Christine LaComb, RN, FNP-C
6000 39th Street Suite B
Groves, TX. 77619
(409) 962-8509 Phone (409) 962-0763 Fax

Welcome To Our Practice! In Order To Properly Serve You, Please Complete The Following Forms In Their Entirety.

Date: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ZIP: _____

Gender: Male / Female SSN: _____ DOB: _____ Marital Status: S M D W

Phone – Home: _____ Work: _____ Cell: _____

E-Mail: _____

How Did You Hear About Us? _____

How would you like to be notified of appointment? Home phone Cell phone Email (Please circle all that apply)

If the patient is a minor, please complete the following Responsible Party Information:

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ ZIP: _____

Gender: Male / Female SSN (If Applicable): _____ DOB: _____

Relationship to Patient: _____

Insurance Information:

Insurance Name: _____

Claims Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Policy Number: _____ Group Number: _____

Subscribers Name: _____ Subscribers DOB: _____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE – I hereby give Christine LaComb, FNP-C, and/or LaComb Health and Wellness, my consent to treatment and medical services for myself. I also consent to the release of medical information for the sole purpose of filing and receiving payment for insurance claims. I am aware that filing insurance is a courtesy and is not a guarantee of payment for services. I authorize the insurance to issue payment directly to Christine LaComb, FNP-C for services provided. I understand that in the event that insurance does not issue payment that I am responsible for payment of all fees incurred.

Signature: _____ Date: _____

LaComb Health & Wellness

PATIENT HISTORY AND HEALTH ASSESSMENT

Are you allergic to any medication? Y __ N __ If yes, please list:	
Medication:	Reaction:

Please list medications you are currently taking. (Including over-the-counter)

Current Medications:	Frequency and Dose	Reason Why	Prescribing Dr.

Preferred Pharmacy: _____

Indicate if you have or have had any of the following by entering the approximate date of diagnosis; month and year.
(If date of diagnosis is unknown, please indicate the approximate age of onset.)

ILLNESS	DATE (MM/YY)	ILLNESS	DATE (MM/YY)
AIDS or HIV		High Cholesterol	
Anemia		Kidney Disease	
Alcoholism		Lipid Profile	
Allergies (other than medications)		Liver Disease	
Anorexia/Bulimia		Lung Disease	
Appendicitis		Mammogram	
Bleeding Disorders		Measles	
Breast Exams		Migraine headache	
Cancer		Mononucleosis	
Chemical Dependency		Mumps	
Chickenpox		Pap Smear	
Depression		Pneumonia	
Diabetes		Pneumonia Vaccine	
DT (booster)		Psychiatric Care	
Emphysema		Rheumatic Fever	
Epilepsy/convulsions		Rubella	
Flu Vaccine		Sexually Transmitted Disease	
Frequent kidney or bladder infection		Stomach ulcer	
Frequent lung infection		Street drugs	
Gallbladder disease		Stool/occult test	
Gout		Stroke	
Glaucoma, eye disease		Thyroid problems	
Heart disease		Tobacco use	
Hepatitis, type		Tonsillitis	
High Blood pressure		Tuberculosis	

Surgical History	Date (MM/DD/YYYY)

FAMILY HEALTH HISTORY

DISEASE	FAMILY MEMBER	COMMENTS
No significant history known		
Alzheimer's		
Autoimmune Disease		
Bleeding or Clotting Disorder		
Cancer (what type)		
Diabetes		
Heart Disease (Congestive Heart Failure, A-Fib, Stints)		
Hepatitis (A, B, or C)		
High Blood Pressure (Hypertension)		
Thyroid Disease (Hypothyroidism, Hyperthyroidism)		

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OTHER HEALTH ISSUES:

TOBACCO USE

Smoke cigarettes: YES NO How many PPD? _____

Quit date: _____ How many years did you smoke? _____

ALCOHOL USE

Do you consume alcohol? YES NO _____# of drinks per day/week/month (circle)

DRUG USE

Do you use marijuana or other recreational drugs? YES NO

Have you ever used needles to inject drugs? YES NO

SEXUAL ACTIVITY

Sexually involved currently: YES NO

Sexual partner(s) is/are/have been MALE FEMALE

Birth Control Method: _____

EXERCISE

Do you exercise regularly? YES NO

What kind of exercise? _____

How long? _____

How often? _____

SOCIAL HISTORY

Occupation (or prior): _____ retired/unemployed/leave of absence/disabled (circle one)

Employer: _____

Marital Status (circle one): Single Partner, Married, Divorced, Widowed, Other

Spouse/partner's name _____ Number of children _____ Ages if under 18 years _____

Number of grandchildren: _____ Number of great-grandchildren: _____

Who lives at home with you? _____

Female Patients Only:

Menstrual History:

Age of onset: _____

Last pap smear: _____

Current gynecologist: _____

Last menstrual cycle: _____

Number of pregnancies: _____ # of live births _____

Complications: _____

Do you perform breast self-exams each month? YES NO

Male Patients Only:

Last Prostate Exam: _____

Current Urologist: _____

Do you perform testicle self-exams each month?

YES NO

Have you completed an (circle all that apply)

Advanced Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?

I certify that the information stated in this History & Health Assessment is true and correct to the best of my knowledge.

Patient Signature: _____

Date: _____

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Authorization to Release Protected Health Information

HIPPA Privacy Act:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read and understand the notice.

I acknowledge that the Notice of Privacy Practices provides information about how this office will use/disclose protected health information about me for treatment, payment, healthcare, and other operations as outlined by law. I understand that this office is not responsible for use or re-disclosure of information by third parties.

I, _____ hereby authorize Christine LaComb, RN, FNP-C and LaComb Health & Wellness to release protected medical, billing, and scheduling information to the individual(s) listed below. I am aware that this may include testing dates and times, testing information, laboratory reports, billing information and other information related to me and my medical condition. I understand that if no person is listed below, no information will be released except for referral and billing/collection purposes.

EMERGENCY CONTACT:

NAME: _____ PHONE: _____RELATIONSHIP: _____

HIPPA RELEASE:

NAME: _____ PHONE: _____ RELATIONSHIP: _____

I understand that this authorization is valid unless revoked in writing by signing and dating a new authorization to release protected health information form.

Patient Name: _____

Patient Signature: _____

Date: _____

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Insurance Filing and Patient Responsibility Agreement

I, _____, understand that LaComb Health and Wellness will file all services rendered to my Insurance Policy if and only if they are in Network with my Insurance Company and are Participating Providers.

I also understand that if I have a Primary Insurance Policy that is in Network with LaComb Health and Wellness, but I have a Secondary Insurance Policy that is Out of Network with this Practice, I will be responsible for any and all remaining balances after the Primary Policy has been filed and has paid its portion in full.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

LaComb
Health & Wellness

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Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, LaComb Health & Wellness, reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

PRINTED NAME SIGNATURE

_____

DATE

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Patient Name: _____ DOB: _____

Form and Letter Fee

This is to notify you that LaComb Health and Wellness, will apply a fee to your account for patient, companies, family members, insurance carriers or other person requesting form and/or letters to be completed.

Forms include, but not limited to FMLA, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgages, industrial information, etc. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, airlines, travel agents, gyms, etc.

In order to comply with federal laws including HIPPA as well as Texas state and federal statues, this office must have a signed authorization from the patient/responsible party stating who we are authorized to release information to. You can contact our office and we can mail or fax the form to you. Please be sure to sign form. Unsigned requests cannot be processed.

Your records will be processed and fulfilled within 30 working days. We will either mail or fax the records to the information you provide on the authorization form.

Medical Records Fee:

Pages 1-2	$10.00
3 -20	$25.00
21 + pages	$0.50 per page
Fee for executing	$15.00

_____ _____

Signature of patient or responsible party Date