FHP Geriatrics - Registration Form Update 2023.7.30

(Even faster and better, skip the paper, visit fhpgeriatrics.com > New Patient)

11007 Northpointe Blvd
Tomball, TX 77375
Phone: 832-599-8336 **Fax: 888-840-6973**
www.fhpgeriatrics.com **Email: admin@fhpgeriatrics.com**

Download SpruceHealth app on your phone for secure text and video visits

Patient Name: _____Male: ____ Female: ____ Marital Status: _____

Name/Location of Facility: _____ **Room/Unit #**_____

Billing Address: _____City: _____ State: _____ Zip: _____

S.S. #: _____Birth Date: _____Ethnicity: _____

Power of Attorney Name _____Relation: _____Phone: _____

Main Contact Name _____Relation: _____Phone: _____

Main Contact E-mail: _____ Other Permitted Contacts:_____

Primary Insurance Policy: ***We must keep photo of the cards, and patient's driver's license on file -***
Please take a picture and text to 832-356-7878, or HIPAA secure email admin@fhpgeriatrics.com

Is the insured a patient?___ Yes Or__ No Patient's relation to the insured: ___ Self ___ Spouse ___ other

Insurance Name: _____Name of Insured: _____

Insured's Date of Birth: _____Insured's ID #: _____ Group #: _____

Secondary Insurance: Insurance Name: _____ Name of Insured: _____
Patient's relation to the insured: ___ Self __ Spouse ___ other

Insured's ID #: _____ Group #: _____

HIPAA Consent and Acknowledgment: 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.

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.

Treatment Policy: 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 Chronic Care Management and Remote Patient Monitoring program to collect vitals regularly, provide more comprehensive care, and anticipate worsening. You may discontinue at any time, but it has proven beneficial in making better-informed decisions and 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. Please be aware of your insurance policy regarding a deductible. The deductible is usually required at the beginning of each calendar year which is payable before benefits are covered. Please note, we cannot schedule the first visit without signed consent.

__DPOA ___Patient Signature: _____Date: _____

Medical Information

If prior records are available, print to pdf and send to our secure email: admin@fhpgeriatrics.com

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:

PATIENT'S DIRECTIVES: How aggressively **the patient** would like us to approach care (we reassess regularly)

__(1) Possible hospice: poor quality of life: consider therapy, tests, meds, specialist referrals, **no hospital**.
If declines further, hospital unlikely to help, likely to cause more stress, consider hospice if no improvement.

__(2) Palliative: stable but fragile, consider therapy, tests, meds, specialists referrals as needed, but
. Prefer **no hospital**, even for non-aggressive treatment (may need ER stabilization if acute issue after hours)

__(3) Nonaggressive: If needed, ok go to hospital, treat things easy to treat, but no aggressive measures

__(4) Somewhat aggressive: ok go to hospital, ventilator while awaiting prognosis, **no CPR** (shock, compressions)

__(5) Full, aggressive treatment to include ventilator and *CPR* (heart shock,compressions) if needed

Preference can always be changed, but it is helpful to have basic understanding before an emergency arises.
If a patient is not on hospice, and condition declines after hours, sending them to emergency room is default plan.
Code Status: ❑ DNR on file ❑ DNR requested ❑ Full Code

PAST MEDICAL HISTORY

Does the patient now or has ever had:

❑ High blood pressure	❑ Arthritis	❑ Dementia
❑ High cholesterol	❑ Anemia	❑ Depression
❑ Heart Failure CHF	❑ Osteoporosis	❑ Hip Fracture: L or R
❑ Coronary Artery Disease / Bypass / Stents	❑ Low Thyroid	❑ Seizures
❑ CVA / TIA / Stroke	❑ Diabetes	❑ Cataracts
❑ Atrial Fibrillation: Occasional / Constant	❑ Kidney Disease / CKD	❑ Glaucoma
❑ Asthma	❑ BPH (Prostate Problem)	❑ Macular Degeneration
❑ COPD / Emphysema / Chronic Bronchitis	❑ Cancer (type) _____	

Other Conditions, Surgical History (Please List, online form will allow more details if needed)

In the past month, has the patient had any other events, new or worse symptoms or problems?

If known, approximately when were last yearly labs (thyroid, cholesterol,etc)? any unstable issues?

Drug allergies: ❑ No ❑ Yes To what?

CURRENT MEDICATION LIST- take a picture and text to 832-356-7878, or email admin@fhpgeriatrics.com
The facility may have on file, but may be unavailable, and we may plan more effectively prior to first visit

- **Circle if seen in the last year: cardiologist eye specialist dermatologist dentist**
- **Circle which Visiting Specialist you may need (in person or through video visit, if available)**

Cardiology (heart)	**Opthalmology (eye)**	**Dermatology (skin)**
Rheumatology (arthritis)	**Nephrology (Kidney)**	**Neurology**
Psychiatry	**Endocrinology (Hormones)**	**Oncology (blood, cancer)**
Wound Care	**Infectious Disease**	**Pain Rehab**
Dentist	**Podiatry (foot)**	**Audiology (Hearing)**
General Surgery	**Pulmonology**	**Integrative Medicine**