Johnson Family Medical
469-656-4602
www.johnsonfamilymedical.com

JOHNSON
FAMILY MEDICAL

12530 Lebanon Rd.
Suite 202
Frisco, TX 75035

Registration Form

GENERAL INFORMATION **TODAY'S DATE:** _____

Patient's Name: _____ **D.O.B.:** _____ **Age:** _____
Last Name **First Name** **MI**

Address: _____ **Phone:** (_____) _____-_____

City: _____ **State:** _____ **Zip Code:** _____ **SSN:** __ __ __ - __ __ - __ __ __ __ **Sex: M / F**

E-mail: _____ **Marital Status: M S D W Dom. Partner**

Emergency Contact: _____ **Relation:** _____ **Phone:** (_____) _____ - _____

Name of Insurance: _____ **Member ID:** _____ **Group ID:** _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

I hereby authorize Johnson Family Medical and/ or agents to use my general information, including address, phone (call or text messages), and email to contact me to facilitate anything related to my medical care.

PERSON RESPONSIBLE FOR PAYMENT

_____ _____
Last Name **First Name** **MI** **Relationship to patient**

Phone: (_____)-_____-_____

SSN: __ __ __ - __ __ - __ __ __ __ **Sex: M / F** **D.O.B.:** _____ **Age:** _____

Address: _____ **Employer:** _____

City: _____ **State:** _____ **Zip code:** _____ **Work Phone:** (_____) _____-_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS
I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Johnson Family Medical for any services furnished me by that provider. I authorized medical information needed to determine these benefits or the benefits payable for the related services to be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services. Please note: It is the policy of this office that any parent who requests treatment for the child is responsible for the payment of all subsequent fees.

Name: _____ **Signature:** _____

Relationship: _____ **Date:** _____

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Name: _____ DOB: _____ Today's Date: _____

Medical History

AutoImmune Disorder:
- □ Alopecia
- □ Celiac
- □ Hashimotos
- □ Lupus
- □ Rheumatoid Arthritis
- □ Sarcoidosis
- □ Scleroderma
- □ Sjogren's
- □ Vasculitis

Cancer or History of Cancer: □ Yes □ No
- □ Chemotherapy / Radiation
- □ Lymph Node Removal
- □ Melanoma or Other Skin Cancer
- □ Precancerous Skin Lesions

Cardiac Conditions:
- □ Arrhythmia
- □ Blood Clotting Abnormalities
- □ Blood Vessel (Vascular) Disease
- □ Heart Attack
- □ Heart Disease / Failure
- □ High Blood Pressure
- □ High Cholesterol
- □ Cardiac Procedures: _____
  _____

Neurological Disorder:
- □ Bell's Palsy
- □ Epilepsy
- □ Fibromyalgia
- □ Multiple Sclerosis
- □ Parkinson's
- □ Peripheral Neuropathy
- □ Seizure Activity
- □ Stroke

Neuromuscular Disorder:
- □ ALS / Lou Gehrig's
- □ Lambert-Eaton Syndrome
- □ Muscle Weakness / Tremors
- □ Myasthenia Gravis
- □ Any Neuromuscular Disorder

Skin Condition / Disease / Lesions:
- □ Active Acne
- □ Actinic Keratosis
- □ Eczema
- □ Fungal Infection (Ringworm)
- □ Impetigo
- □ Keloid Scarring / Raised Scarring
- □ Keratosis Pilaris
- □ Melasma
- □ Psoriasis
- □ Raised Moles / Warts / Lesions
- □ Rosacea
- □ Vitiligo

Other Conditions:
- □ Acid Reflux
- □ ADD / ADHD
- □ Anemia
- □ Anxiety
- □ Any Active Infection (Bacterial / Fungal / Viral)
- □ Arthritis / Rheumatism
- □ Asthma
- □ Cirrhosis
- □ Cold Sores (HSV 1)
- □ COPD
- □ Depression
- □ Diabetes
- □ Digestive / GI Problems
- □ Extreme Fatigue
- □ GERD
- □ Gout
- □ Headaches / Migraines
- □ Hearing / Vision Issues
- □ Hepatitis
- □ HIV / AIDS
- □ Hormone Imbalance
- □ Lymphedema
- □ Nervous Diagnosis
- □ Osteoporosis
- □ PCOS
- □ Seasonal Allergies
- □ Sexual Dysfunction / ED
- □ Shingles Outbreak
- □ Thyroid Imbalance/Disease
- □ Ulcer
- □ Urinary Incontinence
- □ Vision Problems

□ I have reviewed ALL of the above conditions and DO NOT HAVE ANY of those listed or ANY conditions not listed that my provider should be made aware of.

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Name: _____ DOB: _____ Today's Date: _____

Allergies

Medication or Substance:	Describe Reaction or Symptoms:
_____	_____
_____	_____

Ever experienced an anaphylactic response? □ Yes □ No

Current Medications (including Retin-A, Accutane, etc.)

Name of Medication:	Dose / Frequency:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Herbal, Vitamin or Nutritional Therapies (including acids in facial wash products)

Name of Substance / Therapy:	Amount / Frequency:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History

Procedure:	Date			Date
_____	_____	Colonoscopy	□ Yes □ No	_____
_____	_____	Mammogram	□ Yes □ No	_____
_____	_____	PAP Smear	□ Yes □ No	_____

Social History

Cigarettes: □ Yes □ No Vaping: □ Yes □ No
Moist Tobacco: □ Yes □ No Other: _____ Amount / Frequency _____
Alcohol: □ Yes □ No Type _____ Amount / Frequency _____
Caffeine: □ Yes □ No Type _____ Amount / Frequency _____
Recreational Drugs: □ Yes □ No Type _____ Amount / Frequency _____
Exercise: □ Yes □ No Type _____ Duration / Frequency _____
Diet: □ Yes □ No Type _____ Description _____

Family History

	Father	Mother	Siblings		Father	Mother	Siblings
Deceased?	□	□	□	Heart Failure	□	□	□
Alcoholism	□	□	□	High Blood Pressure	□	□	□
Asthma	□	□	□	Mental Illness	□	□	□
Bleeding Disorder	□	□	□	Osteoporosis	□	□	□
Cancer	□	□	□	Stroke	□	□	□
Diabetes	□	□	□	Thyroid Disease	□	□	□
Heart Disease	□	□	□	Other: _____	□	□	□

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Financial Assignment / Authorization Agreement

Medicare Assignments of benefits to Statement to Permit of Health and/or Medical insurance benefits To Johnson Family Medical and Providers

I certify that the information given by me in applying for payment under title XVLlll of the Social Security Act is correct. I authorize any holder of medical or other information about me to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed or for this or a related Medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician and/ or mid level (Nurse Practitioner or Physician Assistant) provider services to the provider or organization furnishing the services or authorized such provider or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any health insurance deductibles and coinsurance.

FINANCIAL RESPONSIBILITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and I agree to honor the current Clinic payment policy. I understand that, in the inability to pay in full at the time service is rendered; Johnson Family Medical may inquire of my credit history to evaluate my credit worthiness. I further understand that unpaid patient accounts may accrue interest (1.5% per month / 18% per year) and I agree to pay any such interest charges in addition to any amount unpaid by any insurance coverage. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to as an attorney or collection agency for collection suit, I agree to pay all reasonable attorney fees and/ or collection expenses.

INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to Johnson Family Medical, Frisco, Texas any benefits under hospitalization, sickness liability, auto or accident insurance, and any other coverage for the payment of such services rendered. I agree to cooperate, aid and assist the clinic in procuring all possible insurance benefits, including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I understand it is my responsibility to the provider for charges not paid pursuant to this assignment.

I hereby authorize the staff of Johnson Family Medical to administer such care / treatment as it is necessary based on the clinical providers assessment and diagnosis. I understand that such care may include medical and surgical treatment, laboratory, and radiologic test(s). I certify that no guarantee of assurance has been made to the results that may be obtained.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize staff of Johnson Family Medical to disclose necessary information from my medical record to the following parties when requested for the purpose as stated herein: to any health care provider for the purpose of providing continuing professional care and to any insurance company or third party payer (or their agent/s) for the purpose of obtaining payment to employees, offices and attending clinical providers are released from legal responsibility or liability for the above information to the extent indicated and authorized herein. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV and other diseases, all of which I specifically authorize to be released.

Name: _____ Signature: _____

Relationship: _____ Date: _____

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Acknowledgements / Consents

Please Initial

_____ **Receipt of HIPAA Notice of Privacy Practices**
I, (print patient or guardian name) _____, have read a copy of Johnson Family Medical *HIPAA Notice of Privacy Practices*. (This document is available at front desk or www.johnsonfamilymedical.com)

_____ **Cancellation Policy**
If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24-hours of the scheduled appointment. Johnson Family Medical reserves the right to charge the patient a $45 fee if the patient does not cancel the appointment within 24-hours. If you are more than 5 minutes late, your appointment may need to be rescheduled. After TWO consecutive no-shows, the practice may elect to terminate our relationship. This policy is strictly enforced. (The complete Office Policy is available at front desk or www.johnsonfamilymedical.com)

_____ **Release of Medical Information**
I do / do not (circle one) authorize Johnson Family Medical and its designated representatives to release medical information to the following individuals:

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

_____ **Contact Permission**
In the event that Johnson Family Medical needs to contact you (patient) regarding appointments, medications, test results, or any other reason, it is permissible to (check all that apply):

- □ Call / Text Cell phone □ Leave a detailed voicemail □ DO NOT leave a detailed voicemail
- □ Call Home phone □ Leave a detailed voicemail □ DO NOT leave a detailed voicemail
- □ Speak with spouse / significant other (Name: _____)
- □ Speak with other family members

_____ **Consent to Treatment**
Johnson Family Medical has an advanced practice nurse to assist in the delivery of primary health care. Johnson Family Medical is a family medical clinic that is owned and operated by Katherine A.W. Johnson, a Family Nurse Practitioner (FNP) who also has a Master of Science in Nursing (MSN). A nurse practitioner is a Registered Nurse (RN), also known as Adult Nurse Practitioners (ANP), has at least a Masters Degree in Nursing and a board certification in their specialty. They have education and training in specialty areas such as family practice, women's health or pediatrics. Family Nurse Practitioners have acquired the necessary knowledge and expertise, skills and training in the care of people of all ages, plus the authority to issue prescriptions for medications.
I have read this document and hereby accept the services of a nurse practitioner for my health care needs.

_____ **Consent for Medical Photos**
I understand Johnson Family Medical uses photographs of patients for identification and patient progress purposes. X-rays and ultrasound, if necessary, are used in diagnosis or identification of specific illnesses or conditions. The Photograph, X-Ray & Ultrasound images will not be distributed outside the medical practice unless collaboration with other physicians or practitioners is medically necessary.

My signature below indicates that I have read and agree with all statements that I have initialed above.

Name: _____ Signature: _____

Relationship: _____ Date: _____