Access Family Health / Wellness Practices of America

**Shaun Kelehan, MD Jayasree Krishnankutty, PA-C Austin Davidson FNP-C**

1420 W Wells Branch Parkway, Ste 450, Pflugerville, TX 78660 Ph: 512-806-0201 Fax 737-300-1420

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Patient’s First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security: \_\_\_\_\_\_\_**-**\_\_\_\_\_\_**-**\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Gender: M\_\_­­­­­­\_\_ F\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best # to Reach Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of an emergency, who should we contact? (Other than a Parent)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Mother / Guardian | Father / Guardian |
| Name: | Name: |
| Address:  City: ST: Zip: | Address:  City: ST: Zip: |
| Hm:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hm:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB: SS#: - - | DOB: SS#: - - |
| DL #: State: | DL#: State: |
| Employer Name:  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Employer Name:  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Occupation: | Occupation: |

Patient lives with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the child have a nickname? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list other siblings:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

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**Information on Health Insurance and Policy Holder**

Name of (Primary) Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ City ST Zip

Social Security Number: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If it’s the Member ID Number)

Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance** (If any)

\_\_\_**No Secondary Insurance**

Name of (Secondary) Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ City ST Zip

Social Security Number: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If it’s the Member ID Number)

Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures they refer to as “Reasonable & Customary Fee.” We do not accept this as payment in full. Also, some of the insurance companies only pay a percentage of the charge. It is the patient’s responsibility to pay any deductible amount, co-insurance or any other balance not paid for you your insurance. Co-insurance is due at the time of the visit.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to Access Family Health. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Patient or Parent / Guardian Signature Date

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**Health History**

Has the child suffered from any of the following? (Check for Yes)

\_\_\_\_High Blood Pressure \_\_\_\_Congenital Heart Disease \_\_\_\_Reflux

\_\_\_\_Diabetes Mellitus \_\_\_\_Anemia \_\_\_\_Wheezing

\_\_\_\_Strep Throat \_\_\_\_Dental Problems \_\_\_\_Ear Infections

\_\_\_\_Vision Problems \_\_\_\_Murmur \_\_\_\_Anemia

\_\_\_\_Food Allergies \_\_\_\_Irregular Heart Beat \_\_\_\_Kidney Disease

\_\_\_\_Trauma/injury \_\_\_\_Asthma \_\_\_\_Cancer

\_\_\_\_ADD/ADHD \_\_\_\_Auto immune Disease \_\_\_\_Bladder Infections

\_\_\_\_COPD \_\_\_\_Pneumonia \_\_\_\_Bleeding Abnormality

\_\_\_\_Allergies \_\_\_\_Bronchitis \_\_\_\_Hearing Problem

\_\_\_\_Liver Disease \_\_\_\_Seizures

\_\_\_\_Constipation \_\_\_\_Developmental Delay

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** List ALL surgeries (Type and Year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medication Allergies:**  List ALL medications that you are allergic to and what happens when you take it.

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**

MEDICATION DOSE (STRENGTH) # TAKEN PER DAY REASON FOR TAKING

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient’s Family and Social History**

**Family History**

**Check if Yes What Family Member(s)**

Heart \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Pressure \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Auto-Immune Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osteoporosis \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain “Yes” Answers/Family Members:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Primary Caregiver:** \_\_\_Parents \_\_\_Day Care \_\_\_Relatives \_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drinking Water:**  \_\_\_Bottled Water \_\_\_Well Water \_\_\_City Water \_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Miscellaneous:** Pets: \_\_\_Dog(s) \_\_\_Cat(s) \_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy and Birth History of Child 6 Yrs. and Under**

(For the Mother)

Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Length: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of Mother at Baby’s Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Infants Gestational Age: (Check one) \_\_\_\_Full-Term \_\_\_\_Post-Term \_\_\_\_Pre-Term If so, # of weeks: \_\_\_\_\_\_

Type of Delivery: (Check one) \_\_\_Vaginal \_\_\_C-Section If so, reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial feeding of baby: (Check one) \_\_\_Breast \_\_\_Bottle \_\_\_Both

How many Ounces at feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many Ounces a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Newborn Hearing Screening: (Check one) \_\_\_Passed \_\_\_Failed \_\_\_Unknown

Newborn PKU (Metabolic) Screening: (Check one) \_\_\_Passed \_\_\_Failed \_\_\_Unknown

Name of OB/GYN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours of Labor: \_\_\_\_\_\_\_\_\_\_ Complications: \_\_\_Yes \_\_\_No

If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Pregnancies: \_\_\_\_\_\_\_\_\_\_ # of Living Children: \_\_\_\_\_\_\_\_\_\_

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**Previous Pediatrician / PCP Information**

Name of facility where child was born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of previous Pediatrician/PCP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP Address and/or City, ST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy and Birth History**

1. Did mother use cigarettes, alcohol, recreational drugs, or medications during the pregnancy?

\_\_\_YES \_\_\_NO

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. Were there any medical problems during pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor?

\_\_\_YES \_\_\_NO

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Were there any medical problems during the nursery stay (i.e., jaundice, prematurity, feeding, difficulties, breathing problems, infections, transfusions, heart murmur, seizure, NICU admission?)

\_\_\_YES \_\_\_NO

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Were there any problems during labor?

\_\_\_YES \_\_\_NO

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Important Appointment Information**

It is our desire to operate in a manner that will best serve the needs of our patients. We ask that you help us by keeping in mind the following requests:

If you are more than 15 minutes late for your appointment, you will need to reschedule if the schedule is full or if your appointment is at the end of the day.

If you will be unable to keep an appointment, please cancel as much BEFORE your scheduled time as possible. Our schedule is usually full and if you do not cancel, you are keeping a sick patient from having the opportunity to have the spot that you have scheduled.

Medication refill requests should be called in to the pharmacy, not the office. Please call them at least 48 hours before you run out of medication. If there are no refills available, the pharmacy will fax the office for approval.

If you are requesting samples, please call the office to verify we have them in stock before coming to the office. We will not be able to provide all of your medications in samples. If available, samples are given to you when you are put on a new medication and then the prescription will need to be filled at your pharmacy.

If your prescribed medications require an authorization from your insurance company, it may take them several days to respond to us. We will send in the request to your insurance company and process the prescription as soon as we receive the approval from them.

If you have lab work or test ordered, we will contact you by phone or we will mail you the results when we receive them. **If you have not received your results within two weeks, please call the office.**

If you have insurance, and you have a co-pay, it is payable at the time of your visit. This is required by our agreements with insurance companies.

Please remember -- When you come in for your routine annual physical, **you must inform the nurse so we can be sure to bill it to your insurance company correctly**. If you need fasting labs and cannot do them when you are in for your visit, you must return within 7 days to have the labs billed with your physical exam.

Thank you for allowing us to work with you in providing your medical care. We appreciate you!

Sincerely,

Dr. Shaun Kelehan and Staff

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Signature of Patient or Parent/Guardian Date

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Thank you for allowing us to work with you in providing your medical care. We appreciate you!

**PATIENT’S COPY - PLEASE KEEP FOR YOUR RECORDS**

Access Family Health / Wellness Practices of America

**Shaun Kelehan, MD Jayasree Krishnankutty, PA-C Austin Davidson FNP-C**

1420 W Wells Branch Parkway, Ste 450, Pflugerville, TX 78660 Ph: 512-806-0201 Fax 737-300-1420

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***Notice of Privacy Act (HIPAA)**

We at Access Family Health take your medical confidentiality very seriously. We will not, and cannot, release information without your written authorization. This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available or you have an adult that helps coordinate your medical care. You should not designate your doctor.

By signing this authorization, I authorize Access Family Health, Inc. to use and/or disclose certain protected health information (PHI) about me to, or for, the party or parties listed below. As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

\_\_\_\_\_ I DO NOT authorize anyone to receive information regarding my medical care.

\_\_\_\_\_ I authorize my physician and the employees of this clinic to speak with: **Date:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Access Family Health, Inc. has acted in reliance upon this authorization.

I have been made aware of the **Notice of Privacy Practices** for **Access Family Health, Inc.**

**My Contact Information:**

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.** Any problems and/or questions concerning this form are to be referred to Access Family Health Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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We are committed to providing you with the best possible care and we are pleased to discuss our financial policy at any time. Please ask us if you have any questions about our financial policy or your financial responsibility.

All new patients are asked to complete a Patient Information Form prior to being seen by the provider. We ask that you complete all of the information including your insurance information. We also ask to make a copy of a picture I.D. and your insurance card. These will remain a permanent part of your patient chart.

**Insurance Coverage and Patient Responsibility**

You are responsible for the payment of co-payment, co-insurance, non-covered services, or any patient responsible balance at the time of service. If you are covered by Medicare, Medicaid, BCBS or plan in which we participate as a provider, we will file your insurance claim. In the event your insurance company does not pay the full balance, we will notify you so that you may contact your insurance carrier or resolve your account. Please remember, payment responsibility rests with the patient, if there is no coverage for services performed.

All non-covered patients are expected to pay for services in full at the time services are rendered.

Please advise the office personnel of any changes in your insurance or any of your contact information or addresses.

Payment arrangements can be negotiated prior to services being rendered. Please ask for assistance, if required.

Should it ever become necessary to use the services of an outside collection agency to collect your account, you could be responsible for any costs incurred for that purpose.

**Assignment of Benefits**

I hereby authorize Access Family Health, Inc. to bill my insurance company directly for the services rendered. I understand that I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration, intermediaries, other providers or treatment or procedures, or intermediaries needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request for payment of medical benefits either to myself or to the party who accepts assignment benefits.

**Unaccompanied Minors**

The parents or guardians will be responsible for the full payment unless covered by a participating managed care plan. Authorization to treat an unaccompanied minor must be on file.

We thank you for carefully reading this financial policy. We trust that you understand its contents. Should you have any questions, please feel free to ask. Please sign below to indicate your understanding and acknowledgment of this policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Responsible Party Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (Please print)

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**MEDICAL RECORDS RELEASE**

**Requesting records on:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Patient’s Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City

\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State Zip Phone

**Authorizing to release:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor, Hospital, or Clinic

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Fax

**Information needed:** \_\_\_\_Complete Medical Records **( including Growth Charts if 16 yrs of age and younger )**

\_\_\_\_Consult Notes \_\_\_\_Labs \_\_\_\_Radiology / Imaging Reports

\_\_\_\_EKG \_\_\_\_Operative Report \_\_\_\_Vaccine / Shot Records

\_\_\_\_ER / Hospital / Discharge \_\_\_\_Pathology Report \_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Patient / Guardian Signature Date

**Release records to:**

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**Contract for ADD / ADHD Prescriptions**

There is a **$5.00** charge when receiving a controlled prescription if you do not have an office visit on the same day it’s written. **The fee must be paid by cash or check at the time the prescription is received… NO EXCEPTIONS!!**

If your account is in bad debt, you will not be issued a prescription until a payment plan is arranged and a payment is made on the account. All payments must be made on time in order to continue re- ceiving the prescription.

Please note that you are required to be seen by a provider every 3 months in order to continue receiving a controlled prescription(s). Although with some patients a provider may ask them to return for follow up office visits much sooner. If you’ve not kept up with your routine 3 month office visits, a prescription will not be written until you have been seen by a provider.

Remember that you cannot refill the prescription earlier than 30 days. Lost or stolen prescriptions are to be reported and in most cases require a police report. If you just left our office and realize that the prescription has been written incorrectly, you must return it to the office of **Access Family Health** before a new one can be rewritten.

By signing below you are stating that you have read and agree to the terms of this contract.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **( If the patient is under the age of 18 )**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and agree to the terms listed above for (Please Print)

receiving my controlled medication prescription(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Signature of Patient or Parent/Guardian Date