KATY
MEDICAL CENTER

Dear Patient

We welcome you to Katy Medical Center.

We appreciate your trust in us to provide your health care. Our practice offers you and your family a safe healthcare environment, and we will strive to meet your medical needs and provide you with the highest quality care.

For your convenience, we have enclosed a health questionnaire and other important documents that are needed to complete your initial registration. Please complete the enclosed forms and bring them with you to your scheduled appointment. This will speed up your registration process. Also, be sure to bring your current insurance card along with your immunization record.

Your appointment will be on _____, at _____AM / PM.

We look forward to serving your medical needs. If you have any questions, please call us at 281-398-7778. We will be happy to answer help you.

Sincerely,

Katy Medical Center

KATY MEDICAL CENTER

Patient Information

Annual Registration

Last Name_____First Name_____Middle Name_____

Address_____Apt#_____

City_____State_____Zip_____

BirthDate_____SSN_____Patient / Guardian E-Mail_____

Home Phone_____Cell Phone_____Employer_____Work Phone_____

Emergency Contact_____Relationship to patient_____Phone_____

Preferred Communication Method: ☐ Phone ☐ Email (MyChart) ☐ US Mail Preferred Pharmacy_____

SEX AT BIRTH: ☐ Male ☐ Female

GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ OTHER ☐ CHOOSE NOT TO DISCLOSE
☐ TRANSGENDER MALE / FEMALE TO MALE
☐ TRANSGENDER FEMALE / MALE TO FEMALE

SEXUAL ORIENTATION
☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ LESBIAN ☐ GAY ☐ BISEXUAL
☐ SOMETHING ELSE ☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

PREFERRED LANGUAGE
☐ ENGLISH
☐ SPANISH
☐ SIGNING / ASL
☐ OTHER_____

VETERAN STATUS
☐ ACTIVE DUTY
☐ DISCHARGED (VETERAN)
☐ NATIONAL GUARD
☐ RESERVES ☐ NONE

ETHNICITY
☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

RACE
☐ WHITE ☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKAN NATIVE
☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER

MARITAL STATUS
☐ SINGLE
☐ MARRIED
☐ WIDOWED
☐ DIVORCED

HOUSEHOLD INFORMATION
HOW MANY PEOPLE ARE IN YOUR HOUSEHOLD INCLUDING YOURSELF? _____
WHAT IS YOUR MONTHLY HOUSEHOLD INCOME?
☐ I HAVE NO INCOME ($0)
☐ MY MONTHLY INCOME IS $_____
☐ MY YEARLY INCOME IS $

FARM WORKER STATUS
☐ MIGRATORY FARM WORKER
☐ SEASONAL FARM WORKER
☐ NOT A FARM WORKER

IN PUBLIC HOUSING ☐ YES ☐ NO

HOMELESS STATUS
☐ DOUBLED UP (LIVING WITH OTHERS)
☐ IN A HOMELESS SHELTER
☐ TRANSITIONAL HOUSING
☐ ON THE STREET
☐ PERMANENT SUPPORTIVE HOUSING (THROUGH MHMR / FAMILY ABUSE CENTER)

PARENT / GUARDIAN / GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) INFORMATION

NAME_____BIRTHDATE_____SSN_____

ADDRESS ☐ CHECK IF SAME AS ABOVE_____

CITY_____STATE_____ZIP_____CELL PHONE_____

WORK PHONE_____HOME PHONE_____EMPLOYER_____

RELATIONSHIP TO PATIENT ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER_____

PRIMARY MEDICAL INSURANCE NAME_____Member ID #_____GROUP #_____

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME_____

☐ MALE ☐ FEMALE BIRTHDATE_____SSN_____RELATIONSHIP TO PATIENT_____

ADDRESS ☐ CHECK IF SAME AS ABOVE CITY STATE ZIP

SECONDARY MEDICAL INSURANCE NAME_____Member ID #_____GROUP #_____

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME_____

☐ MALE ☐ FEMALE BIRTHDATE_____SSN_____RELATIONSHIP TO PATIENT_____

ADDRESS ☐ CHECK IF SAME AS ABOVE CITY STATE ZIP

IF YOU WOULD LIKE TO BE CONTACTED FOR A DENTAL APPOINTMENT PLEASE COMPLETE THIS SECTION

DENTAL INSURANCE NAME_____Member ID #_____GROUP #_____

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME_____

☐ MALE ☐ FEMALE BIRTHDATE_____SSN_____RELATIONSHIP TO PATIENT_____

ADDRESS ☐ CHECK IF SAME AS ABOVE_____CITY_____STATE_____ZIP_____

WORK PHONE_____HOME PHONE_____CELL PHONE_____

General Consent to Treat

I hereby consent to any and all treatment that my Katy Medical Center clinician and I agree is necessary for me or for the patient(s) I am guardian for.

I understand and acknowledge that KMC is a teaching center, and my care, and/or the care of patients(s) I am guardian for, at KMC may be provided by a clinician, including but not limited to medical students and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physicians or medical students, case discussions, or photographic or video images of care activities involving me or my dependents are allowed for teaching purposes unless specifically denied by me. I understand and acknowledge that certain clinical visits may be delivered by telehealth (video or telephone) services, during which I will not be physically in the same room as my clinician. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, my telehealth visit may be discontinued or converted into an in-person visit.

I further understand that as part of its health care services, KMC personnel and my clinician create and maintain a record of care and services provided. I understand that such information may be used and/or disclosed in the management and delivery of care and services provided by KMC, as described in the Notice of Privacy Practices. I understand and acknowledge that KMC participates in an electronic health record exchange program, and that if I seek treatment from other healthcare facilities or providers participating in this exchange program, my health information, or that of the patient(s) I am guardian for, may be shared between KMC and those other facilities or providers. I understand and acknowledge that as part of receiving my healthcare at Katy Medical Center, KMC's clinicians and other personnel may electronically request and/or provide health records for me and/or patient(s) I am guardian for, to those participating facilities or providers. These records include, but are not limited to prescription medication history, as well as information related to mental health treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment, and/or HIV (AIDS) testing/results and/or treatment. I further understand that any such information from any source whatsoever may become part of the requesting party's health records on me and/or the patient(s) I am guardian for.

By providing my mobile phone number, I consent to text messages regarding upcoming appointments and other notifications related to my healthcare and services provided by Katy Medical Center. I understand that there may be text or data charges from my mobile carrier.

NOTICE OF PRIVACY PRACTICES

I hereby understand that I have the right to request a copy of the Katy Medical Center's Notice of Privacy Practices.

LIMITED ENGLISH PROFICIENCY

The Katy Medical Center proudly offers certain language assistance to its patients free of charge. We also strive to make reasonable accommodations for its disabled patients.

PHOTOGRAPHY

I consent to the taking of photographic and/or video images for the purpose of identification and documentation of my medical care.

STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby understand I am the person primarily responsible for payment of all charges for services rendered by Katy Medical Center, regardless of any insurance coverage I might have, including Medicare or Medicaid, and that such payment is due on demand. I further understand that in addition to such service charges, I will be liable for any court costs, attorney's fees, collection expense, or interest that may be incurred should such actions be required to obtain payment for services rendered by Katy Medical Center. I certify that the patient and financial information given at the time of services rendered is accurate and complete.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of service rendered, I hereby irrevocably assign and transfer to KMC, all rights, title and interest in benefits payable for services rendered by Katy Medical Center. I hereby authorize and instruct the insurance company and/or Financial Program to pay directly to Katy Medical Center all benefits due under the terms of my policy or policies. I understand that my insurance policy/ financial program, or their health-insuring agent(s), determine the medical necessity of services/items I request and receive. I also understand that I am responsible for payment of services or items I request and receive if these services/items are determined by my insurance policy/financial program not to be reasonable and medically necessary for my care.

OUTSIDE DIAGNOSTIC CHARGES

Laboratory testing for specimens/x-rays/CT/ultrasounds obtained at Katy Medical Center and sent to a radiologist or independent lab will be billed to me directly from that independent facility. There is also a lab handling fee for obtaining lab specimen(s) which is billed through Katy Medical Center. Upon receiving a statement, I understand that I am to contact that laboratory or radiology company to arrange payment or exchange insurance information. I have been informed in writing and verbally of this. I understand that these diagnostic charges are now my responsibility.

PATIENT /GUARDIAN SIGNATURE

I have read and understand the aforementioned document.

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN* SIGNATURE _____RELATIONSHIP TO PATIENT _____

WITNESS _____

Legal guardian must provide proof of guardianship, a copy of which must be attached to this form.

KATY MEDICAL CENTER

Patient and Center Rights and Responsibilities

Patient Name: _____Patient Date of Birth: ____/____/____

MR#: _____

Welcome to the center

Our goal is to provide quality health care to people in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. The center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us questions you might have.

These rights and responsibilities address:

Human Rights
Payment for Services
Privacy
Health Care
Center Medical Home Responsibilities
Patient Responsibilities
Complaints
Termination
Appeals

I have read, understand, and accept the Katy Medical Center Patient and Center Rights and Responsibilities. A copy of this policy is available to me upon my request.

Signature: _____ ____/_____/____
Today's Date

Name: _____
[Print Name]

If signing for a minor, _____
[Print Minor's Name]

KATY
MEDICAL CENTER

A. Human Rights

You have a right to be treated with respect regardless of race, color, marital status, religion, sex, gender, gender identity, sexual orientation, national origin, ancestry, physical or mental handicap or disability, age or other grounds as applicable to federal, state and local laws or regulations.

B. Payment for Services

1. You are responsible for giving staff accurate information about your present financial status and any changes in your financial status. The staffs need this information to decide how much to charge you and/or so they can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, we will help determine your eligibility to receive a discounted fee schedule.

2. You have a right to receive explanations of the center's bill. You must pay, or arrange to pay, all agreed fees for medical services, with the exception of dental services, which are provided on a prepaid basis. For any unpaid balance you may have, please contact our billing department for a payment plan.

3. Federal law prohibits the center from denying you primary health care services which are medically necessary solely because you cannot pay for these services. Katy Medical Center may require a Co-Pay or a Nominal Fee from our patients. If you cannot afford this required payment, we would be happy to assist you to determine potential eligibility for programs that may reduce your required fee.

C. Privacy

You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. Only legally authorized persons may see your medical records unless you request in writing for us to show them to, or copy them for, someone else. In certain instances, the center may be required to report to the Texas Department of State Health Services regarding your health condition or illness status. The Privacy and Confidentiality in Delivery of Services Policy sets forth the ways in which your medical records may be used or disclosed by the center and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA"). This document is available to you upon request.

KATY MEDICAL CENTER

D. Health Care

1. You are responsible for providing the center with complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.

2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness, treatment plan, including the nature of your treatment; its expected benefits; its inherent risks and hazards (and the consequences of refusing treatment); the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if known. This information is called obtaining your informed consent.

3. You have the right to receive information regarding "Advance Directives." If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally authorized representative.

4. You are responsible for appropriate use of center services, which includes following staff instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill. Center professionals may not be able to see you unless you have an appointment. If you are unable to follow instructions from the staff, please tell them so they can help you.

5. If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed." You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in

your best interest, you may be asked to sign a Refusal to Permit Medical Treatment or Services / Against Medical Advice Release Form.

6. You have a right to health care and treatment that is reasonable for your condition and within our capability, however, the center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that the center cannot provide. The center does not pay for services that you receive from another healthcare provider or any required transportation service.

E. Katy Medical Center Medical Home Responsibilities

1. The practice is responsible for coordinating your care across different settings.

2. The care team will provide you access to evidence-based care, patient/family education and self-management goals.

3. The front office staff at your clinic will help transfer your medical records. You will be required to sign a release of information form.

4. You will receive a written clinical summary at each visit.

F. Patient Responsibilities

1. You have a right to receive information on how to use the center's services appropriately. You are responsible for using the center's services in an appropriate manner. If you have any questions, please ask us.

2. You are responsible for the supervision of children you bring with you to the center. You are responsible for your children's safety and the protection of other patients and our property.

3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments you may be subject to disciplinary action pursuant to the center's policies and procedures.

KATY
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G. Complaints

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Staff will tell you how to file a complaint. If you are not satisfied with how the staff handles your complaint, you may file a complaint in writing to the center's Board of Directors.

2. If you make a complaint, no center representative will punish, discriminate or retaliate against you for filing a complaint, and the center will continue to provide you services.

H. Termination

If the center decides that we must stop treating you as a patient, you have a right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. However, the center can decide to stop treating you immediately if you have created a threat to the safety of the staff and/or other patients. You have a right to receive a copy of the center's Patient Dismissal Policy.

Reasons for which we may stop seeing you include:

1. Failure to obey center rules and policies;
2. Intentional failure to accurately report your financial status;
3. Intentional failure to report accurate information concerning your health or illness;
4. Intentional deception of care team regarding medications and obtaining care outside Katy Medical Center;
5. Verbal abuse of or inappropriate behavior toward our staff or creating a significant disturbance and/or
6. Creating a threat to the safety of the staff and/or other patients.

I. Appeals

If the center has given you notice of termination of the patient and center relationship, you have the right to appeal the decision to the grievance committee in writing. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

Katy Medical Center

The Extended Hours Clinic at Katy Medical Center provides access to routine and urgent care for established patients, outside of regular business hours.
Walk-ins welcome based on availability.

Visit Us

948 S. Fry Road
Katy, TX 77450

Call Us Today

Phone: 281.398.7778

Hours of Operation

Monday-Friday
8:30 am – 5:00 pm

Services Provided in Extended Hours

Urgent Care:
An acute, non-emergent illness, injury or exacerbation of a chronic condition.

Wellness Visits:
An annual visit for the performance of age appropriate preventative care services.

Routine Care:
Routine follow-up and management of a chronic medical condition

Nurse Visits:
Visits requiring care that is limited to the scope of nursing duties to include but no limited to immunizations, blood pressure checks or addressing changes.

Services **Not** Provided in Extended Hours

- Prenatal care
- Fractures
- Hospital follow-ups
- Emergency care
- Radiology (X-ray)
- WFM Pharmacy
- Other services may be limited depending upon available provider's scope of practice

KATY MEDICAL CENTER

Patient Name _____Today's Date _____

Age _____ Date of Birth _____ MRN (office use only) _____

Reason for today's visit _____

Last Primary Care Physician, location and date last seen _____

- ☐ Diabetes- Type I or II? _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Failure/CHF
- ☐ Heart Attack/Coronary Artery Disease
- ☐ Pacemaker/Defibrillator
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Asthma
- ☐ COPD/Emphysema/Chronic Bronchitis
- ☐ Cancer- *what type?* _____
- ☐ Thyroid problems
- ☐ Peripheral Vascular Disease/Circulation problems
- ☐ Blood Clot/DVT
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Tuberculosis
- ☐ OTHER _____

- ☐ Hepatitis- *what type?* _____
- ☐ Cirrhosis/ liver disease
- ☐ Alcoholism/Drug addiction
- ☐ Arthritis- *what type?* _____
- ☐ Gout
- ☐ Osteoporosis/Thin bones
- ☐ Prostate Problem
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Other STD/Venereal Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Suicide attempt
- ☐ Other Mental Illness
- ☐ Seizures
- ☐ Paralysis
- ☐ Migraines

Women ONLY

When was your last PAP smear? _____

Ever had an abnormal PAP? ☐ No ☐ YES *when?* _____

FIRST day of last menstrual period? _____

When was your last mammogram? _____

Ever had an abnormal mammogram? ☐ No ☐ YES

Are you currently pregnant? ☐ No ☐ YES, *Due date?* _____

Ever had complications during a pregnancy? ☐ No ☐ YES

How Many?

- ☐ Total pregnancies
- ☐ Live Births
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions
- ☐ C-Sections
- ☐ Vaginal Birth after C-section

List Allergies to medications

List current **Medications and Dose** you are taking (ex. Prinivil 40 mg daily)

Previous Surgeries	
Date(s)	
	Gallbladder
	Appendix
	Tonsils
	Hernia
	Hysterectomy- ovaries removed?
	Tubal Ligation ("Tubes tied')
	Breast biopsy
	Back surgery
	Other
	Other

Health Habits	
How much of each do you use per day? (If not every day, how much per week?)	
	Caffeine
	Alcohol
	Tobacco
	Street Drugs

Occupation / Travel	
Any exposure to hazardous materials?	☐ No ☐YES
Travel to Foreign Countries	☐ No ☐ YES

Family History	Check family members with the following conditions **(NOT YOURSELF)**									
	Mother	Father	Sister	Brother	Son	Daughter	MGF	MGM	PGF	PGM
Status: A= Alive or D=Descd										
Diabetes										
High Blood Pressure										
High Cholesterol										
Heart attacks										
Kidney Disease										
Bleeding problem										
Strokes										
Cancer *(what kind?)*										
Arthritis										
Asthma										
COPD/lung problems										
Psychiatric Illness										
Alcohol/Drug Abuse										
Other										

Symptoms: *Please check if you are experiencing any of the following:*

	Unintentional weight loss		Diarrhea or Vomiting		Blood in stools or urine
	Leaking urine or stool		Night sweats/Fevers		Penile or Vaginal Discharge
	Shortness of Breath		Swelling in feet/ankles		Irregular/Painful periods
	Chest Pain		Rash		Erection Problems
	Vision Problems		Too thirsty		Constipation
	Persistent Cough		Suspicious lumps or bumps		Difficulty breathing when lying down
	Fainting		Forgetfulness		New headache
	Trouble sleeping		Pain- *where?* _____		Other

KATY MEDICAL CENTER Payment Options and Return Check Policies

Payment Options

Katy Medical Center offers a variety of payment options for patients to help them meet their financial responsibilities, such as Prompt Payment Options and payment plans.

Prompt Payment Option – patients may elect to receive a 50% discount on a self-pay balance when, 1) the balance due is not a cost-share or co-insurance balance due by the patient after insurance paid, or 2) when the patient elects not to use their insurance benefits and is considered as self-pay (full pay) for the specified services.

When electing the prompt pay option, the patient is expected to pay the remaining balance owed after the discount is applied either prior to the services being rendered, or within 30 days of the request. NO personal checks are accepted for prompt pay payments.

Payment Plan Option – patients may elect to set up a monthly payment plan that allows them to pay out their balances over time.

Patients should contact the Billing Department at 948 S. Fry Road, Katy, TX 77450, Phone: 281-398-7778 for assistance with payment options.

Return Check Policy

Personal Checks that get returned as "Insufficient Funds" or as a "Stopped Payment" will incur a $30 service charge. The amount of the check and service charge will be required to be paid by a different payment source (no personal check) within 10 business days of the returned check notice from the bank. Patients will need to come to the Billing Department to make their payment. If the payment due is not made within the 10 business days, the check will be turned over for further action at the District Attorney's office.