

# FHP Geriatrics - Registration Information

11007 Northpointe Blvd  
Tomball, TX 77375

Phone: 832-599-8336, Fax: 888-840-6973

[www.fhpgeriatrics.com](http://www.fhpgeriatrics.com)

Patient Name: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

S.S. #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Power of Attorney Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Main Contact Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Send a Text about 30 minutes prior to visit? Yes / No

\*Email for periodic service updates, never shared: E-mail Address: \_\_\_\_\_

**Ethnicity:** Caucasian Hispanic African-American Other: \_\_\_\_\_

## Insurance Information

**\*\*Note for Medicare Advantage:** Before we start care, you must have the correct Tax ID for Dr Valdez: 26-0849313, GA Valdez & Associates. If Dr Valdez under Village Medical is chosen, we will not be able to provide care. We can direct you to an agent who can help you select us at any part of the year\*\*

### Primary Insurance Policy (We will need a copy of the card, as well as driver's licence)

Insurance Name: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Is the insured a patient? \_\_\_ Yes Or \_\_\_ No Insured's Date of Birth: \_\_\_\_\_

Patient's relation to the insured: \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ other \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Secondary Insurance

Insurance Name: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Patient's relation to the insured: \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ other \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Social Media Consent/Release Form For Media, Photographs:** We are actively engaged with our communities, and periodically post pictures on social media for events we sponsor or participate in. If you authorize FHP Geriatrics to use their photo, this information may be used in publications, including electronic publications, audiovisual presentations, promotional literature, advertising, community presentations, and media. You may revoke permission at any time.

I prefer that: First name only be used. No name be used. Do Not include in photo at all

## Financial Policies

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of the insurance benefit. As a courtesy to you we will file your claims with your insurance company. Insurance payments are usually received within 30-45 days. **Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service.** A copy of your insurance card will need to be kept on file in our office. You are providing consent to services provided in person or via a secure telehealth platform. Patients with chronic conditions are enrolled in CCM and remote-connected devices programs to provide more comprehensive care and anticipate worsening. You may discontinue at any time, but it has proven beneficial in preventing complications. A care plan is created and available for review. The care plan includes the patient's problem list, expected outcome, treatment goals, symptom management, planned interventions, medication management, social services if ordered, and periodic revision of the care plan. We try to answer any questions you may have about your insurance company, however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

## Assignment of Benefit

Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of medical treatment. I hereby authorize payment directly to George Valdez, MD of the insurance benefits otherwise payable to me.

\_\_\_ **Guardian** \_\_\_ **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Patient HIPAA Acknowledgment and Consent Form

\_\_\_\_\_ **(Patient initials)** Notice of Privacy Practices. 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 for the purposes described in the practice's Notice of Privacy Practices.

\_\_\_\_\_ **(Patient initials)** Release of Information. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

**Disclosures to Friends and/or Family Members:** I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name, Relationship, Contact Number

1: \_\_\_\_\_

2: \_\_\_\_\_

\_\_\_ **Guardian** \_\_\_ **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## BRIEF MEDICAL HISTORY QUESTIONNAIRE

Describe briefly current active concerns:

Hospitalizations in last year (include where, when, & for what reason):

Please list the names of other providers currently seeing, type of specialty, and issues they are addressing:

When was last **vision** exam/Name of Specialist: \_\_\_ Not Sure, \_\_\_\_\_

When was last **dental** exam/Name of Specialist: \_\_\_ Not Sure, \_\_\_\_\_

When was last **foot** exam/Name of Specialist: \_\_\_ Not Sure, \_\_\_\_\_

When was last **skin** exam/Name of Specialist: \_\_\_ Not Sure, \_\_\_\_\_

If insurance is regular Medicare, patient can still see prior primary care and we can coordinate with them.

**BASIC DIRECTIVES:** Hopefully not anytime soon, but if illness suddenly happens or gets worse, would the *patient*:

\_\_\_ (1) prefer to not go to the hospital, no matter what

(treat conservatively with meds only, if not responding then pass away at home with comfort meds)

\_\_\_ (2) go to the hospital to diagnose and stabilize but medications only- comfort care only if it worsens further.

\_\_\_ (3) go to hospital, if needed, ventilator/artificial breathing for up to 2 weeks if needed, but *no aggressive CPR*.

\_\_\_ (4) go to hospital with treatment to include ventilator for prolonged period if needed, but *no aggressive CPR*.

or

\_\_\_ (5) go to hospital with treatment to include ventilator and *aggressive CPR*

Preference can always be changed, but it is helpful to have basic understanding before an emergency arises.

please review video at [www.fhpgeriatrics.com](http://www.fhpgeriatrics.com), update us at least once per year

\**Aggressive CPR* usually includes chest compressions/breaking ribs, shocking heart with electricity, medications to artificially support blood pressure, with around 15% short term survival rate after 80 year old

### CURRENT MEDICATIONS - Please list so we may plan ahead prior to first visit

Drug allergies:  No  Yes To what?

Please list any medications that you are now taking. Include non-prescription medications or supplements:  
The facility will also provide a medication list, but we often receive this first, and may respond faster if filled.

Name of drug	Dose (strength & number of pills per day)	Reason for taking?	Concerns?
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## PAST MEDICAL HISTORY

Does the patient now or has ever had:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High blood pressure                       | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Dementia             |
| <input type="checkbox"/> High cholesterol                          | <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Heart Failure CHF                         | <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> Hip/Pelvic Fracture  |
| <input type="checkbox"/> Coronary Artery Disease / Atherosclerosis | <input type="checkbox"/> Hypothyroidism               | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> CVA / TIA / Stroke                        | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Cataracts            |
| <input type="checkbox"/> Atrial Fibrillation                       | <input type="checkbox"/> Kidney Disease / CKD         | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Benign Prostatic Hypertrophy | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> COPD / Emphysema / Chronic Bronchitis     | <input type="checkbox"/> Cancer (type) _____          |   |

Other medical conditions (please list):

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## In the past month, has the patient had any of the following problems?

### GENERAL

- Recent weight gain; how much \_\_\_\_\_
- Recent weight loss: how much \_\_\_\_\_
- Fatigue
- Weakness
- Fever
- Night sweats

### MUSCLE/JOINTS/BONES

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

### EARS

- Ringing in ears
- Loss of hearing

### EYES

- Pain
- Redness
- Double or blurred vision
- Dryness

### HEART AND LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet

### NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

### STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

### SKIN

- Redness
- Rash
- Hair loss
- Color changes of hands or feet

### BLOOD

- Anemia
- Clots

### KIDNEY/URINE/BLADDER

- Frequent or painful urination

### PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Anxiety
- Poor appetite
- Food cravings
- Frequent crying
- Mood swings
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts

### OTHER PROBLEMS:

**FHP GERIATRICS**  
11007 Northpointe Blvd  
Tomball, TX 77375

Phone: 832-599-8336  
Fax: 888-840-6973  
www.fhpgeriatrics.com

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Navigating Health Care with Quality, Efficiency, Compassion

## **Authorization To Obtain/Release Medical Information**

You must complete this form thoroughly.

Patient's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby authorize FHP Geriatrics to obtain or share my health information.

Unless stated otherwise, records will be shared with them. Please send records within 14 business days.

Name of *Prior* Physicians or Medical Facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Information to be released: \_\_\_\_\_

*Current* Other Treating Physicians we may send/receive health information with:

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Others: \_\_\_\_\_

### Conditions Of Authorization

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain records. I may revoke this authorization by writing a letter and mailing it certified, return receipt requested, to the Privacy Officer at the health provider listed above. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and longer protected by Federal Privacy Regulations.

This authorization is valid for the release of information as indicated above. Only records from this facility can be legally released. Any record for other physicians must be obtained from them.

\_\_\_\_ Guardian \_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## The FHP Geriatrics Difference

**Experience.** Dr George Valdez, MD, MBA, is a native Houstonian, practicing in the area since 2002. Double Board-Certified in Family Medicine, as well as Hospice and Palliative Care, he brings a depth and breadth of knowledge, experience, organization, and focus which is difficult to compare with. Medicare supports the right to choose the best provider.

**Dedication.** Our patients are often the eldest, most complex, and frail members of society. They deserve the best care to meet their needs where they are at. Dr. Valdez and his team are fully focused on senior living. We have no distractions from the hospital or clinic. Dr. Valdez is in constant collaboration with his team, not just a passive supervisor. Ask your current provider if they have an experienced, *US medical school-trained Physician* involved, how often your loved one will be seen by them, and are they focused *only* on senior living facilities?

**Relationships.** This is your loved one's journey and we will make sure to understand their priorities. Whether it is to focus on more aggressive care with better specialists, or quality of life and comfort. We value our relationships with the patient, and just as importantly, with family, facility staff, specialists, and hospitals. We must constantly communicate and work toward the same goal with the best options. We have laboratory and x-ray services available 7 days a week.

**Communication.** We have a Family Hotline, and we regularly reach out to make sure you are included. We have a Staff Hotline, so staff members can reach out to get the right care at the right time. Dr. Valdez is able to facilitate multi-specialty care for your loved one. Highly- respected amongst his peers, he speaks Doctor to Doctor, to coordinate with multiple specialists. He maintains access at 9 area hospitals. This means we are able to communicate, Doctor to Doctor, when your loved one is hospitalized, to make sure there is an effective follow up plan. We are unaware of other area senior living providers who perform at this level.

**Innovation.** While we are rooted in old-fashioned compassion and relationships, we are powered by next-generation innovation. We did telemedicine 2 years before the COVID-19 pandemic. When the pandemic suddenly hit, we shifted care delivery at over 70 facilities within 1 week. We continue to lead in care-delivery. While we see each person once per month, we are able to use advanced telemedicine visits to address urgent issues in between. This can help avoid hospitalization. We utilize advanced, map-based scheduling software and call you the week before our visit to anticipate concerns and plan ahead. Dr. Valdez is the first physician in the Western United States to utilize the Nonagon diagnostic device for next-level telehealth. Dr. Valdez is the first physician in North Houston to register for the Compassionate Use Registry of Texas. Under his team at THClinicians.com, he successfully utilizes medical marijuana to substitute some traditional medications and achieve better quality of life for qualified conditions.

**Compassion.** Trained and experienced for all ages and conditions, Dr. Valdez has been inspired to use his training and resources to bring care to our seniors, at a higher level than is usually expected. We are honored by the trust placed in us, and strive to exceed all expectations. Most of all, we love what we do and it shows! You may fill out new patient packets online at [fhpperiatrics.com](http://fhpperiatrics.com), or call 832-599-8336 for more information.