ABUNDANT HEALTH! FAMILY MEDICINE

Tanya R. Grun, M.D.

Patient Registration

(Please Print)

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security # ____-____-_____

City/State/Zip: _____ Gender: ○ Female ○ Male

Home Phone: _____ Cell Phone: _____

Marital Status: _____ Race: _____ Ethnicity: _____ Language: _____

Employed By: _____ Work Phone: _____

Email Address: _____

Guarantor Information

(Insurance policy holder)

Guarantor Name: _____ Date of Birth: _____

Address: _____ Social Security # ____-____-_____

City/State/Zip: _____ Gender: ○ Female ○ Male

Home Phone: _____ Cell Phone: _____

Marital Status: _____ Race: _____ Ethnicity: _____ Language: _____

Employed By: _____ Work Phone: _____

Email Address: _____

Abundant Health! Family Medicine| 652 N. Houston Ave #2 |New Braunfels Texas 78130

Notice to Patients

Abundant Health! Family Medicine providers are not providers for claims regarding accidental injuries as a result of motor vehicle accidents or a work- related injury/ workers comp claim. If you are a victim of a motor vehicle accident or work-related injury and your appointment with our office is in any way a result of that accident, please take this form to the front desk so that we may remove your appointment from the schedule database.

By signing this document, you are attesting that your injuries that we are evaluating in our office are not related to motor vehicle accident or a work-related /workers comp claim.

Print Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Statement of fact:

I, the above signed patient attest to a statement of fact regarding my injury. I acknowledge that knowingly or willfully falsifying medical information will result in an immediate collection based upon the care provided. In addition, I will be personally responsible for the debt incurred during my visit and agree to pay a $200.00 additional processing fee per visit during which the false or misleading information was provided.

ABUNDANT HEALTH FAMILY MEDICINE
FINANCIAL POLICY

Printed Name of Patient: _____ Date: _____

Welcome! Thank you for choosing Abundant Health Family Medicine as your health care provider. We look forward to providing excellent medical care and forming a long-term professional relationship with you. As part of that professional relationship., we feel it is important to provide you information that will allow you to understand our financial policy.

If you have medical insurance, that relationship is between you, your employer and your insurance company. As a courtesy, we will file a claim with your insurance for our services. **Ultimately you are financially responsible for the services rendered by our providers.**

- It is always the patient's responsibility to know their insurance carriers benefits and policy. Pléase provide your current insurance information at the time of your visit. Failure to provide the correct insurance information in a timely manner, could result in the claim being denied by your insurance company. In the case of non-payment by the insurance carrier, patient is ultimately responsible for payment. Please make sure to bring your current insurance card to each visit.
- Before you receive services at our office, you must verify that we are participating providers with your insurance. If we are not participating providers and you still want to be seen, you will need to pay for the service in full at the time of the visit.
- Please be aware that some or perhaps all of the services rendered in our office may not be covered fully by your insurance company.
- You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- If your insurance plan includes a copay, we are required to collect the copay at the time of service.
- Coinsurance and/or deductibles are due at time of service. We will estimate the amount owed based on the information from your insurance company. If additional amounts are owed after the insurance company has paid the claim, you will be responsible for the difference, regardless of our initial estimate.
- **It is your responsibility to provide us with your most current medical billing information.**
- You will be asked at each visit to verify your insurance information as well as your current mailing address and phone number.
- If you have an account balance, we will send a statement to the most recent billing address you have provided. If you have questions about your statement, please contact our office at 830-620-7744.
- **Payment in full is due upon receipt of your statement.** Balances not paid in full within 30 days of statement issue date will be deemed past due. Past due accounts will be subject to a $10.00 rebilling fee.
- Past due accounts may be referred to an independent collection agency for further collection activity.
- If you are unable to pay your balance in full, you must contact our office to discuss a payment plan. Once payment arrangements have been made, it is your responsibility to fulfill that agreement. Failure to follow the payment plan schedule may result in your account being referred to an independent collection agency /or termination of care with our clinic.

ABUNDANT HEALTH FAMILY MEDICINE
FINANCIAL POLICY

- A minimum of 24 hours cancellation notice is required for appointments. A $25.00 "No show" fee will be applied for failure to cancel or reschedule an appointment at least 24 hours prior to your appointment time. All "no show" fees must be paid in full prior to being seen at your next visit. You are responsible for any no-show fees you are charged; your insurance company will not be billed. If you incur (3) no show charges within a one-year time period, you may face dismissal from the practice.
- A $50.00 fee will be applied to the original balance for checks returned by your financial institution. *
- Abundant Health Family Medicine has an on-call provider available after hours to address your urgent medical concerns. A $20.00 fee may be assessed for after- hours care requiring diagnosis and treatment of our medical condition.
- Patients with past due accounts, who have not previously made payment arrangements, will be required to meet in person with a member of our staff prior to making any routine or preventive appointments.
- If the patient has insurance coverage with which this office has a contractual agreement, we will bill the insurance for services rendered. In the case of non-payment by the insurance company, the patient/guardian understands they are responsible for payment.
- The providers at Abundant Health Family Medicine made decisions regarding your health based on medical judgement. This may mean that they recommend laboratory test, x-rays, or procedures that may not be covered by your health plan (if you have one). Please be familiar with your health insurance benefits. The time to address your coverage/cost is before the services/procedure(s) are performed.

I, the undersigned patient/guardian, or responsible party have read and understand Abundant Health Family Medicine's policies.

_____ _____

Signature of Patient/Guardian or Personal Representative **Date**

_____ _____

Name of Patient or Personal Representative **Date**

_____

Relationship to Patient

EMERGENCY CONTACT INFORMATION FORM

First Contact: _____

Address: _____

Home phone number: _____

Cell phone number: _____

Relationship: _____

Second Contact: _____

Address: _____

Home phone number: _____

Cell phone number: _____

Relationship: _____

Patient Signature_____ **Date** _____

ABUNDANT HEALTH! FAMILY MEDICINE

Tanya R. Grun, M.D.

General Consent for Treatment

Patient name (Print):_____ Date of Birth: _____

I voluntarily consent to evaluation and treatment by the Physician, Physician Assistant, or family Nurse Practitioner on staff at **Abundant Health! Family Medicine** clinic. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examination by the staff.

Signature of Patient/Guardian: _____ Date: _____

Mid-Level Provider Consent Form

This practice utilizes Physician Assistants (PAs) and Nurse Practitioners (FNPs) to provide healthcare. PAs and FNPs are educated, licensed, and nationally certified providers that work in conjunction with supervising Physician. There is on-going communication between the Physician and the Mid-Level providers regarding patient care. If at any time a patient requests an appointment with the Physician, this request will be granted at the first availability.

I have read the above information regarding Mid-Level Providers. I herby give my consent of treatment.

Signature of Patient/Guardian: _____ Date: _____

ABUNDANT HEALTH! FAMILY MEDICINE
Tanya R. Grun, M.D.

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before you sign this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

The HIPAA, (Health Insurance Portability and Accountability Act of 1996) law allows for the use/disclosure of patient health information. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with restriction, but if we do, we shall honor this agreement.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Patient/Parent/Legal Guardian Signature: _____

Date: _____

ABUNDANT HEALTH! FAMILY MEDICINE

Tanya R. Grun, M.D.

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____

Address: _____ City/State/Zip : _____

Patient's phone number: _____

Date of Request: _____ Date Needed: _____

o I authorize Abundant Health! Family Medicine to release information to:	OR	o I authorize Abundant Health! Family Medicine to obtain information from:
Name of Provider or Facility: _____		**Name of Provider or Facility:** _____
Address: _____		**Address:** _____
City/State/Zip Code: _____		**City/State/Zip Code:** _____
Phone/Fax: _____		**Phone/Fax:** _____

Purpose for this request: (Check one)

__ Transfer of care __ Upcoming appointment __ Insurance verification

__ Other _____

Type of records requested: (Check one)

__ Complete medical records __ Imaging reports __ Recent visit notes __ Laboratory results

__ Other _____

I understand that:

My right to healthcare treatment is not conditioned on this authorization. I may cancel this authorization at anytime by submitting a written request to the office. This request will be valid for one year from the date signed. There may be a charge for the requested records.

Signature of Patient/Parent/Guardian: _____

Date: _____ **Abundant Health! Family Medicine Fax: 830-625-0353**

Abundant Health! Family Medicine – New Patient Intake Form

Name:_____ DOB:_____

Reason for Visit Today:_____

How did you learn about our practice? Newspaper____Internet____Friend/Relative____Other_____

Name of person who referred you:_____

Past Medical History: Please check any problems you have now or have had in the past

Abnormal Pap Smear		Eating Disorder		Positive TB Test	
Acne		Eczema		Prostate Problems	
ADD/ADHD		Fibromyalgia		Psoriasis	
Alcohol Abuse		Frequent Sinus Infections		Reflux/GERD/Heartburn	
Anemia		Gallstones		Rheumatoid Arthritis	
Anxiety Disorder		Glaucoma		Rosacea	
Arthritis		Gout		Seasonal Allergies	
Asthma		Heart Attack		Seizures	
Bipolar Disorder		Heart Arrhythmia (Ex: a. fib)		Sexually Transmitted Dz	
Blood Clot (Ex: DVT/PE)		Heart Murmur		Specify type:	
Blood Transfusion		Hepatitis (specify A,B,C)		Sleep Apnea	
Cancer (Specify Type)		High Blood Pressure		Stomach Ulcers	
COPD/Emphysema		High Cholesterol		Stroke	
Crohn's Disease		Irritable Bowel Syndrome		Testosterone Deficiency	
Colon Polyps		Kidney Disease		Tuberculosis	
Dementia		Kidney Stones		Thyroid Disease	
Depression		Lupus/Autoimmune Dz		Ulcerative Colitis	
Diabetes		Melanoma or Skin Cancer		Urine/Kidney Infections	
Diverticulitis		Migraines		Vision Problems	
Drug Abuse		Osteopenia/Osteoporosis		Vitamin D Deficiency	

Other medical problems not on list:_____

Please check all of the **SURGERIES/PROCEDURES** you have had:

Type of Surgery	Year	Type of Surgery	Year	Procedure	Year
Appendectomy		Hysterectomy (were ovaries removed? Y/N)		Colonoscopy	
Arthroscopy (joint)		Knee or Hip Replacement		Stress Test	
Back or Neck Surgery		Mastectomy or Lumpectomy (Breast)		Echocardiogram	
Cataract Surgery		Polyp Removal (Colon)		Wisdom Teeth Removal	
Gallbladder Removal		Tonsillectomy		Cardiac Cath/	
Heart Surgery (specify)		Tubal Ligation or Vasectomy		Angiogram	
Hemorrhoid Surgery		Plastic Surgery (specify)			
Hernia Surgery		Other Surgery (specify)			

Other surgeries not on list:_____

Please list any other **providers/specialists** that you see (Example: cardiologist, pulmonologist):

_____ _____

_____ _____

Current Medications: (please include over the counter medications/supplements)

Medication Name	Dose	How often?	Medication Name	Dose	How often?

Please list any **ALLERGIES** to medications or foods: (please also include reaction)

_____ _____ _____

FOR WOMEN ONLY:

Date of:				# of pregnancies	
Last Menstrual Period		Age of First Period		# of live births	
Last Pap Smear		Abnormal Pap Smears?		# of miscarriages	
Last Mammogram		Abnormal Mammograms?		# of abortions	
Last Bone Density		Abnormal Bone Density?		# of living children	

FAMILY HISTORY: Have any of your family members had any of the following problems?

X	Condition:	Family Member(s):	X	Condition:	Family Member(s):
	Heart Dz/Attack			Osteoporosis	
	Stroke			Migraines	
	Diabetes			Breast Cancer	
	High Blood Pressure			Colon Cancer	
	High Cholesterol			Prostate Cancer	
	Thyroid Disease			Lung Cancer	
	Depression			Ovarian Cancer	
	Other Mental Illness			Uterine Cancer	
	Alcohol or Drug Addiction			Skin Cancer	
	Asthma			Other Cancer	
	Autoimmune Disease				

Any other illness in the family not listed? _____

Vaccines:

Date of Last:	
Flu Vaccine	
Shingles Vaccine	
Pneumonia Vaccine	
Tetanus Vaccine	
TB Screen	

Social History:

Marital Status:_____

Highest Level of Education:_____

Occupation:_____

Number of Children and Ages:_____

Health Habits:

Do you smoke currently? **Yes** **No** If so, how much? ___cig/day # of years smoking___

If no, did you smoke in the past? **Yes** **No** # of years?___ ___cig/day Quit date:_____

Are you exposed to smoke? **Yes** **No**

Any other tobacco use? **Yes** **No** Type: Cigars Chewing Tobacco Vaping/E-cigs Other

Do you drink caffeine? **Yes** **No** If so, how much per day?_____

Do you drink alcohol? **Yes** **No** What kind? Beer Wine Liquor

If so, how many drinks per week?____

Have you ever had a problem with alcohol in the past?_____

Have you ever used street drugs? **Yes** **No** Which ones?

If yes, are you still using? **Yes** **No**

Are you sexually active (in the last year)? **Yes** **No**

If yes, how many partners?_____

Which birth control do you or your partner use?_____

Do you wear a seatbelt? **Yes** **No** Do you have a working smoke alarm in your home? **Yes** **No**

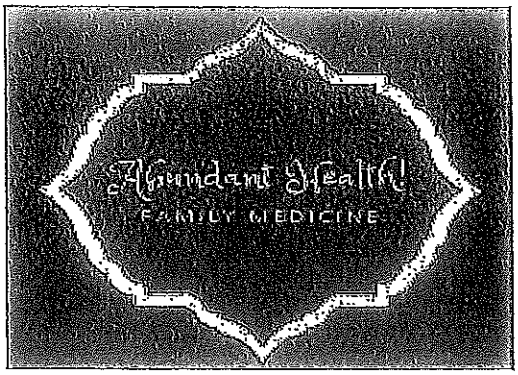
Do you have a living will (Do Not Resuscitate order, Power of Attorney)? **Yes** **No**
If no, you can ask for information on End of Life care/forms.

Do you exercise? **Yes** **No** If so, what type and how often?_____

Is there concern for your safety? (emotional, physical, or sexual abuse) **Yes** **No**

PREFERRED PHARMACY?_____

Who was your last doctor and when were you last seen?_____



Information update

Due to our most recent update to better assist our patients with appointment reminders, we are requesting that you provide an email address and updated cell phone number. With this information we will be able to email your appointment reminder as well as text. This feature will allow you to respond to the text or email. This will save you time from having to call in or being placed on hold. By signing this form you are giving us consent to send you reminders of healthcare services and marketing.

Email: _____

Preferred phone number:

_____

Patient or Guardian

Print name: _____

Signature: _____

Date: _____