muenster Family Medical Clinic, LLC employs a nurse practitioner to deliver care, diagnosis and treat illness and/or injuries that I have incurred, and that I can at any time refuse to see the nurse practitioner and see a physician elsewhere. I also understand that it will be necessary for me to travel to another facility for a physician appointment.

Signature: _____ **Date:**_____

Muenster Family Medical Clinic PO Box 647 Muenster, Tx, 76252
940-759-2502

Muenster Family Medical Clinic

Patient Health History

Name:_____ Age:_____ Birth Date:_____ Gender: _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Currently Living: □ Alone □ With Family □ With Friends □ With Significant Other

Profession (Job): _____ □ Working, Employed By:_____ □ Retired

GENERAL
□ Weight Gain
□ Weight Loss
□ Fatigue
□ Difficulty Sleeping
□ Forgetful

EYE,EAR, NOSE, THROAT
□ Visual Changes
□ Double Vision
□ Ringing in the ears
□ Hearing loss
□ Ear pain
□ Sinus Congestion or Pain
□ Nosebleeds
□ Hoarseness
□ Difficulty Swallowing

DERMATOLOGICA
□ Psoriasis or Eczema
□ Changes in moles
□ Warts
□ Rash

RESPIRATORY
□ Wheezing
□ Coughing
□ Shortness of breath
□ Emphysema/COPD

PSYCHIATRIC
□ Anxiety
□ Depression
□ Moody
□ Irritable
□ Suicidal thoughts

CARDIOVASCULAR
□ Chest Pain
□ Palpitations
□ Murmur
□ Rapid Heartbeat
□ Heart Attack

GASTROINTESTINAL
□ Abdominal Pain
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Rectal bleeding

MUSCLE/JOINT/BONE
□ Muscle Pain
□ Joint Pain
□ Weakness
□ Gout

NEUROLOGICAL
□ Dizzy
□ Loss of conciseness
□ Siezures
□ Numbness
□ Frequent Headaches

ENDOCRINE
□ Thyroid Problem
□ Diabetes
□ Hot Flashes
□ Night Sweats
□ Irregular Menses

QUESTIONS

Do you Smoke?____
___ Per Day
___ Per Week
___ Per Month

Do you drink Alcohol?___
___ Per Day
___ Per Week
___ Per Month

Do you drink Caffeine?___
___ Per Day
___ Per Week
___ Per Month

Do you Exercise? ___
___ Per Day
___ Per Week
___ Per Month

Colonoscopy __ Yes __ No
Date_____

Bone Density __ Yes __ No
Date_____

Result of Bone Density
Normal ___ Abnormal ___

Mammogram __ Yes __ No
Date_____

Date of Last Pap Smear
_____

Hysterectomy __ Yes __ No
If yes, do you still have your ovaries? ___ Yes ___ No

MEN ONLY

Pain or Lump(s) in testicles?
___ Yes ___ No

Penile (penis) itching, burning or discharge?
___ Yes ___ No

Prostate Disease or problems?
___ Yes ___ No

Problems starting or stopping your urine stream?
___ Yes ___ No

Wake in the night to go to the bathroom?
___ Yes ___ No

Sexual Problems or concerns?
___ Yes ___ No

WOMEN ONLY

Number of Pregnancies _____

Births ____ Miscarriages ____
Abortions ____

Birth Control Method:
_____

Sexual Problems or Concerns?
_____

Vaginal itching, burning or discharge?
___ Yes ___ No

Wake in the night to go to the Bathroom?
___ Yes ___ No

Muenster Family Medical Clinic

Patient Health History

CONDITIONS Check all you have or have had in the past

□ AIDS □ Alcoholism □ Anemia □ Anorexia □ Appendicitis □ Arthritis □ Asthma □ Bleeding Disorders □ Breast Lump □ Bulimia	□ Cancer □ Cataracts □ Chemical Dependency □ Diabetes □ Emphysema □ Epilepsy □ Glaucoma □ Goiter □ Heart Disease □ Hepatitis	□ HIV Positive □ Kidney Disease □ Liver Disease □ Migraine Headaches □ Mononucleosis □ Multiple Sclerosis □ Pacemaker □ Pneumonia □ Psychiatric Care □ Stroke	□ Thyroid Problem □ Tuberculosis □ Ulcers □ Sexual Transmitted Disease Type_____ □ Other (please list) _____ _____

Check illnesses which have occurred in any of your Grandparents, Parents, Siblings & List Relation

* If someone in your family has had cancer, please list what kind of cancer

□ Alcoholism _____	□ Diabetes _____	□ Leukemia _____	□ Nervous Breakdown _____	□ Cancer _____
□ Anemia _____	□ Emphysema _____	□ Liver Disease _____	□ Heart Attack _____	□ Type of Cancer _____
□ Arthritis _____	□ High Blood Pressure _____	□ Mental Illness _____	□ Stomach Problems _____	□ Cancer _____
□ Asthma _____	□ Kidney Disease _____	□ Migraines _____	□ Stroke _____	□ Type of Cancer _____

SURGERIES/HOSPITALIZATIONS: List all Surgeries

Surgery	Year	Reason	Physician

MEDICATIONS: List all medications you take (**Including over the counter medications & herbs and medications taken**

Medication	Strength	How Often	Reason

ALLERGIES: list all allergies (medications, foods)

Allergy	Reaction

MUENSTER FAMILY MEDICAL CLINIC, LLC.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Muenster Family Medical Clinic LLC., to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Muenster Family Medical Clinic LLC., describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at PRACTICE.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Muenster Family Medical Clinic LLC., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Amy Dangelmayr, FNP-C at Muenster Family Medical Clinic, LLC.

With this consent, Muenster Family Medical Clinic LLC., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Muenster Family Medical Clinic LLC., may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements.

With this consent, PRACTICE may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Muenster Family Medical Clinic LLC., to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Muenster Family Medical Clinic LLC., may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

FINANCIAL POLICY

Thank you for choosing Muenster Family Medical Clinic as your health care provider. We are committed to providing excellent healthcare services to you, our patient. As a part of 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 deny 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 a contract 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.
- Most plans will not disclose reimbursement until they receive all information from your visit, so please be aware you may owe more than collected on the day of service.
- Before receiving services, you must verify that we are participating provider for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company. You will change the physician to Chance Dingler, MD at this physical address.
- If you have a wellness exam and our provider addresses other problems, you will be expected to pay your copay at the time of visit. Your insurance will be billed for a wellness visit and sick visit.
- If any lab testing is done in the office, you may receive a bill from an outside lab and/or pathologist. We use Clinical Pathology Labs (CPL) and Atherotech (VAP). It is your responsibility to inform this office that your insurance policy requires you to use a different lab other than CPL or VAP.
- If any lab testing is done with Atherotech (VAP) you will not be responsible for the amount shown on your EOB. You the patient will only be responsible for $39.00 regardless of what your insurance company pays.
- 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 is your responsibility to contact our billing service **Valton Billing** within 30-days after receipt of the initial statement. You can call **(940) 634-1699** with any questions regarding your statement.
- If you are not satisfied with the services of Valton Billing you can call our office at **(940) 759-2502**.
- Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due.
- If you are not able to pay the balance due in full, you must contact our 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.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from Muenster Family Medical Clinic. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

By signing below you agree that you have read the above information.

_____ _____

Patient (Guardian) Signature Printed Name

_____

Date

Prescription Refill Policy

PLEASE CALL YOUR PHARMACY FOR PRESCRIPTION REFILLS

ALLOW OUR OFFICE 48 HOURS TO FILL YOUR PRESCRIPTIONS.

IF YOU HAVE NO REFILLS LEFT ON YOUR PRESCRIPTION BOTTLE PLEASE CALL OUR OFFICE

Patient signature_____**Date**_____