MEDSTAR
Family CARE / Urgent Care

601 E FM 544, SUITE 400, MURPHY, TX 75094 TEL : 972-442-4700 FAX: 972-442-1140
3017 E Renner Rd, Suite 100, Richardson TX, 75082 TEL: 972-442-4700 FAX-972-707-0442

Initial Clinical History and Physical Form

Date: _____

Patient Information

Name: _____ Age: _____ Date of Birth: _____ /_____ /_____

Sex: Male / Female Marital **Status:** Single Married Divorced Widowed # Children _____

Reason for Visit: _____

_____

Past Medical History

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____
4._____ 8 _____

Past Surgical History (Please include Year**)** **Last Tetanus: _____year**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medications (Medication Dose)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Drug Allergies /Type of Reaction

1. _____ 4. _____
2. _____ 5. _____
3. _____

Mammogram_____ year **Colonoscopy**_____year

Family Medical History

1.Mom_____

2._____

3..Dad_____

4.Sister_____

5._____

6.Brother_____

7._____

Social History

Tobacco Use Y / N
_____ Packs per day for _____yrs.

Alcohol Use Y / N

Drinks Per Week _____ for_____ yrs.

Recreational Drug Use Y / N

Name:

For _____years.

_____ _____
Patient / Guardian Name **Patient / Guardian Signature**

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Patient Information

Last Name_____ First Name: _____ Date of birth_____

Age_____ Sex: M_____ F_____ Social Security: _____--_____--_____

Home Phone: _____ Cell: _____

Mailing address _____ APT# _____City: _____ State: _____

Zip Code/ Postal _____ Email: _____

Does Patient have Insurance? / Yes ____ No____ Insurance: _____

Subscriber's name: _____ SS# _____-_____-_____ DOB_____

Parent/Guardian Information

Parent /Guardian Name: #1_____DOB_____

Mailing address/: _____ City/: _____ State/Estado: _____

Zip Code/ Postal: _____ Home Phone: _____ Cell: _____

Occupation: _____ Work Address: _____

City: _____State:_____ Zip Code: _____ Work # _____

Parent /Guardian Name: #2_____DOB_____

Mailing address/: _____ City: _____ State: _____

Zip Code: _____ Home Phone/: _____ Cell: _____

Occupation: _____Work Address_____

City: _____State/_____ Zip Code/ Postal: _____ Work #_____

Emergency Contact: (Required)

Name	Relation	Telephone #	Discuss Medical History	Discuss Lab/ Imaging result	Discuss Billing
			YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO

_____ _____

Patient / Guardian Name **Patient Signature**

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Consent for Treatment

Name of Patient: _____ Date of Birth: _____/_____/_____

Name Legal Guardian:_____ Relationship to Patient: _____

I understand that I may be seen under Medstar Family care P.L.L.C and or Medstar Urgent P.L.L.C care depending on my Insurance Plan. Consent I provide today will include both these entities. Term Medstar Used in following will pertain to either or both entities. I, hereby and voluntarily consent to authorize MEDSTAR providers and staff to provide, including but not limited to, evaluation, testing (including HIV and Drug screening), treatment & healthcare services to me/ My child at all locations. Services may be provided in the clinic, via Telehealth or over the Telephone. The health care services may include, without limitation, routine physical and mental assessment; Mental health treatment, genetic testing; counselling; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications and vaccination; and procedures and treatments prescribed by the center's healthcare Providers / Staff. I also authorize Medstar to take my/ my child's picture for Management and Clinical purposes. I authorize release or obtain any information concerning me / my child health information, including but not limited to counseling, test, treatment and Insurance information for the purpose of Evaluation, treatment and insurance claim benefits. I also Authorize to E prescribe my medications and supplies to the Pharmacy. I authorize Medstar Urgent Care to obtain my / my child's Medical History/ Records regarding my medication from third party, Pharmacy, Hospital, Medical Office, Imaging center and other appropriate medical facilities. I authorize Medstar Urgent care to send my test to other laboratory for testing and my health and payer Information to the Laboratory. I acknowledge that I will receive a bill from the Laboratory and I will be responsible for the Laboratory payment, and release Medstar from any responsibility and liability. There may be a portion of billing / Medical Equipment that is not covered by insurance and I will be responsible for the balance. I understand that I am responsible for charges due to services I receive that are not paid by my insurance. I realize that although Medstar, its staff and provider work in my best interest risks, side effects and complications can be unpredictable both in nature and severity. I unconditionally release Medstar of all liability to the greatest extent allowed by law. I understand that this consent is valid and remains in effect as long as I am a patient of Medstar, until I withdraw my consent, or until MEDSTAR changes its services and asks me to complete new consent forms.

My Signature on this form indicates that: I certify that I have read and fully understand the foregoing consent and the facts indicated above are true. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require such. I hereby voluntarily give my consent to Treatment at both or either facility Medstar Family care and or Medstar Urgent care.

_____/_____/_____

Signature of Patient/Legal Representative Date

_____/_____/_____

Name of Patient/ Guardian Date

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Patient Name: _____ DOB: _____

Initial_____I hereby authorize MedStar and its Staff to Disclose (release), Use and/or Request my protected Health information to/from: All medical organizations that I am referred to/from for my continuity of care. I also understand that MedStar is permitted to use and disclose my Health Information as required by law, such as workers' compensation, reporting top public health entities to include reporting to the Department of State Health Services, Immunization Registry (ImmTrac),Animal control, reporting abuse, neglect or domestic violence, judicial and administrative proceedings, law enforcement, death reports, organ donation purposes, or to avert serious threat to public health or safety. MedStar is permitted to use and disclose my Health Information for treatment, payment and health care operations.

Initial: _____ I understand that I have a right to receive a copy of this authorization. I may revoke this Authorization at any time, but I must do so in writing and submit it to address below.

Initial: _____ I understand that it is my responsibility to know the benefits and Network of my insurance and not Medstar and its staff. Also to be aware of my Co-Payment, deductible and Coinsurance in an out of network provider and facility.

Initial: _____ I Give Medstar Urgent care consent to contact me / emergency contact for follow up and discuss test results. I also give permission to leave a message over the phone. Medstar may contact me via text or email for, including but not limited to; scheduling, appointment reminder, Tele-Visit, feedback and update on any policy change.

Initial: _____ I understand that for every 6 billing statements a processing fee of $35 may apply. If unpaid balance is sent to collection agency, I will be responsible for the cost of collection services.

Initial: _____ I understand that if I / my child have not met the deductible, a partial payment will be charged at the time of visit, depending on services rendered. The claim will be submitted to the insurance. I'll receive a bill in mail for any difference and outstanding balance. Which I'll be responsible to pay.

Initial: _____ I understand that I must inform Medstar by 2:00 p.m. on the day prior to my scheduled appointment for any rescheduling or cancellation. If Medstar is not informed, a fee of $30 may apply.

Initial: _____ I understand that if I am being seen under my health insurance, self-pay charges do not apply to me. The self-pay charges do not apply to patient having health insurance and are not interchangeable.

Initial: _____ I give Medstar permission to Charge my Credit / Debit Card. I am charged only at time of visit and no automated payment is set in place. This Authorization will remain in effect until written request is provided.

Initial: _____I acknowledge that Medstar has made their Notice Of Privacy Practices available to me.

_____/_____/_____

Signature of Patient/Legal Representative Date

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Telehealth

An electronic or e-visit is an alternative designed to efficiently respond to routine, non-complex medical problems. (Examples might include: a cold or sinus infection, a mild stomach virus, follow-up of a stable chronic condition).

An e-visit is not designed for complex or non-routine medical care especially problems that might require the relating of extensive history information or a thorough physical exam. E-visits are only offered to established patients and you agree that during the visit you are representing yourself and not another person.

Your e-visit will be filed to your insurance. Co-pays and deductibles may apply. Self-pay rates are available for the uninsured and rates are not interchangeable.

Requests for e-visits must be confirmed and scheduled by our office prior to the e-visit. Prior to the visit you may be asked to complete certain medical questionnaires. Sometimes, after reviewing your information, or during the e-visit it may be determined that your problem is too complex for an e-visit session. In that case our office will schedule you for a traditional office visit and your e-visit fee will be applied and adjusted to the patient balance accordingly as per billing policy.

Communication during an e-visit may be exchanged via teleconference, landline phone, cellular phone and online chat. These methods are by their very nature not as secure as a face-to-face encounter. By requesting an e-visit you acknowledge that personal health information will be communicated in a manner that is subject to hacking and other malicious behavior.

As with any medical service, decision, or treatment, there are risks; and, an e-visit is no different. Because this visit is electronic and not in person, you acknowledge that the risk may be greater than a traditional office visit, and by requesting the visit you agree to accept the outcome-even if it is undesirable. In addition, you agree to abide by our office's routine policies including any policy related to litigation.

I have read all the above and fully understand its terms, and understand that I am giving up substantial rights, consistent with the state and federal laws and regulations concerning the privacy of such information.
I acknowledge that I am signing the release freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

Date: _____

Print Name of Patient/ Guardian: _____

Signature of Patient/ Guardian: _____

Witness: _____ / _____
Name Signature