Kimberly Warfield, MD
Alicia Grossmann, MD
Lauren Hodgkins, PA-C

PATIENT INFORMATION (Who is being seen today?)

Social Security #:	**Employer:**
Name:	**E-Mail:**
Address:	**Married:** Married Single Divorced Widowed
Apt #	**Employed:** Full time Part time Retired
City: **Zip:**	**Student:** Full time Part time
Primary Phone#:	**Emergency Contact:**
Alt Phone#:	**Emergency Phone#:**
Sex: **Birth Date:**	**Emergency Relationship:**
How did you hear about us?	
Can we leave message? Yes No **with spouse?** Yes No **with children?** Yes No **with parents?** Yes No	
Can we use email to communicate? Yes No **Can we call you at work?** Yes No	
Have you gone by another name? (Maiden, etc.)	
Race: White Black Hispanic Asian Other: **Ethnicity:** Hispanic or Non-Hispanic	
Preferred Language: English Spanish Other:	

GUARANTOR INFORMATION (Whose insurance is it?)

Name:	**Sex**
Address:	**Birth Date:**
City, Zip:	**Social Security#:**
Home Phone#:	**Employer:**
Work Phone#:	**Relationship to Guarantor:**
Cell Phone#:	

INSURANCE INFORMATION- Provide copy of insurance card

PHARMACY INFORMATION

Local Pharmacy Name:	**Mail Order Pharmacy Name:**
Local Pharmacy Address:	**Mail Order Pharmacy Address:**
Local Pharmacy Phone Number:	**Mail Order Pharmacy Phone Number:**

- **We do not see work related injuries or motor vehicle injuries.**
- **As a service to you, our office can file insurance.**
- **I authorize the release of any medical information necessary to process my claim and I authorize payment of benefits directly to Alicia W. Grossmann, MD or Kimberly Warfield, MD**

Patient (or Responsible party): _____Date: _____

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PATIENT HISTORY

Name: _____ Age: _____ Date: _____

Reason for Visit: _____

List all other chronic medical problems:

1) _____
2) _____
3) _____
4) _____
5) _____

List all medication dose and frequency:

1) _____
2) _____
3) _____
4) _____
5) _____

List all prior surgeries (include date):

1) _____
2) _____
3) _____

Allergies and drug sensitivities:

1) _____
2) _____
3) _____

FAMILY HISTORY

Has a blood relative had any of the following: (Circle answer & indicate relative, i.e. Mother, Sister, Maternal Aunt, Father, Paternal Grandfather etc. If uncertain, leave blank)

		Relationship			Relationship
Cancer (type)	no yes	_____	Asthma	no yes	_____
Tuberculosis	no yes	_____	Emphysema/COPD	no yes	_____
Diabetes	no yes	_____	Allergies	no yes	_____
Heart disease	no yes	_____	Drug/Alcohol Prob	no yes	_____
High Cholesterol	no yes	_____	Depression	no yes	_____
High blood Pressure	no yes	_____	Mental Illness	no yes	_____
Obesity	no yes	_____	Gout	no yes	_____
Migraine Headaches	no yes	_____	Thyroid Disease	no yes	_____
Stroke	no yes	_____	Ulcer	no yes	_____
Epilepsy/Seizure	no yes	_____	Kidney Disease	no yes	_____
Anemia	no yes	_____	Glaucoma	no yes	_____
Bleeding Tendency	no yes	_____	Other (specify)	no yes	_____
Blood Clots	no yes	_____	Other (specify)	no yes	_____

SOCIAL HISTORY

Do You Smoke? no yes Have you ever smoked? no yes Number of years _____ How much? _____

Do you drink alcohol? no yes How many drinks per day? _____

Do you regularly drink caffeinated beverages, i.e. cola, coffee, tea? no yes How much per day? _____

Do you use any illicit drugs? no yes What kind? _____

Are you sexually active? no yes Marital Status M D S W Sexual preference? Hetero / Homo / Bi

Current Occupation _____ Prior Occupations _____

Females: Pregnancy History: Number of pregnancies _____ Number of deliveries____ Ages of children _____

Any complications with pregnancy or delivery? _____ Number of miscarriages: _____abortions: ____

Immunizations: When was your last: Tetanus _____ Flu _____ Pneumonia _____

When was your last eye exam? _____

Patient Signature: _____ Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

We promise we will not share your private health information without your permission AND you give us permission to file your insurance for you.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand a *Notice of Privacy Practices* has been posted that provides a more complete description of information uses and disclosures. I understand that I have the right to request my own copy and I have the right to review the notice before signing this consent. I understand that I have the right to object to the use of my health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Authorization for Release of Medical Information

I, _____authorize ***Alicia W. Grossmann, MD or Kimberly Warfield, MD*** to discuss with or release my medical information with the following:

Spouse: _____

Parents: _____

Children: _____

Other: _____

- **As a courtesy to you, our office can file insurance to primary and secondary insurance.**
- **I authorize the release of any medical information necessary to process my claim and I authorize payment of benefits directly to Alicia W. Grossmann, MD or Kimberly Warfield, MD**

I understand that I may revoke this consent, in writing, at any time by submitting written notification to Alicia W. Grossmann, MD or Kimberly Warfield, MD attention Medical Release Correspondent, at the above address.
I hereby authorize Alicia W. Grossmann, MD or Kimberly Warfield, MD to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer protected by this rule.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Parent/ Executor/Legal Representative) (Date)

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We are committed to providing comprehensive, high quality medical care and to work with you, the patient, to achieve the highest level of personal health possible. **THANK YOU** for giving us the opportunity to serve you & your family in your healthcare needs.

INSURANCE FILING is done on your behalf as a service to you and requires the presentation of your current insurance card & drivers' license at each visit. It is vital that you notify us **ASAP** of any changes (Insurance, job, address, phone, etc) or you may be required to pay in full and file your insurance yourself. Remember that it is your responsibility to provide us with your correct insurance information, correct address and correct phone contact information before your visit. If your account is overdue or sent to collections, you will incur an additional fee.

AFTER HOURS: "On Call" For Urgent medical problems - Call the main line (512) 568-3565 and choose option 1. Please have your pharmacy number & your current medications & doses on hand. When you call after hours, we will respond promptly. If you do not receive a response within 60 minutes, please call back and verify your phone number. Make sure your phone line does not block caller ID restricted lines, or the provider will not be able to return your call. You will be assessed a $50 fee for afterhours calls. Routine refills are not handled after hours.

REFILLS of regular medicines take 24-72 hours to process. Do not wait until your prescription runs. Contact your pharmacy to begin the refill process at least 2-3 days before running out of medication. Even if your prescription says 0 refills, the pharmacy will submit a refill request to us. Please note that you must keep follow-up appointments or your meds will not be refilled. Any prescriptions for controlled substances (triplicate prescriptions) will need 48-72 hours' notice and must be picked up.

REFERRALS are a labor-intensive process. Your cooperation is appreciated. •You need to be seen for an appointment to obtain a referral. •Contact your insurance to find out who accepts your insurance and please notify us if you have a specific specialist you prefer. •Once the physician orders the referral, our referral coordinator will contact your insurance carrier to obtain authorization. Response times from insurance plans varies and can be anywhere from 1-7 business days. Do NOT go to a specialist without an approval. You may be turned away or billed personally for services. **HELPFUL HINTS for referrals:** Not all insurance plans require a referral. Contact your insurance if you are unsure. Please call the office at least one week in advance for referral changes or extension requests.

MEDICAL RECORDS: Your medical records are maintained and protected by privacy regulations. You may request a copy of your medical records at any time.

LABWORK AND RESULTS: When a physician orders lab work for you, if you come in and have it drawn within one week you will **NOT** be charged an additional co-pay. Once the blood is drawn, the specimen will be sent to a lab to be tested. Within 1 week of having your labs drawn you will receive a phone call with the results. If it has been more than 1 week after a lab draw and you have not gotten the results, then please contact the office.

BILLS FROM LABS: You should call the lab to make sure they have your correct insurance information and to find out why they are billing you. It may be that you are responsible for a deductible. Occasionally, a test may not be covered by your insurance and the lab will bill you.

PRESCRIPTIONS FOR CONTROLLED SUBSTANCES: You may be subject to intermittent drug testing for any long-term prescriptions of controlled substances (for example: some anxiety, ADD, and pain medications).

WE SCHEDULE APPOINTMENTS: based on type and number of problems in an attempt to keep our schedule on time. When scheduling, we ask you to list ALL the problems that you would like to have the doctor address. You are asked to call us back should anything else come up so that we can adjust the appointment or reschedule if necessary.

WORK-INS: We discourage walk-in appointments, please call ahead. As a work-in, your visit may be associated with a wait to see the doctor. Due to schedule constraints, we cannot guarantee which provider you will see. As a work-in, the provider will address one acute issue. Issues such as routine care, refills or follow-ups will **not** be addressed on a work-in basis.

PLEASE CANCEL: If a situation arises where you cannot make your appointment, please notify our office 24 hours before your appointment or you will be charged a "no show" fee. If you arrive more than 15 minutes late to your appointment, please note that you may be asked to reschedule and you may be assessed a "no show" fee of $50.

WORKER'S COMP AND DISABILITY: We will not be able to see you for these issues. Please contact your employer for further instructions.

PRE-OPERATIVE EXAMS: Please bring your surgeon's information, any records pertaining to the surgery and the surgeon's orders with you.

RESPECT: WE EXPECT OUR PATIENTS TO TREAT OUR STAFF RESPECTFULLY AT ALL TIMES. If you are not respectful to our staff, then you will be discharged immediately from the practice.

_____ _____
(Signature of Patient) (Date)

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Consent to Release Protected Health Information

I hereby authorize the Medical Record Custodian to release information from the medical record of:

Patient Name:			Date of Birth:
Address:			Telephone:
City:	State:	Zip:	Date of Service:

Information May Be Released To:		Information Will Be Released From:	
Medical Practice/Doctor: **Alicia Grossmann, MD / Kimberly Warfield, MD**		Medical Practice/Doctor:	
Address, City, State, Zip: **11673 Jollyville Road, Ste 205**		Address, City, State, Zip:	
Phone: **512-834-9999**	Fax: **512-834-9998**	Phone:	Fax:

Please release the following information:

- ☐ Complete Medical Record (Initial and date box below if HIV/AIDS test results are to be included)
- ☐ Records of Care From _____ to _____
- ☐ Other (Specify) _____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infections, antibodies to AIDS or infections with any other causative agent of AIDS with the rest of my medical records.

INITIAL: Date:

Reason for Release:

- ☐ Change of Physician
- ☐ Personal Use
- ☐ Consultation with another physician
- ☐ Other:
- ☐ Workers' Compensation
- ☐ Attorney/Legal
- ☐ Disability

1. I understand that the information in my health records may includes information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assume treatment. I understand that with certain exceptions I may inspect or copy the information to be used of disclosed. I understand that any discloser of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

3. I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been release in response to this authorization. I understand that information released may be subject to re-disclosure and may no longer be protected by federal and state privacy regulations. I understand that this authorization shall remain effective indefinitely unless otherwise stated _____ (Date of Expiration), except to the extent that action has been taken in reliance on this authorization by providing written notice.

Signature of Patient or Legal Representative Date

Relationship to Patient if not Patient