Rocky Creek Family Medicine

Deirdre McMullen M.D. Hillary Spears FNP Jackie Alfaro FNP

Family, Cosmetic, & Bariatric Medicine

3281 Rocky Creek Drive, Suite 500 Missouri City, TX 77459

Phone: 281-206-0068 Fax: 281-499-5045

Demographic Information: (PLEASE PRINT and fill in all that is applicable)

Last Name: _____ First Name: _____

Previous Name: _____ Gender: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Leave Message: Brief / Extended [ ] Home or [ ] Cell Student: Full / Part-Time / NA

Marital Status: Single Married Divorced Widowed Legally Separated Partner

Patient's Social Security Number: _____-_____-_____ Date of Birth: _____

Employment Information: Employer Name: _____

Employment Status: Full-Time Part-Time Self-Employed Retired Not Employed

Emergency Contact Information:

Emergency Contact Last Name: _____ First Name: _____

Relation: Spouse Child Parent/Guardian Other Phone: _____ Guardian: Yes / No

Primary Insurance Information:

Insurance Name: _____ Phone: _____ Group#: _____

Subscriber or Member ID Number: _____ Date of Birth: _____

Guarantor Name: _____ Phone: _____ SS# _____

Secondary Insurance Information:

Insurance Name: _____ Phone: _____ Group#: _____

Subscriber or Member ID Number: _____ Date of Birth: _____

Guarantor Name: _____ Phone: _____ SS# _____

Additional Information (please circle only ONE from each section):

Race: White Black or African American Hispanic American Indian / Alaska Native

Asian Native Hawaiian Other Refuse to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Refuse to Report

Language: English Spanish Indian Other

Advance Directive: (**Advance directives** are legal documents that allow you to spell out your decisions about end-of-life care ahead of time.)

[ ] Patient has declined Advance Directive at this time.
[ ] Do Not Resuscitate (DNR) – please give a copy to the receptionist to scan into your record.
[ ] Organ or Tissue Donor
[ ] Living Will – please give a copy to the receptionist to scan into your record.
[ ] Power of Attorney - please give a copy to the receptionist to scan into your record.

Pharmacy Information: (Pharmacy phone number is required to expedite refill / new prescriptions)

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Patient's email address (to be web enabled for the portal): _____

Consent to Treat, Insurance Authorization and Assignment

I voluntarily request Deirdre McMullen M.D. and/or mid- level provider(s) (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing is recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I authorized Rocky Creek Family Medicine, PLLC to release any medical and social information acquired during the course of my examination and/or treatment, for the purpose of filing for insurance and other financial coverage, legal correspondence and to provide required information to other medical professionals and facilities for my continuing diagnosis and treatment and to state and government facilities as required by law.
I hereby authorize payment of medical benefits directly to Rocky Creek Family Medicine, PLLC. I understand that I am financially responsible for charges not covered by this assignment of benefits, and should the account be referred for collection, I agree to pay reasonable collection and/or attorney's fees.

Print Name: _____ Date: _____

Signature: _____ Office use: entered by _____

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____[Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Rocky Creek Family Medicine

Deirdre McMullen M.D. Toni White M.D. Hillary Spears FNP

3281 Rocky Creek Drive, Ste 500 Missouri City, TX 77459

Phone: 281-206-0068 Fax: 281-499-5045

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your satisfaction. Please assist us in meeting your expectations by reviewing the Financial Policy below.

Forms: You will be asked to complete a registration form which will include your home address, telephone number, social security number as well as the address and telephone number of your insurance company, if applicable. Insurance company information can generally be obtained from a card provided to the company's insured member, and we prefer to make a copy and scan of the card for our records. We also request a copy of your driver's license or other picture identification to include in your record.

Forms of Payment: For your convenience, we accept cash and checks, as well as many credit and debit cards. We must have a copy of your driver's license to accept checks.

Office Visits: All office charges are payable at the time the service is rendered. If you desire, we will provide you with a copy of the superbill documenting the charges and receipts for your visit, which you may use to file for reimbursement with your insurance carrier.

Financial Responsibility for Minors: Unless prior arrangements have been made, charges for a minor child seen in the office will be the responsibility of the adult accompanying the minor child.

Managed Care Plans: We are contracted with many managed care plans. We will file your insurance in accordance with our agreement with the plan. Any copayment or deductible for which you are responsible must be paid at the time of service.

Although we can assist you in many ways, it is your responsibility to be familiar with the coverage provided by your insurance plan, particularly with respect to preventive care, immunizations, the authorization of any procedures and your primary care physician. Please let us know when you call to make an appointment of any changes in your insurance coverage or plan. It will be your responsibility to make payment for any services not covered by your insurance company. If benefits and eligibility cannot be verified prior to service, you will be required to pay for services in full. Any charges denied by your insurance carrier will be your responsibility.

_____	_____	_____
Signature of Patient or Legal Guardian	*Date*	*Relationship to Patient*
_____	_____	_____
Print Patient's Name	*Date of Birth*	*Print name of Legal Guardian, if any*

PATIENT/GUARDIAN MUST BE PROVIDED WITH A SIGNED COPY OF THIS AUTORIZATION FORM.

PLEASE INITIAL IF DECLINING COPY. _____

PHYSICIAN/PATIENT
MEMORANDUM OF UNDERSTANDING

Thank you for choosing our care team for your medical care. We appreciate the trust and confidence you have placed in us.
Our goal is to provide YOU with high quality, personal medical care, which is responsive to your individual needs and values.
In order for this goal to be achievable, it is important that we (the Physician and the Patient and/or the Patient's caregiver) each commit to satisfying certain responsibilities, as follows:

PHYSICIAN RESPONSIBILITIES

- I will listen effectively, provide YOU with explanations as to health care matters, and otherwise encourage a way of life of open, full and honest communication between us.
- I will provide YOU with information regarding the different treatment plan for YOUR acute or chronic condition to enable YOU to select the plan appropriate for YOU.
- I will provide convenient options (telephone, voice mail, and email) for non-urgent communications between YOU and my practice team for scheduling office visits and follow up visits, and for obtaining test results and referrals.
- I will provide YOU telephone availability for urgent communications, 24 hours per day, and 7 days per week by a medical provider in the office.
- As technology develops, every effort will be made to provide convenient options (e-consultations, secure email) for non-urgent communications between YOU and I and/or my team, including post-hospital support, follow up visits and consultations.
- I will coordinate a multidisciplinary approach to YOUR health care by referring YOU to other clinicians and health care institutions when appropriate.
- I will coordinate and integrate care provided by other health care professionals, other clinicians and health care institutions effectively so as to avoid duplication, delay and error.
- I will provide flexible and expanded office hours, schedule YOUR appointments within a reasonable time, and see YOU as closely as reasonably possible to YOUR scheduled appointment time.
- I will furnish YOU with test and treatment results promptly and correctly.
- I will provide YOU with information and recommendations regarding preventative care, maintaining wellness, self-management direction and counseling.
- The health care team in my practice will send YOU reminders of the need for follow up care, preventative care and compliance with treatment plans.
- I will keep clinical information in a system that allows for ready search, retrieval and information transfer while protecting privacy and confidentiality, including participating in the development and maintenance of standardized electronic health records and patient registries.
- My practice team will be trained in the responsibilities described above.

YOUR RESPONSIBILITIES

- Communicate openly, fully, freely and proactively with my Medical Provider and staff.
- Be an active participant in the development with my Medical Provider of a treatment plan for my or the patients acute or chronic condition, and follow agreed-upon treatment plans.
- Provide Medical Provider with feedback regarding my or the patients treatment plan.
- Appear on time for appointments, procedures and other medical tests at my Medical Providers office, and timely submit materials, samples and information as requested by Medical Provider.
- Schedule and attend follow up appointments at intervals suggested by my Medical Provider.
- Follow my Medical Provider and other health care professionals' recommendations with respect to maintenance or improvement of my or the Patient's health and wellness.
- Participate in developing and maintaining a comprehensive Patient health record by authorizing delivery and circulation of my or the patients clinical information to and from clinicians and health care institutions.

Please take the time to carefully read and understand each of our respective responsibilities. To show that you accept and agree with them please sign your name below
Thank you once again

SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE	RELATIONSHIP TO PATIENT
PRINT PATIENT'S NAME	DATE OF BIRTH	PRINT NAME OF LEGAL GUARDIAN (if applicable)