Dear Valued Patient,

On behalf of the physicians, associate practitioners, nurses and staff of USMD Physician Services, I want to welcome you to our organization and thank you for choosing a USMD physician to care for you and/or your loved ones.

At USMD, our physicians put their patients' needs first. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Our physicians are board certified and committed to promoting good health and guiding patients toward a healthy lifestyle.

With nearly 70 locations and more than 250 physicians and associate practitioners in just under 20 different specialties, USMD offers convenient locations all across the Dallas-Fort Worth metroplex to care for everyone in your family at every stage of life.

One of the unique features that USMD offers is NextMD for MCNT patients and Follow My Health for UANT patients. Through NextMD and Follow My Health, patients have communication with their physician's office through a protected, online portal. NextMD and Follow My Health also give patients the ability to access and review lab results and request appointments and prescription refills. Please talk with a staff member if you have questions or would like more information.

To learn more about USMD, please visit our website at www.usmd.com.

Again, thank you for choosing USMD for your healthcare needs.

Sincerely,

Richard C. Johnston MD, FACP
Chief Executive Officer and Chief Physician Officer
USMD Health System

USMD Health System

PEDIATRIC NEW PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Date of Birth: _____/_____/_____ Sex: ○ Male ○ Female SS # (optional): _____

Main Contact:

Parent/Guardian Name: _____ Relationship: _____

Occupation:_____ Home Phone #:_____ Work Phone #: _____

Parent/Guardian Name: _____ Relationship: _____

Occupation:_____ Home Phone #:_____ Work Phone #: _____

○ Divorced ○ Separated

Are there any special custody arrangements we should be aware of ? ○ Yes ○ No

Siblings:_____ DOB: _____/_____/_____ Other Siblings:_____ DOB: _____/_____/_____

If Yes, please describe: _____

_____

_____

Living Arrangements: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

OTHER PATIENT INFORMATION

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____(Please Specify)

USMD Health System

PEDIATRIC NEW PATIENT INFORMATION

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

INSURANCE INFORMATION

Primary Insurance:_____ Policy/ID # _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance: _____ Policy/ID #: _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

USMD Health System

GENERAL CONSENT FORM

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

Assignment of Benefits. I authorize USMD Physician Services, ("USMD") to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that USMD will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for USMD to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, USMD may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at USMD's expense.

Patient Initials: _____

Electronic Prescription. I understand USMD utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone Calls. By providing contact information, I authorize USMD, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize USMD to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #: _____ Secondary Phone #: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Minor Patient Photograph (when applicable)

I consent for USMD to photograph the minor patient for identification purposes only. **Patient Initials:** _____

_____

Print Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

USMD Health System

FINANCIAL POLICY

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

Please read prior to receiving services.

USMD Physician Services ("USMD") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, USMD will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

- **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

- **MEDICARE:** USMD providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

- **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-paying patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of USMD.

USMD Health System

FINANCIAL POLICY

- **SECONDARY INSURANCE:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage.

- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.

- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(817) 514-5200**.

- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

USMD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (817) 514-5200.

USMD Health System

PATIENT HISTORY (PEDIATRIC)

Today's Date: _____

Patient's Name (First, Middle, Last): _____

Date of Birth: _____/_____/_____ Race: _____ ☐ Male ☐ Female

Primary Care Physician: _____

Reason For Visit: _____

PAST SURGERIES (include all surgery in your lifetime) or ☐ **NONE**

Type of Surgery	Date (approximate)	Hospital or City if known

Pharmacy: _____ Phone: _____

CURRENT MEDICATIONS (include prescription, over the counter, and herbal medications) or ☐ **NONE**

Name of Medication	Dose (mg)	How often is the medication taken	Reason for taking medication	Physician prescribing

MEDICAL HISTORY

High Blood Pressure	☐ Yes ☐ No ☐ Family		Ulcers	☐ Yes ☐ No ☐ Family	
High Cholesterol	☐ Yes ☐ No ☐ Family		Emphysema	☐ Yes ☐ No ☐ Family	
Heart Attack	☐ Yes ☐ No ☐ Family		Stroke	☐ Yes ☐ No ☐ Family	
Mitral Valve Prolapse	☐ Yes ☐ No ☐ Family		Asthma	☐ Yes ☐ No ☐ Family	
History Kidney Stones	☐ Yes ☐ No ☐ Family		Diabetes	☐ Yes ☐ No ☐ Family	
Cancer	☐ Yes ☐ No ☐ Family		Hearing Problems	☐ Yes ☐ No ☐ Family	
Urinary Tract Infections	☐ Yes ☐ No ☐ Family		ADD or ADHD	☐ Yes ☐ No ☐ Family	
Down Syndrome	☐ Yes ☐ No ☐ Family		Spina Bifida	☐ Yes ☐ No ☐ Family	
Autism	☐ Yes ☐ No ☐ Family		Cerebral Palsy	☐ Yes ☐ No ☐ Family	

SOCIAL HISTORY

Is patient adopted? ☐ Yes ☐ No Foster Child? ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No If yes, how much? _____

Caffeine use: ☐ Yes ☐ No If yes, how much? _____

Tobacco use: ☐ Yes ☐ No If yes, how much? _____

USMD Health System

PATIENT HISTORY (PEDIATRIC)

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

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Weight changes	☐ Yes	☐ No

Current weight _____

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No

Allergic/Immunologic

Hay fever	☐ Yes	☐ No
Drug allergies	☐ Yes	☐ No

Drug name: _____

Immunizations current?	☐ Yes	☐ No

Neurological

Dizzy spells	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No
Tired/sluggish	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Integumentary

Skin rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent itch	☐ Yes	☐ No

Musculoskeletal

Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No

Current height _____

Ear/Nose/Throat/Mouth

Ear infection	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No

Respiratory

Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Hematologic/Lymphatic

Swollen glands	☐ Yes	☐ No
Blood clotting problems	☐ Yes	☐ No

Genitourinary

Urinary frequency	☐ Yes	☐ No

Nighttime urination _____

Daytime urination _____

Painful urination	☐ Yes	☐ No
Urinary urgency	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Straining to urinate	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Do you leak urine?	☐ Yes	☐ No

Patient Name: _____ Date: _____

Form Completed by: _____ Signature: _____

(Parent or Guardian) (Parent or Guardian)

USMD Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO USMD PHYSICIAN SERVICES

Name of Patient: _____ D.O.B._____ Age:_____
LAST FIRST M.I.

I, _____, hereby authorize
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address of person/entity who should release records)

to release the following information by mail, fax, electronically or orally to USMD Physician Services:

Address: _____

_____

Phone: _____

Fax: _____

Information is for:

☐ Dr. _____

For the purpose of: _____

- ☐ All Health Information
- ☐ Statements of Charges or Payments
- ☐ AIDS or HIV Information *Initials* _____
- ☐ History and Physical Examination
- ☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- ☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* _____
- ☐ Progress Notes
- ☐ Substance Abuse Records *Initials* _____
- ☐ Genetic Information (inc. genetic test results) *Initials* _____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, Videotapes, Digital, or Other Images

☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

☐ Other (must be specific):

_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. USMD Physician Services, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above

_____ _____
Witness Signature Date

A minor individual'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 (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Individual Date