Michael M. Johnson, MD
John "Rad" Kothmann, MD
Jeff Holt, MD
Rebecca W. Daley, DO
Maggie Gainer, MD
Lisa Kott, RN, FNP-C

1308 South State Highway 16
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(830) 997-2181 Fax: (830) 997-4453
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Elliana Wiesner, MD
Aaron Saul, FNP-C

Last Name: _____ First Name: _____ MI: _____

Gender: ☐Male ☐Female Date of Birth: ____/____/____ Social Security# _____-_____-_____

Referring Physician: _____ Marital Status ☐Single ☐Married ☐Widowed ☐Divorced ☐Domestic Partner

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Numbers Primary: _____ Secondary: _____

Employer's Name: _____ Occupation: _____ Phone: _____

Race: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black/African American
☐American Indian/Alaskan Native ☐White ☐More than one Race ☐Decline to answer

Ethnicity ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Decline to answer

Language ☐English ☐Spanish ☐Other: _____ E-Mail: _____

Insurance

Insurance card(s) or proof of insurance must be presented at the time of service

Primary Insurance: _____

If you are not the policy holder, please complete the following information

Policy Holder's Name: _____ Date of Birth: _____ Policy Number: _____

Secondary Insurance:

If you are not the policy holder, please complete the following information

Policy Holder's Name: _____ Date of Birth: _____ Policy Number: _____

Assignment and Authorization of Benefits for Patients with Insurance

I hereby state that the above information is true and correct to the best of my knowledge. I hereby assign, transfer, and set over to Fredericksburg Clinic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____

Signature of Patient or Personal Representative Date

Financial acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative Date

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Patient Name: _____ Date of Birth: ____/____/____

Notice of Privacy Practices

_____ (Patient Initials) I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information and for the purposes described in the practice's Notice of Privacy Practices.

Release of Information

_____ (Patient Initials) I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: * Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. * Obtain payment from designated third-party payers. * Conduct normal health care operations such as quality assessments or evaluations and physician certifications. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions. I understand that I may revoke this consent in writing at any time

I authorize Fredericksburg Clinic to contact me via the following methods: (Check all that apply)

☐ Telephone ☐ Work Phone ☐ Cell Phone ☐ Mail ☐ E-Mail ☐ Patient Portal

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed by phone, fax or in person for purposes of picking up prescriptions, communicating results, findings, and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

****This release will remain in effect until it is revoked in writing by the patient****

_____ _____

Signature of Patient or Personal Representative **Date**

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1. Cancellation Policy/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you may be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we may have to reschedule the appointment.

3. Account Balances

We will require that patients with balances pay their account balances to zero ($0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Print Patient Name	Patient Signature	Date

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Nurse Practitioner Consent Form

This facility has on staff Nurse Practitioners to assist in the delivery of medical care.

A Nurse Practitioner is not a doctor. A Nurse Practitioner is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, a Nurse Practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of the supervising Physician, but rather overseeing the activities of and accepting responsibility for the medial services provided.

A Nurse Practitioner may provide such medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Nurse Practitioner for my health care needs. I understand that at any time I can refuse to see a Nurse Practitioner and request to see a Physician.

_____	_____
Patient's Name	Date of Birth
_____	_____
Signature of Patient or personal Representative	Date

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Please indicate if you have ever received any of the following immunizations or screening procedures along with date if known

Procedure	Date	Procedure	Date	Immunization	Date
☐ Pap Smear	_____	☐ Colonoscopy	_____	☐ Influenza	_____
☐ Mammogram	_____	☐ Prostate Exam	_____	☐ Pneumovax	_____
☐ Bone Density	_____	☐ Eye Exam	_____	☐ Tetanus	_____
☐ PSA	_____	☐ Cholesterol Testing	_____	☐ Shingles	_____
				☐ Prevnar 13	_____
				☐ Hepatitis B	_____

Please list the date of your last Menstrual Cycle: _____

Please complete the following information about your relatives:

Family Member	Living	Dead	Health Problems
Mother	_____	_____	_____
Father	_____	_____	_____
Brothers (No.____)	_____	_____	_____
Sisters (No.____)	_____	_____	_____
Children (No.____)	_____	_____	_____

Please complete the following information about yourself:

Social History:

Occupation: _____ Education Completed: ☐ Grade:_____ ☐ High School/GED ☐ College

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

How many Children do you have? _____ What are the ages of your children? _____

Who do you live with? ☐ alone ☐ with spouse ☐ with parents ☐ with children ☐ other _____

Personal Habits:

Tobacco Use: ☐ None ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco Amount/Day: _____ Years: _____

☐ Former Smoker Used to smoke amount/day: _____ Years Smoked: _____ Year you quit smoking: _____

Alcohol use: ☐ Yes ☐ No Type: _____ Amount per day: _____

Did you ever drink considerably more than you do now? ☐ yes ☐ No Has anyone urged you to cut down? ☐ yes ☐ No

Use recreational Drugs? ☐ Current ☐ Former ☐ Never Type: _____ Frequency: _____

Use Injection Drugs? ☐ Current ☐ Former ☐ Never Type: _____ Frequency: _____

Exercise Regularly? ☐ Yes ☐ No Type: _____ Frequency/Week: _____

Sexual History:

Currently Sexually Active? ☐ Yes ☐ No If yes are you sexually active with a member of ☐ Same Sex ☐ Opposite sex ☐ Both

Travel History:

Have you recently traveled outside of the United States? ☐ Yes ☐ No If yes please list countries traveled to: _____

Other History:

Is anyone Hurting you at home? ☐ Yes ☐ No

Do you have a living will or advanced directive? ☐ Yes ☐ No If not, are you interested in more information? ☐ Yes ☐ No

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New Patient Information

Please take the time to complete the following form so that we may better understand your medical history. This information will be treated with strict confidentiality.

Patient's Name: _____ Date of Birth: ____/____/____

Please indicate if you have ever been treated or hospitalized for any of the following conditions and provide the date if known.

Condition	Condition	Condition	Condition
☐ Abnormal Heart rhythm	☐ Hemorrhoids	☐ Kidney failure/dialysis	☐ Tuberculosis
☐ High Cholesterol	☐ Cirrhosis	☐ Osteoporosis	☐ Psoriasis
☐ High Blood Pressure	☐ Gallstones	☐ Osteopenia	☐ Eczema
☐ Heart Attack/CAD	☐ Stroke/TIA	☐ Osteoarthritis	☐ Shingles
☐ Congestive Heart Failure	☐ Seizures/Epilepsy	☐ Back pain	☐ BPH
☐ Murmur	☐ Headaches/Migraines	☐ Anemia	☐ Abnormal Pap Smear
☐ Peripheral Vascular Disease	☐ Neuropathy	☐ Lupus	☐ Breast Lumps
☐ COPD/Emphysema	☐ Depression	☐ Rheumatoid Arthritis	☐ Fibromyalgia
☐ Asthma	☐ Anxiety	☐ Diabetes Mellitus	☐ Gout
☐ Blood Clot to lungs	☐ Cataracts	☐ Thyroid Problems	☐ Insomnia
☐ Reflux/GERD	☐ Glaucoma	☐ Seasonal Allergies	☐ Cancer (Please List)
☐ Polyps	☐ Retinopathy	☐ HIV/AIDS	_____
☐ Diverticuli	☐ Recurrent UTI	☐ Hepatitis B or C	☐ Other (Please List)
☐ Irritable Bowel Syndrome	☐ Kidney Stones	☐ Sexually transmitted diseases	_____

Please List all past surgeries or Injuries and dates if known.

Surgery /Injury	Date	Surgery/Injury	Date

Please list any Other Physicians You see

Physician	Specialty

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Please List all Medications you are currently taking including over-the-counter and herbal products

	Medication	Dose	How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Please List any Medication Allergies along with Reaction and Date if known

Medication/Reaction	Date	Medication/Reaction	Date

☐ No Known Drug Allergies

Are you allergic to Iodine or X-Ray Dye? ☐ Yes ☐ No

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Review of Systems: Please check any symptoms you have suffered from in the past few weeks.

General:
- ☐ Weight Loss
- ☐ Fever/Chills
- ☐ Weakness
- ☐ Fatigue/Tiredness

Skin:
- ☐ Itching
- ☐ Pallor
- ☐ New Lesions
- ☐ Dryness
- ☐ Rash/Hives
- ☐ Change in wart/mole

HEENT: (eyes, ears, nose, and throat)
- ☐ Blurred vision
- ☐ Eye pain/Irritation
- ☐ Need Corrective Lenses
- ☐ Seasonal Allergies
- ☐ Hoarseness
- ☐ Toothache
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Nosebleeds
- ☐ Sore Throat
- ☐ Post Nasal Drainage
- ☐ Runny Nose
- ☐ Nasal Congestion

Respiratory:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Snoring
- ☐ Coughing Up Blood
- ☐ Cough
- ☐ Difficulty Breathing with Exertion

Breast:
- ☐ Breast Lump/Mass
- ☐ Breast Pain
- ☐ Nipple Discharge

Cardiovascular:
- ☐ Chest Pain/Pressure/Angina
- ☐ Leg Swelling
- ☐ Pain in Legs w/ Exercise
- ☐ Elevated Blood Pressure
- ☐ Heart Fluttering/Racing

Gastrointestinal:
- ☐ Stomach Pain
- ☐ Reflux/Indigestion
- ☐ Bloating
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Rectal Bleeding
- ☐ Constipation
- ☐ Nausea/Vomiting

Genitourinary:
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Painful Intercourse

MEN:
- ☐ Penile Discharge
- ☐ Dribbling
- ☐ Testicular Pain

Women:
- ☐ Vaginal Discharge
- ☐ Vaginal/Pelvic pain
- ☐ Irregular Menstrual Cycle

Musculoskeletal:
- ☐ Joint Pain
- ☐ Joint Swelling/Stiffness
- ☐ Back/Neck pain
- ☐ Muscle Weakness
- ☐ Muscle Spasm

Neurologic:
- ☐ Arm/Leg Weakness
- ☐ Numbness/Tingling
- ☐ Headache
- ☐ Dizziness
- ☐ Tremors/Shaking
- ☐ Balance Disturbance
- ☐ Fainting
- ☐ Memory Loss

Psychological:
- ☐ Crying Spells
- ☐ Anxiety
- ☐ Stress
- ☐ Easily Irritated
- ☐ Trouble Sleeping
- ☐ Loss of Interest in Usual Activities

Endocrine:

Change in tolerance to ☐ Heat ☐ Cold
- ☐ Unusual Thirst/Hunger
- ☐ Hair Changes
- ☐ Changes in Libido

Hematology:
- ☐ Abnormal Bleeding
- ☐ Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Painful Lymph Nodes

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all sections that apply to their decisions relating to the use or disclosure of their protected health information.

Patient's Name: _____ Date Of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email (optional): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Sending Physician: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Information regarding person or entity who can receive and use this information:

Receiving Physician: _____ Phone: (830) 997-2181 Fax: (830) 997-4453
Address: 1308 South State Highway 16 City: Fredericksburg State: TX Zip: 78624

Information to be disclosed:
☐ Medical Records from _____ to _____ ☐ Entire Medical Record(except psychotherapy notes)
☐ Other (Please list)Last Colonoscopy, Last year of labs, Immunization records. If female: Last mammogram. If Male: Last PSA
I authorize the above named facility to include the following in my medical records:
☐ Drug, Alcohol, or Substance Abuse Records ☐ Mental Health Records (except Psychotherapy notes) ☐ Genetic Information
☐ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
Reason for release of information (Choose all that apply):
☐ Continuing Medical Care ☐ Personal Use ☐ Billing or Claims ☐ Insurance ☐ Legal Purposes ☐ Disability Determination
☐ School ☐ Employment ☐ Other (Please Specify) _____
The Individual signing this form agrees and acknowledges as follows:

- This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- This authorization may include disclosure of information relating to **Drug, Alcohol** and **Substance abuse, Mental Health Information,** except psychotherapy notes, **Confidential HIV/AIDS-Related Information,** and **Genetic Information** only if I check the appropriate boxes above. In the event the health information described above includes any of these types of information, and I check the corresponding box above, I specifically authorize release of such information to the person or entity indicated herein.
- I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of heath information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
Signature of patient or Personal Representative (If not patient please list relationship) Date:

_____ _____
Signature of Minor (If applicable): Date:

A minor's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol, or substance abuse, and mental health treatment.