TOWN & COUNTRY
Family Physicians

Anthony J. Popek, MD Laurel M. Tucker, MD Thai V. Nguyen, DO Henry C. Jackson, MD
Bailey Hilburn, PA-C Stephanie Heflin, RN, ANP-C
10497 Town and Country Way Suite 360 Houston, Texas 77024 Phone 713-341-2100 Fax 713-932-7072
www.townandcountryfamilyphysicians.com

REGISTRATION

Please check here □ if no changes since your last visit. Only complete Patient's first, last name, sign and date form.

PATIENT INFORMATION

Patient's Last Name: First: Middle:			SS#	TDL#
Address:	Apartment#	City:	State:	Zip:
Birth Date: / / Age:	Sex: □ M □ F		Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed	
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )	
Email:	Race:	Ethnic Group:	Do you have an advance directive: □ No □ Yes (*please provide copy*)	
Employer:			Occupation:	
Employer Address: City: State: Zip:			Employer Phone: ( )	
Preferred Contact Method: □ Home Phone □ Cell Phone □ Patient Portal		In Case of Emergency Who Should Be Notified: Relationship: Phone Number: ( )		
How did you hear about us? □ TV □ Internet □ Friend □ Family □ Magazine □ Other:				

PRIMARY INSURANCE (Please give your insurance card to the receptionist)

Policyholder: Last Name: First: Middle:			
Patient's Relationship to Policyholder: □ Self □ Spouse □ Child □ Other:	Birth Date:	SS#	
Address (if different from above):	City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )
Policyholder Employer:			Occupation:
Name of Primary Insurance:	ID#/Subscriber#		Group:

SECONDARY INSURANCE

Policyholder: Last Name: First: Middle:			
Patient's Relationship to Policyholder: □ Self □ Spouse □ Child □ Other	Birth Date:	SS#	
Policyholder Employer:			Occupation:
Name of Secondary Insurance:	ID#/Subscriber#		Group:

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize Town & Country Family Physicians to file my medical claims to my insurance and release medical information necessary to process any claim. I authorize payment of medical benefits to Town & Country Family Physicians. I hereby acknowledge and understand that I am financially responsible for all charges rendered to me (or my dependent) whether or not paid/covered by my insurance carrier. I authorize the use of this signature on all insurance submissions. I, the patient give consent for treatment.

Patient/Guardian Signature: _____ Date: _____

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CHILD MEDICAL HISTORY FORM

Name: _____ Sex: M F Date of Birth: _____ Age: _____
Last First Middle

PAST MEDICAL HISTORY

	Yes	No		Yes	No	
City Water	□	□	Diabetes	□	□	Other: _____
Well Water	□	□	Thyroid or Glandular	□	□	_____
Bottled Water	□	□	Asthma & Lung	□	□	_____
Daycare	□	□	Back/Spine Disorder	□	□	_____
Household Pets	□	□	Kidney Disease	□	□	_____
Recent Travel	□	□	Heart Disease	□	□	_____
Head Injury, Seizures	□	□	Headaches	□	□	_____
Depression	□	□	Constipation	□	□	_____
Tobacco Smoke in Home	□	□	Irregular Heart Beat	□	□	

PAST SURGICAL HISTORY

	Yes	No	
Ear Tubes	□	□	Other: _____
Tonsillectomy	□	□	_____
Thyroidectomy	□	□	
Heart Surgery	□	□	_____
Hernia	□	□	
Knee Surgery	□	□	_____
Hip Surgery	□	□	

MEDICATIONS

Regular Medications (include vitamins, over the counter, birth control, herbal meds)
(Example: Lipitor 20 mg, 1 a day)

	Drug	Drug Strength	Frequency		Drug	Drug Strength	Frequency
1				6			
2				7			
3				8			
4				9			
5				10			

Pharmacy Name _____ **Phone Number** _____

ALLERGIES AND REACTIONS TO MEDICATIONS

Please list any allergic reactions or other adverse reactions you have had to any medications, including over-the-counter medications. Please specify what kind of reaction you had. (if you had a reaction to penicillin, did it involve collapsing, difficulty breathing or did it occur in less than an hour after taking penicillin?)

□ **Please check this box if you have had no medication allergies or reactions.**

Name of Medication	Allergic Reaction	Other Adverse Reaction

Date of Last Immunization:

VACCINE	YES	NO	YEAR	VACCINE	YES	NO	YEAR
Hepatitis A				Typhoid			
Hepatitis B				Yellow Fever			
Pneumonia				Measles, Mumps, Rubella			
Polio				Small Pox			
Tetanus				Influenza (yearly flu shot)			
Chickenpox (varicella)				Other			
Meningococcal							

BIRTH HISTORY

Pregnancy Complications? □ Yes □ No If yes, explain _____

_____

FAMILY HISTORY

		IF LIVING		**IF DECEASED**
	Age	Health	Age	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers/	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____

Do you have a family history of: (Circle any that apply and explain below, include blood relatives only)

Diabetes	Cancer	Heart Disease	High Blood Pressure
Peptic Ulcer	Stroke	Heritable Disorder	Rheumatoid Arthritis
Epilepsy	Gout	Tuberculosis	Glaucoma
Alcohol/Drug Abuse	Kidney Disease	Migraines	Asthma/Lung Disease
Colon Disease	Blood Disease	Mental Illness	Sickle Cell Anemia

Please indicate which family member (include maternal or paternal) is/was affected and any details:

_____

_____

_____

RISK FOR FALLS

Have you had an accident fall in the last three months? □ No □ Yes
Do you use a cane, walker, crutches, wheelchair, or need help from someone to walk? □ No □ Yes
Do you feel or are you taking medicine that make you feel dizzy, weak, sleepy, confused or need to go to the bathroom often? □ No □ Yes

PLEASE CHECK THE APPROPRIATE BOX Y= YES N= NO O= OCCASIONALLY

GENERAL

	Y	N	O		Y	N	O		Y	N	O
Fatigue				Night Sweats				Difficulty Sleeping			
Loss of Appetite				Intolerance to Heat				Bleeding Tendency			
Loss of Weight				Intolerance to Cold				Sexual Dysfunction			
Fever				Any Skin Troubles				Chills			

HEAD AND NECK

Headaches				Nasal Congestion				Frequent Colds			
Eye Trouble				Nose Bleeds				Sore Throat			
Hearing Difficulty				Hay Fever				Lumps in Neck			
Earaches				Dental Trouble				Neck Pain			
Sinus Trouble				Sore Tongue				Other:			

RESPIRATORY

Cough				Wheezing				Cigarette Smoker #day _____			
Sputum				Shortness of Breath				**Date of last Tetanus**			
Cough up blood				Exposure to Tuberculosis				**Date of last TB skin test**			
Other:				**Date of Last Chest Xray**				**If done, was it positive**			

_____, **20**

CARDIOVASCULAR

Chest Pain				Swelling of Ankles				Shortness of Breath			
Varicose Veins				Irregular Heartbeat				High Blood Pressure			
Heart Murmur				Date of last EKG				Poor Circulation			
Palpitations				Blue or Very White Fingers				**Date of Last Stress Test**			

_____, **20**

DIGESTIVE

Heartburn				Difficulty Swallowing				Do you take Laxatives?			
Gas				Abdominal Pain				Nausea/Vomiting			
Constipation				Blood in Stools				Black Stools			
Diarrhea				Hemorrhoids				**Date of Last Colonoscopy**			

_____**, 20**

URINARY

Incontinence				Frequency of Urination				Appearance Change of Urine			
Painful Urination				Bloody or Discolored Urine				Get Up at Night to Urinate? _____			

MUSCLE AND JOINT

Back Pain				Pain, Stiffness, Swelling				Limitations of Joint Movement			
Broken Bones				Deformities				Leg Cramps When Sleeping			
Feet Trouble				Injuries in the Past Year				**Date of Last Bone Density Test**			

_____, **20**

NERVOUS SYSTEM

Forgetfulness				Abdominal Sensation				Loss of Balance			
Tremors				Nervousness				Muscle Weakness			
Depression				Spells of Any Kind				Difficulty Walking			
Clumsiness				Dizziness				Fainting			

WOMEN ONLY

	Y	N	O		Y	N	O		Y	N	O
Menopause				Irregular Menstruation				Abnormal Vaginal Discharge			
Birth Control Pills				Trouble with Breast				Bleeding Between Periods			
Breast Lump				**Date of Last Pap Smear**				# of Pregnancies			
Hot Flashes				**Date of Last Mammogram**				# of Miscarriages			

_____, **20**

MEN ONLY

Lump in Testicles				Penis Discharge				Impotence or Difficulty with Erections			
Sore Penis				Prostate Trouble				Difficult Urination or Weak Stream			

The above is complete and true to the best of my knowledge. I, the undersigned, voluntarily consent and grant permission to the physician or nurse practitioner to perform tests, treatment and procedures as indicated for myself, or the above named minor for as long as I am a patient of Town & Country Family Physicians.

_____ _____

Name of Patient Signature of Patient/Legal Representative

_____ _____ _____ _____

Relationship to Patient Date Reviewed by Date

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO A FRIEND OR FAMILY MEMBER

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name_____ Date of Birth _____

I authorize Town and Country Family Physicians to disclose my health information to:

Name	**Relationship**

Please release the following:

___Entire Record
or:_____Progress Notes
___History/Physical Exam
___Medication List
___Immunization Record
___List of Allergies
___X-Ray/Imaging Reports-from (date)_____to (date)_____
___Laboratory Results-from (date)_____to (date)_____
___EKG Reports
___Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___**Yes**, I consent to the release of this information. ___**No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____. Unless otherwise indicated, this authorization will expire in ninety (90) days from date of signature.

I give Town and Country Family Physicians the authorization to leave me a recorded message at the following numbers regarding any medical information or diagnosis and the confirmation of any appointments.

_____ please leave recorded messages ( ) _____

_____ do not leave recorded messages ( ) _____

This office has established an **Email Policy-Patient Portal** to better serve our patients. If you provide us with your Email address, you are giving us permission to Email your test results or other personal health information. Email sent from this office is a one-way communication and return emails will not be accepted. You will need to contact this office or schedule an appointment if you have questions about any information contained in the email. Although this office is dedicated to keeping your medial record information confidential, third parties may have access to email messages despite our best efforts. You should be aware that some companies consider property and your messages may be monitored if you communicate from work. This office is not responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

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HIPAA Privacy Notice

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The Terms of our Notice may change. If we change our Notice, you may obtain a revised copy of contacting our office. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care options.
The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Policies.
The patient may revoke this Consent in writing at any time and all future disclosures with then cease.

The right to access your medical records

Patients have the right to see and get copies of their own records. We do charge for making copies of your records to cover our cost and staff time involved. You have the right to view your records within a certain time limit after requesting them, 15 days for records kept on-site and 30 days for records kept off-site. The office can ask a patient for an extension in writing and by stating the reason for the request.

The right to request restrictions

Patients have the right to restrict who sees their records. For example, the patient may ask that the spouse or family member not see the record. Sometimes the request is not feasible. If a family member works at the office, they will have limited access to the record. If this is the case, you will have the option of changing to another physician.

The right to confidential communication

Patients have the right to receive communication about their records in a confidential manner. Please let our staff know where you prefer to be contacted. On the intake form, you are asked for a daytime phone number. If this is your work number and you prefer we do not contact you there, please list only your home phone number.

The right to amend the record

Patients have the right to request amendments to their records when they disagree with the content. At the same time, doctors have the right to deny those requests. Remember that once written, a record cannot be changed. The doctor will be able to draw a line through the disputed entry, initial and date it, and write an addendum, or the doctor can add a statement that this is the patient's view of the situation.

The right to an accounting of disclosures

Patients have the right to know everyone to whom the office discloses record information for purposes other than treatment, payment, and health care operations

If the office shares information, the date of each disclosure, and the person to whom it is made, what information is provided and for what purpose will be listed in our logbook. Record requests that a patient makes will not be in this log. Also, releases made for purposes of treatment, payment, or health care operations will not be in this log. Releases to correctional institutions or releases made for national intelligence or research will not be included in this log either. The only entries on this log will be where we are required to obtain the patients authorization.

I request the following restrictions to the use or disclosure of my medical information:

Patient Signature Date

Revised 08/27/2014

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I _____ have received a copy of Town and Country Family Physicians HIPAA Privacy Notice.

_____

Please Print Name

_____

Signature Date

For Town and Country Family Physicians Only

We attempted to obtain written acknowledgement of receipt of our HIPAA Privacy Notice, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____

_____

_____

_____

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OFFICE POLICIES

1. I authorize Town and Country Family Physicians (herein referred to as TCFP) to provide me and/or my dependents medical care.
2. In consideration for other patients and the doctor, please cancel your appointment at least 6 hours in advance if you are unable to keep your appointment. There will be a $25.00 charge added to your account if you fail to notify us to cancel your appointment.
3. If you are more than 15 minutes late for your appointment, we reserve the right to reschedule your appointment.
4. If you have a balance after your insurance company has made payment, and all contractual adjustments have been applied, you are responsible for the amount and payment in full is due within thirty days.
5. Please allow **two weeks (2)** to obtain lab results. You will receive notification via secure email message of your test results. If you have not received notification of your results in two weeks, please call our office. You will have to register for our patient portal services to access your medical information.
6. If your doctor has evaluated you and you need a referral for that condition, please allow **five to seven business days for your insurance company to process the referral**. Insurance companies will not approve same day referrals.
7. We are now set up to accept electronic prescription refills. For your convenience and safety **Prescriptions** are issued during office hours only. Due to HIPAA guidelines and to protect your confidentiality, we no longer refill medications by phone or fax. TCFP will only issue prescriptions for the appropriate time period. After that you are required to see the physician every three months. Please DO NOT wait until you are out of medications to schedule an appointment. **We require a minimum of 2 business days turnaround time for all refill requests.**
8. If a parent or legal guardian would like their child under the age of eighteen to be seen without the parent or guardian present, written consent will be required for each visit.
9. TCFP is not a walk-in clinic. We work by appointment only.
10. When leaving a message for the medical assistant or provider, please be aware we see patients all day so your call may not be returned until the end of the day. Please DO NOT leave voice messages for emergencies; go straight to the nearest emergency room or call 911.
11. TCFP reserves the right to charge for services your insurance company requires but does not pay for, such as pre-certs, prior authorizations, lengthy telephone conversations, etc. Fee for Pre-Authorization is $25.00-pre-payment is required before the physician is able to start the pre-certification process.
12. Due to the increase cost of doing business, it has become necessary for TCFP to charge the patient an administrative fee for medical supplies and biohazard disposal. Your insurance company does not cover this cost and it will be collected at time of service. Currently the charge is $2.00 per visit but this is subject to change without prior notice. Administrative fee will not be billed to your insurance company.
13. It is the patient's responsibility to notify the office upon arrival if your insurance has changed. Failure to do so may result in your insurance company not paying the claim due to timely filing deadlines. Patient is responsible for payment in full if this occururs.
14. It is the patient's responsibility to understand your insurance benefits and which laboratories are covered by your plan. If services provided are not covered under your plan, you will be responsible for payment at time of service. WE DO NO BALANCE BILL FOR COPAYS, COINSURANCE OR DEDUCTIBLES.
15. All requests for medical records will be assessed a charge of $35.00 for the first 20 pages and $.50 cents per page thereafter. There will also be a $25.00 fee for billing records. Also, a reasonable fee not to exceed $15.00 for executing an affidavit. Payment will be required in advance. Please allow fifteen business days for processing. If we need to mail records, a flat fee of $5.00 will be assessed also.
16. **There is a $35.00 charge on all Returned Checks**. Repayment will be accepted in cash or money order only. If we receive more than one returned check, we will no longer be able to accept this form of payment from you.
17. We are not certified to treat any injuries that have occurred at your place of employment. You must contact your Human Resources Department to find out whom they require you to see.
18. Either party can terminate this doctor/patient relationship at any time with written notice.
19. We make every effort to accommodate our patients. Our exam rooms are very small. We request that you do not ask for two patients to be seen in the same room, i.e., husband and wife, several children, etc.
20. TCFP will no longer mail out copies of test results. Patients will have to register to our Patient Portal Services to access their results. Our staff will provide you with the documentation you will need in order to register.

I have read and understand the above terms of payment and other office policies and I agree to the terms stated therein.

Patient Signature/Guarantor:_____

Printed Name: _____ Date:_____

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PHYSICIAN OWNERSHIP DISCLOSURE FORM

During the course of your physician/patient relationship with Anthony J. Popek, M.D., and/or Laurel M. Tucker, M.D. you may be referred to **West Houston MRI & Diagnostics, Memorial Premier Sleep Center and/or Houston Precision Cancer Center.**

The addresses of the Facilities are:

Memorial Premier Sleep Center
12850 Memorial Drive
Suite 1125
Houston, TX 77024

Houston Precision Cancer Center
10405 Katy Freeway
Suite 150E
Houston, TX 77024

West Houston MRI & Diagnostics
4001 W. Sam Houston Pkwy N
Suite 110
Houston, TX 77079

In connection with any referral to the Facility, you are hereby advised that Anthony J. Popek M.D. and Laurel M. Tucker, M.D. have an investment interest in the Facility and therefore will receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you both at the time of Anthony J. Popek, M.D. or Laurel M. Tucker, M.D.'s first contact with you as a patient and at the time of referral to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the Facility. You will not be treated differently by your physician or the Facility if you choose to use a different facility.

By signing below, you certify that you were advised of alternative health care providers and your right to choose one of these alternative health care providers. Further, you confirm and agree that you were assured by your physician that you will not be treated differently by the physician or the physician's staff if you choose an alternative health care provider or entity. Lastly, you further acknowledge by signing below that you signed this Physician Ownership Disclosure Form on the date of your first contact with Anthony J. Popek, M.D. or Laurel M. Tucker, M.D. As a patient and at the time of Anthony J. Popek, M.D. or Laurel M. Tucker, M.D.'s referral of you to the Facility.

_____ _____

Patient name (please print) Date

_____

Patient Signature