Ranch Road Family Medicine & Wellness Clinic

PATIENT INFORMATION

Patient Information

Name: _____ Date of Birth: _____ SSN: _____

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M F **Race**: Caucasian Black or African American Asian Other Disclosure Declined (Circle)

Ethnicity: Not Hispanic or Latino Hispanic or Latino Unknown Disclosure Declined (Circle)

Parent or Guardian (If Under 18): _____

Emergency Contact: _____ Home Phone: _____

Relation to Patient: _____ Other Phone: _____

Primary Insurance Information ☐ **SELF-PAY**

Insurance Co: _____ ID #: _____ Group: _____

Name of Insured: _____ Date of Birth: _____ SSN: _____

Relation to Patient: _____ Address (If Different): _____

Insured Employer: _____ Work Phone: _____

Secondary Insurance Information

Insurance Co: _____ ID #: _____ Group: _____

Name of Insured: _____ Date of Birth: _____ SSN: _____

Relation to Patient: _____ Address (If Different): _____

Insured Employer: _____ Work Phone: _____

Consent for Treatment and Release of Medical Information

hereby agree and give my consent for medical care and treatment to Ranch Road Family Medicine & Wellness Clinic, hereinafter referred to as the Clinic, der the care of my attending physician. I authorize my physician, consulting physician designated by my doctor, and any other Clinic personnel to perform stic procedures, including x-rays, examinations, and laboratory procedures, nursing or medical/surgical treatments. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as a result of treatments or examinations in the Clinic. I authorize the Clinic to release information regarding my medical care and treatment including diagnosis and test results to the guarantor on my account or to insurance companies, third party carriers, state or federal health care program representatives, for which I have assigned benefits for my treatment and care, and to all physicians, healthcare facilities or other providers engaged in my further care or treatment.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPPA)

With my consent, ***Ranch Road Family Medicine & Wellness Clinic*** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations, (TPO). Please refer to ***Ranch Road Medicine & Wellness Clinic's*** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ***Ranch Road Family Medicine & Wellness Clinic*** reserves the right to revise its **Notice of Privacy Practices** at anytime. A revised **Notice of Privacy Practices** may be obtained by forwarding a written request to Ranch Road Family Medicine & Wellness Clinic Privacy Officer at 27008 Ranch Rd, Unit A, Dripping Springs, TX 78620.

With my consent, ***Ranch Road Family Medicine & Wellness Clinic*** may call my home or other designated location and leave a message on the voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, ***Ranch Road Family Medicine & Wellness Clinic*** may mail to my home or other designated location any item that assist the practice in carrying out TPO, such as appointment reminder cards & patients statements as long as they are addressed to me.

I have the right to request that ***Ranch Road Family Medicine & Wellness Clinic*** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to ***Ranch Road Family Medicine & Wellness Clinic's*** use and disclosure of my PHI to carry out TPO.

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, ***Ranch Road Family Medicine & Wellness Clinic*** may decline to provide treatment to me.

Print Patient Name	Patient Signature/Guardian Signature	Date

Ranch Road Family Medicine & Wellness Clinic

Office Policies

PLEASE READ CAREFULLY, INITIAL BLANKS AND SIGN BELOW

Welcome to **Ranch Road Family Medicine & Wellness Clinic! Dr Juan Ivan Ramirez** has been trained to treat a wide variety of medical problems for patients of all ages. In addition to treating illnesses and injuries, we offer well-child checks, general physicals, gynecological services (excluding obstetrics), and minor surgical procedures. We also have in-house x-ray facilities and offer lab services and immunizations.

Our office hours are 8:00-12:00 and 1:30-5:00 Monday thru Thursday, and 8:00-12:00 Friday. If there is a medical urgency after hours, please call the office number and the answering service will contact the doctor on call. If it is a serious emergency, proceed to the nearest emergency room.

____Medication refills are done during regular office hours only. Please allow **2** working days for call-backs to the pharmacy on routine medication refills. ****WE DO NOT PRESCRIBE LONG-TERM USE OF NARCOTICS.**

____In order to accommodate the needs and requests of our patients, we have enrolled in numerous manage care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed. Therefore, **it is the responsibility of the insured to know and understand their insurance coverage**, i.e. immunizations, well-child checks, annual physicals, etc. and the insured is responsible for any unpaid balances denied by their policy. If you have specific questions about how your claim was processed, you need to contact your insurance company directly.

____If you are on an insurance plan, your co-pay is due at the time of service. Please do not ask us to bill you for or waive your co-pay.

____When you have lab work done here and the results are normal, you will be notified by telephone or mail within a week. If the results are abnormal, or if we have specific questions or instructions, we will contact you by telephone. If your insurance requires you to use a specific laboratory, you must inform your nurse at each visit. Failure to do so may result in charges which your insurance company may not cover. We cannot perform lab work without the doctor's order and we cannot perform lab work ordered by other physicians.

It is the responsibility of the insured to know if a referral is needed to see a specialist. Please request referral at least **one week** prior to your appointment with your specialist.

We do not accept Workman's Compensation.

_____ _____

Patient Signature Date

MISSED APPOINTMENT FEE NOTICE

In order to provide quality medical care, it is important that we are notified promptly if you are unable to make your scheduled appointment time. RRFM will hold an appointment for *15 minutes*, you will be asked to reschedule if you are any later. Continued missed appointments may result in dismissal from our practice. While we understand you may have extenuating circumstances, without advance cancelation notice from you, we are unable to open up your unused appointment time for patients needing urgent medical care. We would appreciate a 24-hour advance notice if you need to reschedule your appointment. In order to prevent paying a $25.00 missed appointment fee, appointments must be canceled at least 4 hours in advance.

Thank you,
Ranch Road Family Medicine & Wellness Clinic

Patient Signature _____ *Date* _____

RANCH ROAD FAMILY MEDICINE & WELLNESS CLINIC
FINANCIAL POLICY

Please understand that payment of you bill is considered part of your medical file. We accept uninsured patients as well as commercial insurance and Medicare. We DO NOT accept Medicaid, Chips, Workers Comp, or Auto Accident Insurance. Payment for services is due at the time services are rendered. We do not accept payment plans. It is the patient's responsibility to call their insurance and make sure Ranch Road Family Medicine & Wellness Clinic is considered "In Network". Our billing company will file your insurance claim as a courtesy to you but in no way are we obligated to do so. If your insurance company has not paid your account in full within 45 days, the balance will automatically become your responsibility. It is the patient's responsibility to contact their insurance company to find out why a claim has not been paid and why any additional payment other than the usual co-payment is due. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary. Please let us know when your insurance changes so that the billing company files the claims to the correct insurance company.

Labs: If your insurance has a preferred contract with a Lab (such as Quest CPL, or LabCorp) please let the nurse know PRIOR to drawing the labs.

Referrals: It is the patient's responsibility to locate specialists that are In-Network for their Insurance Company. It can take our staff 7-10 days to process referrals depending on what insurance you have.

Prior Authorization: Some medication will need a prior authorization to be covered by insurance. This can take several days depending on the pharmacy and insurance. Please know if it gets denied we do not attempt the prior authorization again unless the diagnosis or dosage has changed.

Collections: Accounts that have balances older than 120 days that show no attempt to make payments will be sent to collections.

Ways to Pay: We accept cash, check, or credit card. On our website you can pay by your PayPal account. www.wimberleymedicalclinic.com. You can also call in and press option #6, then option #1 to pay by credit card over the phone.

Billing Questions: If you have questions about your bill and would like to speak with our billing company, they can be reached at 779-216-3002.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient Name: _____ Date of Birth: _____

Patient Signature _____ *Date* _____

RRFM - PATIENT HISTORY FORM

Patient Name: _____ Date _____

Date of Birth:_____ Gender: Male / Female

Patient History: Please indicate if **YOU** have any of the following:

Illness / Diagnosis	Date Diagnosed:	Illness/Diagnosis	Date Diagnosed:
Aids/HIV		Hepatitis (A, B, C, D)	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Alcoholism		Liver Disease	
Allergies		Lung Disease	
Arthritis (RA or Osteo)		Fibromyalgia	
Asthma		Headaches/Migraines	
Cancer (what kind)		Measles/Mumps	
Drug Dependency		Pneumonia	
Chicken Pox		Psychiatric Care	
COPD/Emphysema		Rheumatic Fever	
Depression		STDs (what kind)	
Diabetes (I or II)		Stomach Ulcers	
Bladder/Kidney disease		Stroke	
Seizures		Thyroid Problems	
Eye Conditions		Gout	
Heart Disease		Tuberculosis	
Prostate Problems		Chronic Pain (why)	
Skin Problems		Eating Disorder	
ADD/ADHD		**OTHER:**	

DRUG Allergies: _____

Surgical/Hospitalization History:

Example: Hernia repair	2003	CTMC	Dr. Jane Doe

Patient Name_____ Date:_____

Preventative Care History:

Exam/Screen	Date	Exam/Screen	Date
Cholesterol		Flu Vaccine	
Eye exam		Pneumonia Vaccine	
Hearing Test		Shingles Vaccine	
TB skin test		Hepatitis Vaccines	
Colonoscopy			
Results of Colonoscopy			
Females:			
Mammogram		PAP smear (any abnormal?)	
Clinical Breast Exam		Bone Density Scan	
Last Menstrual Cycle		Age at first menses	
Regular periods?		Birth Control Method	
# of Pregnancies		# of Living children	
Complications of any pregnancies:			
Males:			
Prostate Exam		PSA blood test	

Social History: Please indicate if you use or have used any of the following:

Alcohol : Yes No	Drinks/ week:	How Long:	When stopped:
Caffeine: Yes No	Ounces /day:		When stopped:
Tobacco: Yes No	Type:	Amount /day:	When stopped:
Street Drugs: Yes No	Type:	How Long:	When stopped:

Sexual History:

Sexually Active? Yes No	Male or Female Partners, or Both?	# partners in last year:
Any Concern for STDs? Yes NO		

Patient Name_____ Date _____

Family History: Please indicate if any of your relatives have any of the following:

Illness	Relation	Illness	Relation
Aids/HIV		Hepatitis (A, B, C, D)	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Alcoholism		Liver Disease	
Allergies		Lung Disease	
Arthritis (RA or Osteo)		Fibromyalgia	
Asthma		Headaches/Migraines	
Drug Dependency		Pneumonia	
COPD/Emphysema		Psychiatric Care	
Depression		Rheumatic Fever	
Diabetes (I or II)		Stroke	
Bladder/Kidney disease		Thyroid Problems	
Seizures		Gout	
Eye Conditions		Tuberculosis	
Heart Disease		CANCER: **(what type)**	
Prostate Problems			
OTHER:			

Any other Significant Illnesses, Injuries or Information about you:

_____

_____

_____

_____

Patient Name: _____ Date:_____

Medications and/or Supplements that you are currently taking:

(Please include OTC meds as well)

RX name	Dose:	How often?	Prescriber:	Pharmacy filled at:
Example: Lisinopril	20mg	Once /day	Dr. Jane Doe	Walgreens

Please list any other medical providers you are under the care of:

Example: Dr. Jane Doe	Cardiologist