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.

NAME:

DOB:

AGE: GENDER:

MEDICAID ID:

INFORMANT/RELATIONSHIP:

MEDICAL HOME:

Texas Health Steps

IF CHILD OVER 5 YEARS: uncomplicated pregnancy, labor, delivery and nursery course: Y ☐ * N ☐
**If yes, proceed with "Family and Personal Medical History"*

IF < 5 YEARS OLD

PREGNANCY

G ☐ P ☐ AB ☐

Total number of living children: Weight gain/loss:
Mother's age at birth:
Number of years between previous pregnancy and this child:
Trimester Prenatal Care Began: 1 ☐ 2 ☐ 3 ☐
Prenatal Care Provider:
Vitamins: Y ☐ N ☐ Iron: Y ☐ N ☐

MATERNAL COMPLICATIONS

- ☐ Vaginal bleeding
- ☐ Anemia
- ☐ Hypertension
- ☐ Rh negative
- ☐ Diabetes
- ☐ Premature labor
- ☐ Dental disease
- ☐ Flu-like illness or high temp.
- ☐ Kidney or bladder infection
- ☐ STIs
- ☐ Hepatitis (A, B, or C)
- ☐ Exposure to TB or had TB
- ☐ Exposure to lead/chemicals
- ☐ Injury/hospitalization/surgery

MATERNAL SUBSTANCE USE

- ☐ OTC meds:
- ☐ Prescription meds:
- ☐ Tobacco:
- ☐ Alcohol:
- Street drugs:
- ☐ Caffeine:

BIRTH/DELIVERY

Place of birth:
Birth attendant:
Hours of labor:

☐ Term ☐ Premature (weeks):
☐ More than two weeks overdue

Type of delivery:
☐ Vaginal ☐ C-Section ☐ Forceps ☐ Other/Explanation:

Complications:
☐ Breech ☐ Multiple birth ☐ Other:

NURSERY COURSE

Birth Weight: Birth Length: FOC:

- ☐ Difficulty with initial breathing
- ☐ Jaundice req. treatment
- ☐ Infection
- ☐ Transfusion
- ☐ Heart murmur
- ☐ Seizures

☐ NICU: days. Age at discharge:

Newborn blood screening (date/location):
1:
2:
Newborn hearing test (in hospital): ☐ Normal ☐ Abnormal
Type of test: ☐ ABR ☐ OAE ☐ Unknown
Referral made: Y ☐ N ☐
Comments:

FAMILY MEDICAL HISTORY

Abbreviations for relatives listed below.

M-Mother	MGM-Maternal Grandmother	PGM-Paternal Grandmother
F-Father	MGF-Maternal Grandfather	PGF-Paternal Grandfather
S-Sibling	MA-Maternal Aunt	PA-Paternal Aunt
	MU-Maternal Uncle	PU-Paternal Uncle

- ☐ ___ Anemia/blood disorder
- ☐ ___ Heart disease before age 50
- ☐ ___ Cholesterol req. treatment
- ☐ ___ Hypertension/stroke
- ☐ ___ Asthma/allergy
- ☐ ___ Cancer
- ☐ ___ Diabetes
- ☐ ___ Epilepsy/seizures
- ☐ ___ Kidney problems
- ☐ ___ Muscle/bone disease
- ☐ ___ Genetic disease or major birth defects
- ☐ ___ Tuberculosis
- ☐ ___ Other/Explanation:
- ☐ ___ HIV + individual in household *(do not identify)*
- ☐ ___ Other immunosuppression
- ☐ ___ Dental decay
- ☐ ___ Alcohol/drug abuse
- ☐ ___ Tobacco use
- ☐ ___ Learning disorder
- ☐ ___ Mental retardation
- ☐ ___ Psychiatric disorder
- ☐ ___ Physical/sexual/emotional abuse
- ☐ ___ Domestic violence
- ☐ ___ Childhood hearing impairment

PERSONAL MEDICAL HISTORY

Immunizations current: Y ☐ N ☐ Record unavailable ☐
Dental care current: Y ☐ N ☐ Sealants: Y ☐ N ☐

- ☐ Trauma/injuries
- ☐ Hospitalizations
- ☐ Surgery
- ☐ Medications
- ☐ Anemia
- ☐ Early childhood caries
- ☐ STIs
- ☐ Hepatitis
- ☐ Strep throat
- ☐ Ear infections
- ☐ Bladder/kidney infections
- ☐ Pneumonia
- ☐ Physical/sexual/ emotional abuse
- ☐ Muscle/bone disease
- ☐ Other/Explanation:
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Seizures
- ☐ Environmental toxin exposure (lead, etc.)
- ☐ Allergies
- ☐ Cancer
- ☐ Asthma
- ☐ Eczema
- ☐ Substance use (alcohol, drug, tobacco)
- ☐ Developmental delays/ learning disorder
- ☐ Immune suppression
- ☐ Psychiatric disorder

Date:

Signature/title

Signature/title

ECH-1 REV 6/11

BIRTH THROUGH 20 YEARS HEALTH HISTORY

REGISTRATION

(PLEASE PRINT)

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

PATIENT INFORMATION

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

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 _____ and assign directly to
Name of Insurance Company(ies)
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

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

Please list all children who will be patients at Family Medical Centers

Name: (Last, First, MI)	Preferred Name (If not 1st name)	Sex	Date of Birth

(Please list additional children on back)

Home Address _____ Apt # _____ Home Phone _____

City/State _____ Zip Code _____ Other Phone _____

Responsible Party

Responsible party is the individual who agrees to accept financial responsibility for the payment of all services performed at Family Medical Centers. This individual may not necessarily be the insurance card holder. Responsible Party must read and sign below.

Name _____ Relationship to Patient _____

Address (if different from above) _____

E-mail address _____ Occupation: _____

Social Security Number _____ Phone (Home) _____ (Cell) _____ (Other) _____

Authorized Individuals

Parent (name) _____ DOB _____ Parent (name) _____ DOB _____

Occupation/Employer _____ Occupation/Employer _____

Work Phone _____ Work Phone _____

It is the policy of Family Medical Centers that you must authorize family members and others who make appointments and accompany your child(ren) to their appointments. Therefore, the following other individuals (other than parents) are authorized to act in your place with respect to any and all medical matters. Please note that as we have no control over these individuals, any private health information disclosed under this authorization is not longer protected by the Privacy Rule.

Name _____ Phone # _____ Relationship to patient _____

Name _____ Phone # _____ Relationship to patient _____

Name _____ Phone # _____ Relationship to patient _____

Stockdale _____ Floresville _____ La Vernia _____

Daryl C. Currier, M.D., P.A. _____ David Santiago, M.D. _____ Ann Kothmann, FNP _____ Alice Finegan, FNP _____

Preferred Pharmacy (Optional): Name/Location: _____ Phone Number _____

Telephone/Email Contact Authorization

Phone: _____ **Phone:** _____ **Email:** _____

In compliance with Federal HIPAA Privacy Regulations, will you authorize Family Medical Centers to leave a detailed message on your answering machine/voice mail/email that may include appointment reminders, lab and x-ray results, and other private health information protected by privacy rules?

Phone: Yes No **Phone:** Yes No **Email:** Yes No

This authorization will remain in effect until changed or terminated by you or another individual/legal entity authorized to do so by court order or law by submitting a written request to the Family Medical Centers Privacy Manager in person or by mail to: **Family Medical Centers**

I hereby acknowledge that I have read and agree to the attached financial policy dated _____ and the Family Medical Centers Notice of Privacy Practices. I also acknowledge that I am the Responsible Party, and as such will be responsible for all payments and financial arrangements.

_____ _____

Responsible Party **Date**

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