Daryl C. Currier, M.D., P.A.

Family Medical Centers
Stockdale: (830) 996-3701
Floresville: (830) 216-7979
La Vernia: (830) 779-3800

To All Patients:

WE WANT TO SEE YOUR MEDICINES!

Modern advances in medical treatment and extended lifespan mean that patients are often taking multiple medications. Many patients see more than one physician who prescribes medications for them. Pharmacies sometimes dispense medications incorrectly or label medications incorrectly. We want to be absolutely certain that you are taking your medicine as prescribed. The only way that we can be sure of this is to physically see your medications. That means you must bring in all of your medicines every time you come in. We will make every effort to remind you to bring in you medicines by including a reminder in your appointment recall letter and placing reminder posters in our offices. We sincerely hope that all of our patients understand the importance of our providers having the opportunity to review all of your medicines at each clinic visit. Getting into the habit of bringing your medicine with you to our clinic will minimize the risk of medication errors and will avoid delaying your appointment by having you go back home to get your medications for us. Let's all work together to be sure we get it right when we prescribe medications for you.

Thank you,

Daryl C. Currier, M.D., P.A.

CONFIDENTIAL SELF-ADMINISTERED
HEALTH HISTORY **Date: ___/___/___**

Name: _____
Address: _____
City: _____ St: _____ Zip: _____
Are you employed outside the home? ___Y___N
Name of Employer: _____
May we contact you at work? ___Y ___N
Phone: Hm (_____)_____Work_____

DOB: ___/___/___ Marital Status __S__M__D__W
Children (ages)_____
Emergency Contact:_____
Phone Number:_____
To the best of my ability, the answers I have given on this questionnaire are true.
Signature: _____

I. PAST MEDICAL HISTORY

If you have had any illness or disease listed below place a checkmark next to the illness. Write in the date of the problem or diagnosis If you have been hospitalized for the condition, write "H" in parenthesis --i.e.(H)--after the date.

A. Childhood illnesses	**Date**
Chicken Pox	
Measles	
Mumps	
Rubella (German Measles	
Tuberculosis (TB)	
Positive TB skin test reaction	
Pneumonia	
Hepatitis	
Meningitis	
Fever Convulsions	
Anemia	
Rheumatic Fever	
Birth Defects	
Other	

B. Surgery (operations, type and date)	**Date**
Skin	
Eye/Cataract	
Ear/Mastoid	
Tonsil/Adenoid	
Chest/Heart	
Cardiac/Cath	
Ulcer/Stomach	
Gall Bladder	
Intestines/Colon	
Appendix	
Hysterectomy	
D & C	
Prostate	
Hernia	
Bladder/Kidney	
Bone/Joint	
Back/Neck/Disk	
Other	

C. Allergies to medication, food, or other factors, Describe reaction:

Allergic to:	Reaction

D. Severe injuries (e.g., head injury, fracture) and date.

Date	Injury	After effects

E. Adult Illnesses	**Date**
Diabetes	
High Blood Pressure	
Stroke	
Heart Attack or Angina	
Rheumatic Fever	
Heart Failure	
Chronic Bronchitis or Emphysema	
Pneumonia	
Asthma	
Bladder/Kidney infection	
Kidney Stones	
Prostate Disorders	
Migraine or Severe Headaches	
Seizures/Convulsions	
Muscle Disorder	
Emotional/Psychiatric Problems	
Other Neurological Disorder	
Ulcer Disease	
Gall Bladder Problem	
Pancreas Disorder	
Liver Disorder/Hepatitis	
Arthritis	
Back Problem	
Phlebitis (Blood Clots)	
Venereal Disease (V.D.)	
Skin Disease	
Vertigo	
Glaucoma	
Bleeding Disorder	
Cancer	
Other	

F. Medications List medications you take regularly, now or in the past including "over the counter medications." Specify name, dosage and frequency if you know them.

Over the counter medications

_____
_____
_____
_____

Prescription medications

_____
_____
_____
_____
_____

Do you have a Living Will? YES / NO
Would you like information on a Living Will? YES / NO

III. FAMILY HISTORY

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Brothers	Sisters	Children
Asthma									
Alcoholism									
Anemia, Severe									
Cancer									
High Cholesterol									
Diabetes									
Glaucoma									
Gout									
Heart Attack									
High Blood Pressure									
Suicide									
Tuberculosis (TB)									
Stroke									
Other									
Deceased									

IV. General

A. Do you feel that you are in good health at the present time?_____If not, why not? _____

B. Are you under treatment for any problems (high blood pressure, diabetes, heart disease, kidney disease, other).
List: _____

C. If you have seen a physician within the year, please list the problem and the Doctor's name and address.

Problem Physician

D. What are the symptoms or problems, if any that are bothering you today?_____

Have you ever had a colonoscopy? Y or N if Yes, where _____Date_____

Anyone in your family have a "heart attack"? if Yes, who _____age_____

Are you exposed to passive smoke regularly? _____

How many cups of caffeine do you consume on a daily basis (such as coffee, tea, soda, etc.)_____cups.

Do you use smokeless tobacco? Such as "tobacco chew" or "dip"? Y or N if Yes, how many years _____

E. **For Women only**

a. Age you started your menstrual period:_____
b. Date of your last period:_____
c. Are your cycles regular___Yes___No Painful? ____
d. When was your last pap test?_____
e. Has your pap smear ever been abnormal?___Yes___No
f. Have you ever had: Condyloma (warts)?___Yes___No
Cryotherapy of Cervix?___Yes___No
Colposcopy?___Yes___No
g. Do you do regular breast self-exams?___Yes___No
h. Have you stopped your periods?___Yes___No
At what age?_____Why?_____
i. Have you had bleeding since then?___Yes___No
j. Have you ever had a D&C?_____
k. How many pregnancies? _____
l. What type of Birth Control?_____
m. Have you had difficulty with pregnancy or delivery?
___No___Yes, describe _____
n. Have you ever had a mammogram? Y or N if Yes, where_____Date _____

V. Life Habits

A. Did you ever smoke?___Yes___No
Do you smoke now? ___Yes___No
If yes, how long and how much?_____
B. Do you drink alcohol? ___Yes___No Drinks/week ____
C. Do you use "recreational drugs"? _____
D. What is your occupation?_____
E. Have you ever worked with dangerous materials? If so what? _____
F. Do you exercise regularly? _____
G. Do you wear a seat belt? _____
H. When was your last tetanus booster?_____
I. Heterosexual____Bisexual____Homosexual _____

VI. Mental Health

A. Do you take tranquilizers, sleeping pills, anti-depressants, or other "nerve" medication? If yes, what?
_____
B. Have you ever been hospitalized for "nerves," "breakdown," depression, or other emotional problems? _____
Explain: _____
C. Does someone in your immediate family, or someone you live with, have a problem with drugs, alcohol, or "nerves"?
Explain: _____
D. Are you concerned about your drinking? ___Yes ___No
E. Are you annoyed by people asking you about your drinking? ___Yes ___No
F. Do you feel guilty about your drinking? ___Yes ___No
G. Do you drink soon after waking up? ___Yes ___No
H. Would you like to talk to a counselor about any of these problems? ___Yes ___No

VII. Nutrition

A. Do you consider your weight___normal,___over,___under
B. Have you ever been counseled to lose weight or control fats, cholesterol, no salt? ___Yes ___No
Explain:_____
C. Are you on any vitamins, food supplements, or self-imposed dietary restrictions? Explain: _____

VIII. COMMENTS_____

REGISTRATION

(PLEASE PRINT)

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

REGISTRO

(POR FAVOR, ESCRIBA
EN LETRA DE IMPRENTA)

Fecha _____ Teléfono de Casa _____ Teléfono Cellular _____

INFORMACIÓN SOBRE EL PACIENTE

Nombre _____ No. Seg. Soc. _____
Apellido Primer Nombre Inicial

Dirección _____ Email _____

Ciudad _____ Estado _____ Código Postal _____

Sexo ☐ M ☐ F Edad _____ Fecha de Nacimiento _____ ☐ Soltero(a) ☐ Casado(a) ☐ Viudo(a) ☐ Separado(a) ☐ Divorciado(a)

Paciente Empleado por _____ Ocupación _____

Dirección del Empleador _____ Teléfono del Empleador _____

¿A quién podemos agradecer por habernos referido a Ud? _____

En caso de emergencia, ¿a quién se deberá notificar? _____ Teléfono _____

SEGURO PRINCIPAL

Persona Responsable por la Cuenta _____
Apellido Primer Nombre Inicial

Relación con el Paciente _____ Fecha de Nacimiento _____ No. Seg. Soc. _____

Dirección (Si es diferente a la del paciente) _____ Teléfono _____

Ciudad _____ Estado _____ Código Postal _____

Persona Responsable Empleada por _____ Ocupación _____

Dirección del Empleador _____ Teléfono del Empleador _____

Compañía de Seguros _____

Contrato No. _____ Grupo No. _____ Suscriptor No. _____

Nombres de otras personas a su cargo cubiertas por este plan _____

SEGURO ADICIONAL

¿Está el paciente cubierto por seguro adicional? ☐ Sí ☐ No

Nombre del Suscriptor _____ Relación con el Paciente _____ Fecha de Nacimiento _____

Dirección (Si es diferente a la del paciente) _____ Teléfono _____

Ciudad _____ Estado _____ Código Postal _____

Suscriptor Empleado por _____ Teléfono del Empleador _____

Compañía de Seguros _____ No. Seg. Soc. _____

Contrato No. _____ Grupo No. _____ Suscriptor No. _____

Nombres de otras personas a su cargo cubiertas por este plan _____

TRASPASO DE LOS BENEFICIOS DEL SEGURO Y AUTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN

Yo, el suscrito, certifico que yo (o la persona a mi cargo), tengo (tiene) cobertura de seguro con _____
Nombre de la(s) Compañía(s) de Seguros

y traspaso directamente al Dr. _____ todos los beneficios del seguro, si los hubiere, que de otra manera son pagaderos a mí, por servicios prestados. Yo entiendo que soy financieramente responsable por todos los cargos incurridos, ya sea que son pagados por el seguro o no. Por el presente yo autorizo al doctor a divulgar toda la información que sea necesaria para asegurar el pago de los beneficios. Yo autorizo el uso de esta firma en todas las presentaciones que se hagan ante el seguro.

_____ _____ _____
Firma de la Persona Responsable Relación Fecha

Effective: August 8, 2013

To all of our valued new and established patients,

Across the country there is growing concern regarding the abuse of prescription medications. Of all medications, the most commonly abused are pain medications such as hydrocodone and oxycodone, and anti-anxiety medications such as alprazolam, lorazepam, and diazepam.

In an effort to protect all of our patients who are taking any of these medications responsibly and to detect inappropriate use of controlled medications our clinics will be instituting the following policies effective immediately:

- As always, the decision to prescribe or not prescribe any medication is the responsibility of the treating provider and ultimately, Dr. Currier. We will therefore continue to reserve the right to agree or deny any narcotic or controlled substance prescription.
- Any patient who is receiving prescriptions for controlled substances may and will be required to provide urine and/or serum for drug testing at all follow up visits.
- Every effort will be made to bill the cost of these tests to the appropriate insurance carrier. However, ultimately the responsibility for payment rests with the patient.
- All patients receiving controlled prescriptions will be required to have office visits every 1-3 months, as determined by the prescribing provider.
- If, at any time, there is a concern that any prescriptions are being used inappropriately or other illicit drug use is suspected, prescription refills will be discontinued and the patient discharged from the practice.

Thank you, in advance, for your cooperation in these efforts. It will take all of us, patients and providers, parents and caregivers, to make an impact in preventing abuse and possible deaths due to the misuse of these important but possibly harmful medications.

_____ _____

Patient Name Date

_____ _____

Parent/Guardian Date

Daryl C Currier, MD, PA and Staff

Daryl C. Currier M.D., P.A.

601 Person Street
Stockdale, Texas 78160
(830) 996-3701

402 W. Chihuahua
La Vernia, Texas 78121
(830) 779-3800

921 10th Street, Suite 111
Floresville, Texas 78114
(830) 216-7979

I have been given the opportunity to read the HIPAA Privacy Notice and/or have also been given a copy of same. I hereby consent to medical treatment by Dr. Daryl C. Currier for myself/minor child and understand that this office is committed to protecting all medical information in a confidential manner.

May we release health information about you to family member(s) or another individual or care giver(s)? ☐ Yes ☐ No

☐ Wife _____ ☐ Husband _____
☐ Mother _____ ☐ Father _____
☐ Other _____ ☐ Other _____

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications be made by alternate means, such as ending correspondence to the individual's home. I wish to be contacted in the following manner:

☐ **NO RESTRICTION REQUESTED**

Telephone

Leave detailed message at home.	☐ Yes	☐ No
Leave call back number at home.	☐ Yes	☐ No
Leave detailed message at work.	☐ Yes	☐ No
Leave detailed message on cell phone.	☐ Yes	☐ No

Written Communication (Billing Procedures Excluded)

OK to mail to my home	☐ Yes	☐ No
OK to mail to my work/office	☐ Yes	☐ No
OK to fax to this number _____	☐ Yes	☐ No

General Information

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic
☐ Caucasian ☐ Black/African American ☐ Other: _____

Main Language Spoken:

☐ English ☐ Spanish ☐ Other _____

Ethnicity:

☐ Hispanic ☐ Non-Hispanic ☐ Unknown

_____ _____
Patient/Parent/Legal Guardian Signature Witness

_____ _____
Printed Name Printed Name

_____ _____
Date Date

Daryl C. Currier, M.D., P.A.
Family Medical Centers

Financial Policy

Family Medical Centers is a service-oriented practice association that manages patient care and the delivery of care in a manner consistent with quality, compassion and cost effectiveness.

In order to ensure insurance benefit coverage for any services rendered, it is imperative that the patient provide a current insurance card at each office visit. If insurance verification and coverage cannot be determined prior to the visit, payment will be requested at the time of service. *Please be advised that the eligibility and benefit information supplied by your insurance company is only and estimate and is not a guarantee of payment by the insurer.* Actual benefits are subject to all plan terms, definitions, limitations and exclusion in effect on the date of service. **Family Medical Centers will submit your bill to your insurance company for services performed by our medical providers; however, it is ultimately the patient's responsibility to pay for any and all services provided.**

If the patient's insurance is a PPO or POS plan, ***it is the patient's responsibility*** to secure their own appointment to a ***specialist.*** In addition, please be aware that not all medical providers or facilities participate in each patient's insurance policy; therefore, the patient should verify a provider and facility's participation **prior** to scheduling specialty care, or diagnostic appointments outside of Family Medical Centers.

Co-payments and deductibles are due at time of service. For your convenience, payments can be made via cash, check, Visa, MasterCard or Discover.

State law requires that insurance companies pay most claims within 45 days of submission. If there is difficulty processing any claim(s) submitted, we may ask for your assistance working with your health care plan provider. It is very important that you respond promptly to any inquiries from your insurance company since failing to do so could result in delay or denial of claim coverage.

_____ _____
Patient's Signature Date

_____
Patient's Printed Name

_____ _____
Witness' Printed Name Date

DARYL C. CURRIER M.D., P.A.
FAMILY MEDICAL CENTERS

By signing below, I give permission for Daryl C. Currier, M.D., P.A. to access my pharmacy benefits data electronically, through E-scribe. This consent will enable Daryl C. Currier, M.D., P.A. to:

- **Determine the pharmacy benefits and drug co-pays for a patients' health plan.**
- **Check whether a prescribed medication is covered (in formulary) under a patient's plan.**
- **Display therapeutic alternatives with preference ran (if available) within a drug class for non-formulary medications.**
- **Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-scribe to these pharmacies.**
- **Download all historic list of all medication prescribed for a patient by any provider.**

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using E-scribe.

_____ _____

Patient Name (Printed) **Date of Birth**

_____ _____

Patient/Guardian Signature **Date**

FAMILY MEDICAL CENTER
Daryl C. Currier, M.D., P.A.

Consent for Nurse Practitioner/ Physician Assistant Care

I, hereby give authorization to receive care by one of the Registered Nurse Practitioners / Physician Assistant working in collaboration with Daryl C. Currier, M.D., P.A. I understand that a Nurse Practitioner/ Physician Assistant may diagnose and treat certain acute minor illnesses, injuries, or chronic medical conditions under the supervision of a licensed physician. I further understand that I may request to see Dr. Currier at any time.

_____ _____

Signature Date