KELLER FAMILY MEDICAL CENTER AND BURLESON HEALTH AND WELLNESS

Welcome!
We appreciate this opportunity to serve you. This handout contains information about our practice and is provided to answer most of the questions you might have about us.

Appointments
Patients are seen by appointment. When scheduling an appointment, please give the receptionist as much information as possible to ensure you are scheduled in an appropriate appointment time. If you arrive after your scheduled appointment time, you may be asked to reschedule depending on the provider's schedule for that day.

Cancelation Policy
A two (2) hour notice must be provided when canceling your scheduled appointment. If a two-hour notice is not received, you will be charged a $45.00 fee. This charge will be your responsibility.

Phone Calls
Our main office number, 817-431-2573, is answered 24/7, after hour calls are forwarded to our answering service. In a life-threatening situation call 911.

Phone calls answered by the office are returned after morning and afternoon patients in the office have been seen. Calls received after 4:00 will be returned the next business day.

Medication Refills
When you need a refill, please contact your local or mail order pharmacy. They will fax our office a refill request. Please allow 24-48 hours to process refill requests. Requests are not processed after office hours, weekends or holidays.

A refill request will be denied if you missed a scheduled appointment, are not current on any laboratory tests required for the medication, or have not had your annual physical exam. If you are **stable** on your medications the schedule below is followed:

- Diabetic medications require labs drawn every 4 months and exam with provider
- Cholesterol medications require labs drawn every 6 months and exam with provider
- Thyroid medications require labs drawn every year at annual physical exam
- Hypertension medications require an exam every 6 months with provider
- An annual physical is required on every patient with a medical condition that is treated in our office

Patient Portal
We invite you to register for our patient portal. The portal which allows electronic access to your personal health record and electronic communication with our office.

Referrals Many insurance plans or specialist office require a referral from your primary care office. Please allow 5-7 business days for our office to process a referral. Our referral specialist will contact you when the referral has been completed so that you can then contact the specialist office for an appointment.

Treatment of a Minor
A minor is any person under the age of 18 who has never been married or declared an adult by a court.

- In order for our office to treat a minor, we must have a written consent from a parent or legal guardian, including a statement as to the nature of the medical treatment to be given on a specific day.

CONTINUED ON BACK

Updated 4/12/2024

- Minors age 15 and under **MUST** be accompanied by an adult who is 18 years of age and older, with a consent form from a parent or legal guardian.
- Minors age 16 or 17 must have written consent from a parent or legal guardian.

All minors must be accompanied by their parent or legal guardian in order to provide immunizations, invasive procedures, or injections.

Payment Policy
We are contracted with many insurers and health plans. We will bill those plans with which we have a contract and will collect any required co-payment, deductible or co-insurance amount at the time of service. The co-payment will be collected when you arrive for your appointment. New patients establishing care will have a co-payment or deductible amount due.

You are responsible for ensuring that we are providers on your insurance plan and for knowing what services you have coverage for, including but not limited to office visits, labs, procedures, physicals and immunizations. You will be responsible for paying for all services not covered by your insurance plan within thirty days of receiving a statement. Statements are sent by text and/or email.

If your insurance, address or phone number should change, please notify us immediately so that we can update your chart. Please bring your insurance card to each visit.

Past Due Accounts
Any account with a patient balance older than ninety (90) days may be given to a collection agency. Prior to your next visit the balance due and the collection agency fee of 40% of the balance must be paid. Continued non-payment of an account may result in termination of our patient/physician relationship.

Motor Vehicle Accidents (MVA)/Third-Party Liability
Our office does not file charges related to an MVA or third-party liability injury with your insurance. Payment is due at the time of service; an itemized receipt will be provided that you can submit to your MVA insurance carrier or third party insurance payer.

Workers' Compensation/DOT Physicals
We are not a Workers' Compensation or DOT authorized provider; therefore, we cannot treat you for any work related illness or injury or perform your DOT physical. Workers' Compensation benefits could be denied if you claim your condition is not work related but it actually is.

FMLA/Disability Forms
There is a $25 fee for completion of these forms and our office requires 7 business days to complete.

Privacy Practices
You may at any time request a copy of our privacy practices. Our privacy practices are posted on our website at KellerFamilyMedical.com, in the lobby and in each exam room.

Medical Records
All requests for medical records must be in writing. There is a HIPAA compliant records release form on our website. Requests require ten (10) days to process.
There is no charge to send one copy of your medical records to another physician office.
Records sent directly to you will be charged at $25.00 for the first twenty (20) pages of your medical record and an additional $0.50/page charge for each additional page.

KELLER FAMILY MEDICAL CENTER
BURLESON HEALTH AND WELLNESS
REGISTRATION FORM

PLEASE PRINT

Today's date:	Name you wish to be called:

PATIENT INFORMATION

Patient's last name:	First:	Middle:			Home or Cell phone no:

Last 4 Digits of SSN:	Marital status:	Divorced Widow(er)	Birth date:	Age:	Sex:
	Single Married	Separated Partner	/ /		M F T

Street address:	Apartment No:	Do you want a copy of privacy notice?

City:	State:	ZIP Code:	Email Address:

Occupation:	Employer:	Employer phone no:
		( )

Race: (Circle one)	Ethnicity:	Primary Language:
White Hispanic Asian Black/African Amer. Other Race American Indian	o Hispanic or Latin o Not Hispanic o Refuse to report	

Referred to clinic by (please check one box):

❑ Insurance ❑Family ❑ Close to home/work ❑ Yellow Pages ❑ Other _____

Other family members seen here:

Do you give consent for us to obtain your medication history?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policy Holder's Name:	Birth date:	Address (if different):	Home phone no:
	/ /		( )

Is this person a patient here?

Occupation:	Employer:	Employer address:	Employer phone no:
			( )

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance:	Policy Holder's name:	Group no:	Policy no:

Relationship to patient. ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Cell phone no:
		( )	( )

By my signature below, I hereby authorize payment of medical benefits directly to Keller Family Medical Center for services rendered. Authorization is hereby granted to Keller Family Medical Center to release information as may be necessary to process and complete my claim. I understand I am financially responsible for this account.

_____ _____

Patient/Guardian signature ***Date***

KELLER FAMILY MEDICAL CENTER
BURLESON HEALTH AND WELLNESS
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Keller Family Medical Center and/or Burleson Health and Wellness to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Keller Family Medical Center or Burleson Health and Wellness describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Keller Family Medical Center and/or Burleson Health and Wellness reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, 808 Keller Parkway, Keller, Texas 76248.

With this consent, Keller Family Medical Center and/or Burleson Health and Wellness may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder calls and patient statements as long as they are marked "Personal and Confidential".

I have the right to request that Keller Family Medical Center and/or Burleson Health and Wellness restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Keller Family Medical Center and/or Burleson Health and Wellness to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I have read and understand the consent for PHI and have been provided a Keller Family Medical Center or Burleson Health and Wellness practice information handout.

Signature:_____Date:_____Relationship to Patient:_____

Print Patient's Name:_____

Print Name of Legal Guardian, if Applicable_____

CONTINUED ON BACK

PHI CONSENT

In order to protect your privacy, we have developed a policy on leaving messages or discussing in person your PHI with someone other than yourself:

We will not discuss any medical information with anyone except the patient or legal guardian.
We will not leave any medical information on an answering machine.
We will not leave any medical information on a voice mail system.
We will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment.

UNLESS

We have your written permission to leave messages for you. Please read the information below and consider carefully whom you want to have access to your medical information, such as test results. Please fill out only **ONE** of the following sections below to make your preferences known.

A. I **DO** consent to leave detailed messages or discuss in person my PHI:

I, _____ give Keller Family Medical Center permission to leave phone messages or discuss my medical care with the following individuals: (Initial each option) This consent will remain in effect until rescinded in writing.

My home phone answering machine number_____ Initials_____

My cell phone voice mail number_____ Initials_____

My spouse (name)_____ Initials_____

Other (name)_____Phone#_____ Initials_____

Signature_____ Date_____

B. I **DO NOT** consent to leave detailed messages or discuss in person my PHI:

I, _____wish to be contacted personally and I do not authorize detailed messages regarding my medical care to be left on an answering machine, cell phone or with others.

Signature_____ Date_____

C. Revocation of prior consent

I, _____ wish to rescind the above authorizations.

Signature_____ Date_____

Screening Assessment

Patient Name:_____ Today's Date:_____/_____/_____

Date of Birth:_____/_____/_____ Patient Phone: (___) - _____- _____

Symptoms	Severity				Frequency		
	N/A	Mild	Moderate	Severe	Occasionally/Never	Seasonal	Most of the Year/Daily
Itchy Eyes	0	1	2	3	0	1	2
Watery Eyes	0	1	2	3	0	1	2
Red Eyes	0	1	2	3	0	1	2
Runny Nose	0	1	2	3	0	1	2
Itchy Nose	0	1	2	3	0	1	2
Stuffy Nose	0	1	2	3	0	1	2
Frequent Sneezing	0	1	2	3	0	1	2

Circle One

1. Have you ever been diagnosed with asthma, recurrent wheezing, or recurrent bronchitis?	Yes	No
2. Have you ever been diagnosed with atopic dermatitis, eczema, or recurrent sinusitis?	Yes	No
3. Do you take prescription or OTC medications to manage your allergy symptoms?	Yes	No

Circle each medication that you use to manage your allergy symptoms:

Allegra (Fexofenadine) Xyzal (Levocetirizine) Benadryl (Diphenhydramine) Zyrtec (Cetirizine)

Claritin (Loratadine) Singulair (Montelukast) Clarinex (Desloratadine) Other: _____

4. Do you take any steroidal or non-steroidal anti-inflammatory drugs?	Yes	No

Circle each medication that you use to treat inflammation:

Aleve (Naproxen) Aspirin Advil/Motrin (Ibuprofen) Prednisone Other: _____

5. Have you ever had a reaction to any foods in the past? If so, describe the event.	Yes	No

Circle the reaction(s) you experienced during the event(s):

Tingling/itchy mouth Hives/rash/eczema Swelling Wheezing/difficulty breathing

Abdominal pain/ diarrhea/nausea/vomiting Dizziness/lightheadedness/fainting

If the answer to question 5 was "No", please skip questions 6 and 7.

6. Do you have any family members that have been diagnosed or have suspected allergies? If so, list those family members and their diagnosed/suspected allergies.	Yes	No
7. Have you ever been tested for food allergies?	Yes	No

Patient/Guardian Signature: _____ **Date:** _____

Office Use Only:		
Sum of severity of symptoms (0-21)	**Sum of frequency of symptoms (0-14)**	**Order 95004?**
		Yes / No
Diagnosis (circle one) J30.89 J30.1 J30.2 **Other** _____		**Circle Test(s)**
		Environmental / Food
Provider Signature:	**Date:**	Environmental & Food

210812

KELLER FAMILY MEDICAL CENTER
BURLESON HEALTH AND WELLNESS

Nurse Practitioner / Physician Assistant
Consent Form

This facility has on staff a Nurse Practitioner and a Physician Assistant to assist in the delivery of quality medical care.

A Nurse Practitioner/ Physician Assistant are not doctors. A Nurse Practitioner and a Physician Assistant are advanced graduates of a certified program and are licensed by the appropriate state board. Under the supervision of a physician, a Nurse Practitioner or a Physician Assistant can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.
"Supervision" does not require the constant physical presence of the doctor, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Nurse Practitioner or a Physician Assistant may provide such medical services that are within his or her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Nurse Practitioner or a Physician Assistant for my health care needs.
I understand that at any time I can refuse to see the Nurse Practitioner or Physician Assistant and request to see the physician.

_____. _____.
Name Date

_____.
Signature

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)

Adult Consent Form

First Name | Middle Name | Last Name

Date of Birth (mm/dd/yyyy) | Gender: ☐ Male ☐ Female | Telephone | Email address

Address | Apartment # / Building #

City | State | Zip Code | County

Mother's First Name | Mother's Maiden Name

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your immunization records. With your consent, your immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, my immunization information may by law be accessed by: a Texas physician, or other health-care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ **I am a FIRST RESPONDER.** ☐ **I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas Immunization Registry.

Individual (or individual's legally authorized representative):

Printed Name | Signature | Date

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunizations

Stock No. F11-13366
Revised 02/2022