Johnson Family Medical
469-656-4602
www.johnsonfamilymedical.com

9300 John Hickman Parkway
Suite 102
Frisco, TX 75035

Registration Form

GENERAL INFORMATION/ INFORMACION GENERAL

DATE: _____/_____/_____
Fecha (mm/dd/yyyy)

Patient's Name: _____
Nombre de paciente: Last/Apellido First/ Primero SI

D.O.B.: _____/_____/_____ **Age:** _____
Fecha de Nacimiento Edad

Address: _____
Dirreccion: (Street, Apt. #)

Phone: (_____)-_____-_____
Numero de telefono

City: _____ **State:** _____ **Zip Code:** _____
Ciudad Estado Codigo postal

S**SN**: __ __ __-__ __-__ __ __ __ **Sex:** M / F

E-mail: _____
Correo electronico

Marital Status: M S D W Dom. Partner

Emergency Contact: _____ **Relationship to patient:** _____ **Phone:** (_____) _____ - _____
Contacto de emergencia Relacion del paciente Numero de telefono

Name of Insurance: _____ **Member ID:** _____ **Group ID:** _____
Nombre de seguranza Identificación de miembro Identificación de grupo

Preferred Pharmacy: _____ **Pharmacy Phone:** _____
Pharmacia preferida Pharmacia numero de telefono

I hereby authorize Johnson Family Medical and/ or agents to use my general information (address, phone (text messages), and email) to contact me to facilitate anything related to my medical care.
Autorizo el uso de mi informacion general (direccion, telefono (mensajes de texto), y correo electronico) para ser contactado por Johnson Family Medical y/o agentes para facilitar el siguimiento de mi cuidado medico.

PERSONAL RESPONSIBLE FOR PAYMENT/ PERSONA RESPONSIBLE DE PAGO

_____ Relationship to patient/ Relacion a Paciente
Last Name First and Middle Name ☐ Mother/ Madre ☐ Father/ Padre ☐ Other/Otras

_____
Apellido Primer y Segundo Nombre

SSN: __ __ __-__ __-__ __ __ __ Sex: M F _____/_____/_____ Age/Edad: _____
D.O.B/ Fecha de nacimiento (mm/dd/yyyy)

Address/ Direccion: _____ Employment/Trabajo: _____
(Street, apt #)

City: _____ State: _____ Zip code: _____ (_____) - _____- _____
Ciudad Estado Codigo postal Work phone/ Numero de telefono de trabajo

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS
I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Johnson Family Medical for any services furnished me by that provider. I authorized medical information needed to determine these benefits or the benefits payable for the related services to be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services. Please note: It is the policy of this office that any parent who requests treatment for the child is responsible for the payment of all subsequent fees.
Solicito que el pago de las presentaciones de seguros autorizadas de cualquier compania de seguro aplicables se hagan en mi nombre a Johnson Family Medical para todos los servicios prestados por mi a ese proveedor. Yo autorize la informacion medica necesaria para determinar estos beneficios o, los beneficios pagaderos por los servicios relacionados sean entregados a la compania de seguros y sus agentes. Entiendo de incluso pense que tener algun tipo de cobertura de seguro, yo soy responsible del pago de los servicios. Tenga en cuenta, es la politica de esta oficina que qualquier padre se solicita tratamiento para el nino es responsible del pago de los servicios del pago de todas las cuotas subsiguentes.

Name/Nombre: _____ Signature/Firma: _____

Relationship/Relacion: _____ Date/ Fecha: _____

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Authorization Form

Patient Name: _____ **DOB:** _____

Medicare Assignments of benefits to Statement to Permit of Health and/or Medical insurance benefits To Johnson Family Medical and Providers

I certify that the information given by me in applying for payment under title XVLlll of the Social Security Act is correct. I authorize any holder of medical or other information about me to the centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed or for this or a related Medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician and/ or midlevel (Nurse Practitioner or Physician Assistant) provider services to the provider or organization furnishing the services or authorized such provider or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any health insurance deductibles and coinsurance.

FINANCIAL RESONSIBLITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and I agree to honor the current Clinic payment policy. I understand that, in the unable to pay in full at the time service is rendered; Johnson Family Medical may inquiry of my credit history to evaluate my credit worthiness. I further understand that unpaid patient accounts may accrue interest (1.5% per month / 18% per year) and I agree to pay any such interest charges in addition to any amount unpaid by any insurance coverage. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to as attorney or collection agency for collection suit, I agree to pay all reasonable attorney fees and/ or collection expense.

INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to Johnson Family Medical, Frisco, Texas any benefits under hospitalization, sickness liability, auto or accident insurance, and any other coverage for the payment of such services rendered. I agree to cooperate, aid and assist the clinic in procuring all possible insurance benefits, including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I understand it is my responsibility to the provider for charges not paid pursuant to this assignment.

I hereby authorize the staff of Johnson Family Medical to administer such care / treatment as it is necessary based on the clinical providers assessment and diagnosis. I understand that such care may include medical and surgical treatment, and laboratory, and radiologic test. I certify that no guarantee of assurance has been made to the results that may be obtained.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize staff of Johnson Family Medical to disclose necessary information from my medical record to the following parties when requested for the purpose as stated herein: to any health care provider for the purpose of providing continuing professional care and to any insurance company or third party payer (or their agent/s) for the purpose of obtaining payment to employees, offices and attending clinical providers are released from legal responsibility or liability for the above information to the extent indicated and authorized herein. I understand this released specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV and other diseases, all of which I specifically authorize to be so released.

_____	_____	_____
Signature of Patient or Representative	Relationship to patient	Date
_____	_____	_____
Responsible Party (if different)	Relationship to patient	Date

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Advanced Practice Nurses Consent for Medical Treatment

Johnson Family Medical has an advanced practice nurse to assist in the delivery of primary health care. Johnson Family Medical is a family medical clinic that is owned and operated by Katherine AW. Johnson, a Family Nurse Practitioner (FNP) who also has a Master of Science in Nursing (MSN).

A nurse practitioner is a Registered Nurse (RN), also known as Adult Nurse Practitioners (ANP) has at least a Masters Degree in Nursing and a board certification in their specialty. They have education and training in specialty areas such as family practice, women's health or pediatrics. Family Nurse Practitioners have acquired the necessary knowledge and expertise, skills and training in the care of people of all ages, plus the authority to issues prescriptions for medications. I have read this document and hereby confine the services of a nurse practitioner for my health care needs.

_____ _____
Patient's Name Date

_____ _____
Patient's Signature Date of Birth

_____
Parent/ Guardian Signature and Date

_____
How did you hear about us?

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Name: _____ **DOB:** _____/_____/_____ Date: _____

Medical History

Auto Immune Disorder:
- ☐ Alopecia
- ☐ Celiac
- ☐ Hashimotos
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Scleroderma
- ☐ Sjogren's
- ☐ Vasculitis

Cancer or History of Cancer: ☐ Yes ☐ No
- ☐ Chemotherapy / Radiation
- ☐ Lymph Node Removal
- ☐ Melanoma or Other Skin Cancer
- ☐ Precancerous Skin Lesions

Cardiac Conditions:
- ☐ Arrhythmia
- ☐ Blood Clotting Abnormalities
- ☐ Blood Vessel (Vascular) Disease
- ☐ Heart Attack
- ☐ Heart Disease / Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Cardiac Procedures: _____
  _____

Neurological Disorder:
- ☐ Bell's Palsy
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Peripheral Neuropathy
- ☐ Seizure Activity
- ☐ Stroke

Neuromuscular Disorder:
- ☐ ALS / Lou Gehrig's
- ☐ Lambert-Eaton Syndrome
- ☐ Muscle Weakness / Tremors
- ☐ Myasthenia Gravis
- ☐ Any Neuromuscular Disorder

Skin Condition / Disease / Lesions:
- ☐ Active Acne
- ☐ Actinic Keratosis
- ☐ Eczema
- ☐ Fungal Infection (Ring Worm)
- ☐ Impetigo
- ☐ Keloid Scaring / Raised Scarring
- ☐ Keratosis Pilaris
- ☐ Melasma
- ☐ Psoriasis
- ☐ Raised Moles / Warts / Lesions
- ☐ Rosacea
- ☐ Vitiligo

Other Conditions:

- ☐ Acid Reflux
- ☐ ADD / ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Any Active Infection (Bacterial / Fungal / Viral)
- ☐ Arthritis / Rheumatism
- ☐ Asthma
- ☐ Cirrhosis
- ☐ Cold Sores (HSV 1)
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive / GI Problems
- ☐ Extreme Fatigue
- ☐ GERD
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Hearing / Vision Issues
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Hormone Imbalance
- ☐ Lymphedema
- ☐ Nervous Diagnosis
- ☐ Osteoporosis
- ☐ PCOS
- ☐ Seasonal Allergies
- ☐ Sexual Dysfunction / ED
- ☐ Shingles Outbreak
- ☐ Thyroid Imbalance/Disease
- ☐ Ulcer
- ☐ Urinary Incontinence
- ☐ Vision Problems

☐ I have reviewed ALL of the above conditions and DO NOT HAVE ANY of those listed or ANY conditions not listed that my provider should be made aware of.

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Name: _____ **DOB:** _____/_____/_____ Date: _____

Allergies

Medication or Substance:	Describe Reaction or Symptoms:
_____	_____
_____	_____

Ever experienced an anaphylactic response? ☐ Yes ☐ No

Current Medications (including Retin-A, Accutane, etc.)

Name of Medication:	Dose / Frequency:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Herbal, Vitamin or Nutritional Therapies (including acids in facial wash products)

Name of Substance / Therapy:	Amount / Frequency:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History

Procedure:	Date			Date
_____	_____	Colonoscopy	☐ Yes ☐ No	_____
_____	_____	Mammogram	☐ Yes ☐ No	_____
_____	_____	PAP Smear	☐ Yes ☐ No	_____

Social History

Cigarettes: ☐ Yes ☐ No Vaping: ☐ Yes ☐ No Moist Tobacco: ☐ Yes ☐ No Other: _____
Amount / Frequency _____
Alcohol: ☐ Yes ☐ No Type _____ Amount / Frequency _____
Caffeine: ☐ Yes ☐ No Type _____ Amount / Frequency _____
Recreational Drugs: ☐ Yes ☐ No Type _____ Amount / Frequency _____
Exercise: ☐ Yes ☐ No Type _____ Duration / Frequency _____
Diet: ☐ Yes ☐ No Type _____ Description _____

Family History

	Father	Mother	Siblings		Father	Mother	Siblings
Deceased?	☐	☐	☐	Heart Failure	☐	☐	☐
Alcoholism	☐	☐	☐	High Blood Pressure	☐	☐	☐
Asthma	☐	☐	☐	Mental Illness	☐	☐	☐
Bleeding Disorder	☐	☐	☐	Osteoporosis	☐	☐	☐
Cancer	☐	☐	☐	Stroke	☐	☐	☐
Diabetes	☐	☐	☐	Thyroid Disease	☐	☐	☐
Heart Disease	☐	☐	☐	Other: _____	☐	☐	☐

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Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPAA, the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies, and others, put in place controls to ensure that your personal medical information is safe.

Johnson Family Medical requires that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company.

By signing this form, consent to our use and disclosure of protected health information about your treatment, payment, and health care operation. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient: _____ Date: _____

Name of Patient: _____ Date of Birth: _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or other to call and request the results of tests and procedures. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to a family member you must sign this form. Signing this form will only give consent to release laboratory and radiology results to family members indicated below. This consent will not allow Johnson Family Medical, PLLC to release any other information to these family members.

You have the right to revoke this consent in writing, except where we have already made disclosures in reliance to your prior consent.

Family Member Name	Relation to patient	Date
Family Member Name	Relation to patient	Date

Patient Name	**Patient Signature**	**Date**

Authorization to Leave Messages with Household Members/ Answering Machine

From time to time it is necessary for representatives of Johnson Family Medical to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that medical staff would like to discuss lab or procedure results, or to ask a patient to call us regarding an issue or concern. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name	**Patient Signature**	**Date**

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Policy on Cancellations of Appointments / No Shows

Política de Cancelación de Nombramientos / Falta de presentación

We at Johnson Family Medical care very much about your health, however because many patient's arrive late, don't come for their appointments and don't cancel 24 hours before their appointment, it has forced us to put a policy in place because of undue burden on other patients.
Nosotros en la Familia Johnson Atención médica mucho sobre su salud, sin embargo, porque muchos pacientes llegan tarde, no vienen para sus citas y no cancelar 24 horas antes de su cita, nos ha obligado a poner una política en su lugar debido a la indebida Sobre otros pacientes.

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment. If you're 10 or more minutes late, we will still see you but your appointment may be placed behind a patient who took your time slot.
Cuando no se presenta para una cita programada, crea una ranura de citas no utilizada que podría haber sido utilizada por otro paciente. Es muy importante que llame con 24 horas de antelación para cancelar su cita. Si tiene 10 o más minutos de retraso, todavía lo veremos, pero su cita puede ser colocada detrás de un paciente que tomó su intervalo de tiempo.

If for any reason you need to cancel an appointment, please notify our office as a soon as possible.
Si por alguna razón usted necesita cancelar una cita, notifique a nuestra oficina lo antes posible.

After **TWO** consecutive no-show occurrences, the practice may elect to terminate our relationship with you.
Después de tres ocurrencias consecutivas no presentadas, la práctica puede optar por terminar nuestra relación con usted.

If you have any questions, please contact the office at (469) 658-4602.
Si tiene alguna pregunta, comuníquese con la oficina al (469) 658-4602.

Please read and sign that you understand this policy.
Lea y firme que entiende esta política.

Patient Name Nombre de paciente	**Patient Signature** Firma de paciente	**Date** Fecha

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Consent and acknowledgement of Receipt of Privacy Notice

I understand that as part of provision of healthcare service, Johnson Family Medical, create and maintain health record and other information describing among other things, my health history symptoms, diagnosis, treatment, examination, and test results, prescription drug history, and any plans for future care or treatment.

I have been provided with a notice of privacy practice that provides a more description of the use and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of revised notice to the address I have provided. I understand that I have the right to request restriction as to how my information may be used or disclosed to carry out treatment, payment or healthcare operation (Quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restriction requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, where written or oral in electronic format, are confidential and cannot be discussed for reasons outside of treatment, payment or healthcare operation without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my protected health information, which is or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that Johnson Family Medical and I must agree to any restriction in writing that I requested on the use and disclosure of my protected information which have been previously agreed upon.

_____ _____
Full Patent Name Date

_____ _____
Signature Date of Birth

_____
Guardians Signature (if child)

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Release to Photograph, X-Ray & Ultrasound

Johnson Family Medical requests patients to allow photographing of patients for identification purposes, X-rays taken if necessary and ultrasound to be used in diagnosis or identification of specific illnesses or conditions. The Photograph, X-Ray & Ultrasound images will not be distributed outside the medical practice unless collaboration with other physicians or practitioners is medically necessary.

_____ _____
Full Patent Name Date

_____ _____
Signature Date of Birth