Dr. Scott Hastings, DO

Family Medicine Plus
11330 Legacy Drive, Suite 301
Frisco, TX 75033

Thank you for selecting our healthcare team. We will strive to provide you with the best possible healthcare. To help us meet your needs, please fill out this form completely. You will be asked to update this information every six (6) months due to our changing healthcare environment. We will also ask for a copy of your Insurance Card or cards (if you have more than one insurance) and a copy of your Driver's License.

Today's Date: ______________________________
Patient Last Name:_________________________
First Name: ____________________ Middle:____
Address:___________________________________
____
City: ____________ State:_______ Zip: __________
Marital Status: □ Married □ Single
□ Divorced □ Widowed □ Legally Separated
E mail:____________________________________
Emergency Contact:_________________________
Relationship:______________________________
Phone Number:_____________________________

Date of Birth: __________________________
Nickname:_____________________________
Primary Phone: _______________________
Secondary Phone: ____________________
Language: ____________________________
Race:_________________________________
Sex: □ Male □ Female
Social Security #:_______________________
Patient Employer:_______________________
Patient's Occupation:__________________

How were you referred to our office? □ Friend □ Family □ Insurance Company List
□ Facebook □ Print Ad □ Other

Insurance Policy Holder OR if No Insurance, Person Responsible for this account

Relationship to Patient: ____________________________
Last Name: ___________________________________
First Name:_____________________________ Middle:___
Address:____
City:________________________ State:____ Zip:_______

Primary Phone: ______________________________
Secondary Phone: ____________________________
Employer: ____________________________________
SS#:________________________ DOB:__________
Sex: □ Male □ Female

Company Name:_____________________________________ Phone: ___________________ Fax:_______________
ID/Policy Number:_________________________________ Group Number:_____________________________
**For Policy & Group Number, be sure to include all characters – letters & numbers (For Example: XJQ1236785)

Other Family Members on Policy:
Name: _________________________________ Birthdate: _____________ Relationship: ________________________
Name: _________________________________ Birthdate: _____________ Relationship: ________________________

Please indicate your response to the following:
Primary Telephone:
□ OK to leave message on machine with detailed appointment / medical information
□ OK to leave message with our office name and call back number only
Secondary Telephone:
□ OK to leave message on machine with detailed appointment / medical information
□ OK to leave message with our office name and call back number only 5/16

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Patient's Financial Responsibility

Please initial in the blank to the left each statement to denote agreement.

______ I hereby authorize Scott Hastings DO, and Family Medicine Plus to release any information concerning my condition and treatment or examination (including HIV and psychological records) rendered to me, my child or person under my legal guardianship to third party payers and / or health practitioners.

______ I understand the insurance company may not pay the actual bill for services, and I agree to be responsible for payment of all services rendered for myself, my child or the person under my legal guardianship.

______ Patient or his / her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician that are not covered or adjusted by the insurance company.

Financial Policies

• Copayment is due at the time of the visit. If you do not have your co-payment, we will ask that you reschedule your appointment.

• If you have not met your deductible, you are expected to pay in full at the time of the visit.

• We charge the insurance carriers our "normal fees". We are paid their allowable amounts, and write off the difference between those two amounts as the discount. We do not write off amounts that have gone to the deductible, non-covered services, or co-payments.

• After your insurance company has paid their portion, if there is any amount not covered due to your deductible, non-covered services such as preventive care, etc., we will send you a bill for the amount due. We ask that you remit the owed amount upon receipt of the bill.

• It is ultimately the patient's responsibility to be aware of their plan's limitations and restrictions on covered services.

• If you need a referral to a specialist, we will ask that you see our physician first. We need specific information and documentation in our files in order to obtain authorization for you to see another doctor, be hospitalized, or have certain procedures.

• Failure to keep the patient's account current may result in Family Medicine Plus being unable to provide additional services except for emergencies.

• We reserve the right to charge you (not your insurance company) a $25 office fee if you do not cancel your appointment within 24 hours of your appointment time, or if you no-show for your appointment.

• A $25 service fee will be added for any checks returned for any reason and guarantor will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds.

• Accounts not paid in full within 90 days of a statement date, will be turned over to collections for further processing, and a collection agency processing fee will be added to the outstanding balance.

Please sign below to indicate your understanding and agreement with our financial policies.

____ ______________________

Signature Date

HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used
and disclosed and how you can get access to this information.
Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, or office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Patient's Rights

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is **not** required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before May 1, 2016.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____ Date of Birth: ______________________________

Signature ____ Date: _____________________________________

Please list any other individuals or family members that you authorize access to your medical information:

____ ____

____ ____

Name ___________________________DOB_____________ Age_____ Today's Date__________

Past Medical History

Current Medications & Dosages

Medication	Dosage	Medication	Dosage

What medications are you allergic to and what kind of reaction did you have? ______________

____

Do you take herbs or supplements? ☐Yes ☐No Which ones? ____

Circle all diseases you have or have had in the past:

☐High Blood Pressure ☐Elevated Cholesterol ☐Cancer ☐Diabetes

☐Thyroid Disease ☐Heart Disease ☐Others: _____________________________________

Please list Hospital Admissions / Surgeries / Procedures / Biopsies

Year		Year	

Family History

Father: ☐ Living - Illness ___________________________ Mother: Living - Illness ______________________________

☐Deceased - Cause of death________________ Deceased - Cause of death ___________________________

Age at death ______________________________ Age at death ____________________________________

Has any parent, brother or sister had: (Please indicate which relative and approximate age at diagnosis)

☐ Colon Cancer ☐Ovarian Cancer ☐Thyroid Cancer ☐Heart Disease

☐ Colon Polyps ☐Prostate Cancer ☐Breast Cancer ☐Osteoporosis (bone thinning)

☐Melanoma ☐Stroke Diabetes ☐Bleeding Disorders ☐Alcoholism

☐Kidney Disease ☐Arthritis ☐Depression ☐Glaucoma

Social History

Occupation ________________________ ☐Married ☐Single ☐Divorced ☐Widowed # of children _______________

Alcohol: drinks per week

Have you ever had problems with alcohol use? ☐ Yes ☐No

Have you ever felt you needed to cut down on your drinking? ☐Yes ☐No

Have people annoyed you by criticizing your drinking? ☐Yes ☐No

Have you ever felt guilty about drinking? ☐Yes ☐No

Have you ever felt you needed a drink in the morning (eye opener) to steady your nerves or to get rid of a hangover? ☐Yes ☐No

Cigarettes: __________packs per day for __________ yrs. Quit (when) ? __________

Snuff: __________ per day for __________years

Coffee / Tea: __________cups per day Caffeinated Sodas: per day

☐Heterosexual ☐Homosexual

Recreational Drug Use / Substance Abuse (injections or other): ☐Yes ☐No; ☐Current ☐Past Which substances? _________________

What type of exercise do you do? ____ How often? ______________________

Name: ____
Date:____

- **REVIEW OF SYMPTOMS**

CHECK □ THE BOX FOR **CURRENT** PROBLEMS

Your 3 Main Problems:

(1) _______________________________(2)__________________________________(3)________________________________

General

□ Fatigue/Weakness
□ I do not feel rested when I wake up
□ I am not satisfied with my sleep
□ I am very sleepy during the day
□ I fall asleep easily during the day
□ Unhappiness
□ Depression/Sadness
□ Have felt down or hopeless for months
□ Have little interest/joy in usual activities
□ Tearfulness
□ Feelings of worthlessness
□ Concentration difficulty
□ Excessive irritability
□ Lack of motivation
□ Moodiness
□ Nervousness/Anxiety
□ Always feel ill
□ Unexplained fever >100
□ Frequent night sweats
□ Weight loss - recent
□ Weight gain
□ Allergies
□ Anemia
□ Phobias
□ Mental Illnesses

Skin

□ I have a mole(s) I want you to check
□ Changes in moles/unusual moles
□ Concerned about skin spots/growths
□ Bruise easily
□ Rashes
□ Hives
□ Itching
□ Psoriasis
□ Dry skin
□ Excessive hair growth
□ Hair Loss

Ears/Nose/Throat

□ Allergy symptoms
□ Frequent colds mouth sores
□ Decreased hearing
□ Ringing in the ears
□ Ear infections - frequent
□ Dizzy spells - dizziness
□ Nose Bleeds - frequent
□ Sinus trouble
□ Sore throat - frequent
□ Hoarseness - frequent
□ I would like allergy testing

Eyes

□ Watery eyes
□ Itchy eyes
□ Eye Pain
□ Double or blurred vision
□ Other visual disturbances

Lungs

□ Pneumonia
□ Asthma/Wheezing
□ Cough - persistent
□ Coughing blood
□ Snoring
□ Stop breathing/gasp at night
□ TB/Positive TB skin test

Heart/Circulation

□ Shortness of breath
□ On exertion □ Lying flat
□ Chest Pain or Chest Discomfort
□ High blood pressure
□ Heart Murmur
□ Palpitations/Racing heart
□ Irregular pulse
□ Fainting spells
□ Swollen ankles
□ Leg pain with walking
□ Varicose veins
□ Cold/Numb feet
□ Phlebitis – Blood clots

Gastrointestinal

□ Change in bowel habits - recent
□ Indigestion or heartburn
□ Loss of appetite - recent
□ Difficulty swallowing
□ Persistent nausea/vomiting
□ Peptic ulcers
□ Swallowing pain
□ Abdominal pain
□ Diarrhea
□ Constipation
□ Bloody or tarry stools
□ Hemorrhoids
□ Gallbladder problems
□ Hepatitis/Jaundice
□ Require laxative – How often?

Genital/Urinary

□ Hernia
□ Urine infections - frequent
□ Painful urination
□ Frequent urination
□ Urinary leakage/Incontinence
□ Blood in urine
□ Overnight urination x 2
□ Loss of control of urination
□ History of sexually transmitted diseases?
□ Are there sexual issues or dysfunctions you want to discuss?
□ Loss of interest in sex

Male

□ Decrease in force of urination
□ Erection problems
□ Too rapid ejaculation
□ Testicle lumps/swelling

Female

□ Pain/Bleeding during or after sex
□ Vaginal discharge/itching
□ Abnormal Pap smear
□ Flushing/Menopause symptoms
□ Significant pain/cramps with periods

Breast

□ Pain
□ Cysts
□ Lumps/Nodules
□ Nipple discharge
□ Biopsy of a nodule/lump

Female Menstrual History

Age of Onset ______ □ Reg □ Irreg □ Menopause
Flow: □ Heavy □ Moderate □ Light
______Days of flow ______ Length of cycle
# of pregnancies ________
# of live births _________
# of miscarriages/other _________
Birth control method ________________

Central/Peripheral Nervous System

□ Headaches - frequent
□ Seizures/convulsions
□ Stroke
□ Memory loss
□ Tremor/Hands shaking
□ Dizzy/Lightheaded
□ Muscle wasting
□ Numbness/Tingling sensations

Musculoskeletal

□ Arthritis
□ Back pain - recurrent
□ Bone pain/fracture
□ Gout
□ Foot pain

Miscellaneous

Date of last tetanus booster shot_____________
Have you ever been physically hurt by your partner?
□yes □no
Blood transfusion before 1992? □ Yes □ No □
I want sexually transmitted disease testing □ Yes □ No
I want HIV testing □ Yes □ No
Frequent foreign travel? □ Yes □ No
Date of last flu shot ________________________
Date of last pneumonia shot _________________
Date of last colonoscopy ____________________

I would like more information on

□ Allergy testing & treatment
□ $7 office visit and other ways to save on healthcare

Other

Other diseases or symptoms or concerns
____
____
____

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EXPLANATION OF COMPLETE PHYSICAL

A complete physical is a crucial, preventative service. It is routine care. Some insurance companies do not cover routine care.

The physical will be performed in **two parts**. While they can sometimes both be done in one visit for your convenience, they will be billed out as two separate medical services. The **first part** includes blood tests and a discussion with your doctor of medical problems and symptoms you may be having. The office visit and related blood work will be billed under a medical diagnosis if that is why the tests are ordered. The **second part** of the physical will include your examination and other testing such as EKG's and X-rays. If you are treated for a medical condition during your physical, those non-routine fees will be submitted separately from the routine complete physical.

You may wish to contact your insurance company to see if routine benefits are covered. The company may have a maximum dollar limit for routine care. Your physician cannot always be sure that the cost will be under that dollar amount. Our staff can discuss acceptable payment arrangements for any of these services.

PLEASE SIGN THE WAIVER BELOW:

WAIVER FOR POSSIBLE NON-COVERED SERVICE

Routine/Preventative services to include but not limited to complete physicals, school, sports, and camp physicals, travel counseling, immunizations, pap smears, well child appointments and flu shots may not be an expense covered by your insurance company.

I understand that my insurance company may or may not cover preventative services of labs being performed today. Some insurance companies may pay a portion and others may not cover these services at all. If you have a large deductible, some or all of this may go to your deductible. I understand this and I am willing to be responsible for charges not covered by my insurance.

______________________________________ ________________________

Signature (Patient/Guardian) Date

______________________________________ ________________________

Print Name (Patient) Date of Birth

______________________________________ ________________________

Witness Date