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

PATIENT INFORMATION

Name:	**DOB:** **Sex:**
Address:	**E-Mail:**
Apt #	**Married:** Married Single Divorced Widowed
City: **Zip:**	**Employed:** Full time Part time Retired
Primary Phone#:	**Employer:**
Alt Phone#:	**Emergency Contact:**
Social Security #:	**Emergency Phone#:**
Previous Provider *(if applicable)*:	**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:	

PRIMARY INSURANCE INFORMATION (PROVIDE COPY OF CARD(s))

Insurance Company Name:	**Subscriber Name:**
Policy Number:	**Insured's Date of Birth:**
Group Number:	**Sex:**
Address:	**Employer:**
Insured's Social Security:	**Relationship to Insured:**

SEONCDARY INSURANCE INFORMATION

Insurance Company Name:	**Subscriber Name:**
Policy Number:	**Insured's Date of Birth:**
Group Number:	**Sex:**
Address:	**Employer:**
Insured's Social Security:	**Relationship to Insured:**

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:**

- **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**

Signature of Patient or Legal Representative: _____Date: _____

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PATIENT HISTORY

Name: _____ Age: _____ Date: _____

Reason for Visit: _____

List **all medical problems**:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____

List **all medications** (dose and frequency):

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____

List **all prior surgeries** (include date):

1) _____
2) _____
3) _____

List **all drug allergies** (medication and reaction):

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	_____	COPD/Emphysema	no yes	_____
Diabetes	no yes	_____	Asthma	no yes	_____
Heart Disease	no yes	_____	Blood Clots/Clotting	no yes	_____
High Cholesterol	no yes	_____	Depression/Anxiety	no yes	_____
High Blood Pressure	no yes	_____	Anemia	no yes	_____
Migraine Headaches	no yes	_____	Thyroid Disease	no yes	_____
Stroke	no yes	_____	Drug/Alcohol Prob	no yes	_____
Kidney Disease	no yes	_____	ADOPTED/Family History Unknown	yes	_____

SOCIAL HISTORY

Do you use tobacco products? no yes Previously? no yes Number of years _____ How much? _____
Do you drink alcohol? no yes How many drinks per day, week, or month? _____
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 _____
Females: Pregnancy History: Number of pregnancies _____ Number of deliveries and year(s)_____
Number of Miscarriages: _____ Abortions: _____ Birth Control Method? _____
When was your last Mammogram? _____ Pap Smear? _____ Bone Density? _____

Immunizations: Tetanus (Td or TdaP) _____ Flu _____ Pneumonia _____ Shingles _____
When was your last eye exam? _____ Dental cleaning? _____

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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.
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 or Legal Representative Date

_____
Patient Name

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

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. It is vital that you notify us **ASAP** of any changes (Insurance, job, address, phone, etc) or you will 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. If your account is sent to collections then you will be discharged from the practice immediately.

AFTER HOURS: For urgent medical problems - Call the main line (512) 568-3565 or (512) 834-9999 and choose option 2. 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.

REFILLS of regular medicines take 24-72 hours to process. Do not wait until your prescription runs out. Contact your pharmacy to begin the refill process at least 7 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.

REFERRALS are a labor-intensive process and can take 1-7 business days depending on your insurance company. •You need to be seen for an appointment to obtain a referral. •Contact your insurance to confirm that the specialist you are referred to is in your insurance network. •Please notify us if you have a specific specialist you prefer. • Do NOT go to a specialist without a referral approval from your insurance company. You may be turned away or billed personally for services from the specialist. **HELPFUL HINTS for referrals:** Not all insurance plans require a referral. Contact your insurance if you are unsure.

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: 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 received 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. **Quest billing** questions phone number: 1-866-697-8378

PRESCRIPTIONS FOR CONTROLLED SUBSTANCES: You will be subject to intermittent drug testing for any long-term prescriptions of controlled substances.

APPOINTMENTS: Appointments are scheduled based on type and number of problems. When scheduling, we ask you to list ALL the problems that you would like to have the provider address. You are asked to call us back should anything else come up so that we can adjust the appointment or reschedule if necessary. 24 hours' notice is required for rescheduling or a fee ($50) will be assessed.

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/ late cancel fee of $50. 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/ late cancel fee of $50.

WORKER'S COMP, MOTOR VEHICLE ACCIDENTS, AND DISABILITY: We will not be able to see you for these issues.

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 or Legal Representative	Patient Name	Date

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

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:			Phone:
City:	State:	Zip:	

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) _____

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 include 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.

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:

Signature of Patient or Legal Representative Date

Relationship to Patient if not Patient