10310 W Grand Pkwy S
Suite 103
Richmond, Texas 77406
Phone: 832-446-9444 | Fax: 832-482-1700
Monday-Friday 9:00AM-4:00PM

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME	LAST NAME	DATE OF BIRTH ________/________/________

SEX ❑ Male ❑ Female	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS

ADDRESS

CITY	STATE	ZIP CODE

MARITAL STATUS ❑SINGLE ❑MARRIED	RACE	ETHNICITY
EMERGENCY CONTACT NAME	EMERGENCY CONTACT RELATIONSHIP	EMERGENCY CONTACT PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? ❑YES ❑NO	PRIMARY CARD HOLDER ❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER__________	GUARANTOR'S NAME
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	RELATION TO PATIENT
DO YOU HAVE SECONDARY INSURANCE? ❑YES ❑NO	SECONDARY CARD HOLDER ❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER__________	GUARANTOR'S DATE OF BIRTH
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	PHONE #/ADDRESS

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- I also understand that I will receive a single payment receipt, if with that receipt I cannot receive reimbursement from my insurance, it is my responsibility and not Fusion Primary Care and Wellness, just as it will be my sole responsibility if the medications prescribed here are not covered by my insurance.

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER

- Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be Denied.

PATIENT SIGNATURE	**DATE**

PATIENT MEDICAL HISTORY

Allergies

❑ NONE/Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast ❑ Latex ❑ Morphine ❑ Penicillin

OTHER:

FAMILY HISTORY – **Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.**

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

□**Yes** □**No -** Do you drink alcohol? □ Daily □Weekly □Infrequently □ Recovering Alcoholic
□**Yes** □**No -** Do you smoke? □ Smoke (___ packs per day) □ Chew
□**Yes** □**No -** Do you drink caffeine? □ Daily □Weekly □Infrequently
□**Yes** □**No –** Are you sexually active?
□**Yes** □**No –** Do you wish to be checked for STDs?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ Allergies
❑ Anemia
❑ Arthritis conditions
❑ Asthma
❑ Atrial fibrillation
❑ Bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ Cancer
❑ Cardiac arrest
❑ Celiac disease
❑ Chest pain
❑ Congestive heart failure
❑ Chronic fatigue syndrome
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Erectile dysfunction
❑ Fibromyalgia
❑ Gerd
❑ Heart disease
❑ Hyperinsulinemia
❑ Hyperlipidemia
❑ Hypertension
❑ Hypogonadism male
❑ Hypothyroidism
❑ Infection problems
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney problems
❑ Menopause
❑ Migraines/headaches
❑ Neuropathy
❑ Onychomycosis
❑ Organ injury
❑ Osteoporosis
❑ Pulmonary embolism
❑ Seizure disorders
❑ Shortness of breath
❑ Sinus conditions
❑ Stroke
❑ Syndrome X
❑ Tremors
❑ Wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

HIPAA Compliance Patient Consent Form

[illegible]

[illegible]

[illegible]

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ______________________________________ (PRINTNAME)

Signature: ____ Date: ____________

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Fusion Primary Care and Wellness assisting my care.

Financial Agreement: I understand that all charges are due at the time of service. I agree to pay Fusion Primary Care and Wellness for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If Fusion Primary Care and Wellness is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, Fusion Primary Care and Wellness is not involved. In order for Fusion Primary Care and Wellness to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that Fusion Primary Care and Wellness will need to verify my health insurance coverage. In the event that Fusion Primary Care and Wellness is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees
(including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

Insurance Authorization and Release: I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to Fusion Primary Care and Wellness for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Fusion Primary Care and Wellness to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Fusion Primary Care and Wellness charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Fusion Primary Care and Wellness to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Fusion Primary Care and Wellness any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize Fusion Primary Care and Wellness to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize Fusion Primary Care and Wellness to provide a copy of my medical records to my Primary Care Physician (PCP) to allow for continuity of care.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of Fusion Primary Care and Wellness. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Fusion Primary Care and Wellness at (832)446-9444

In House Pharmacy: I understand that, for my convenience, Fusion Primary Care and Wellness can dispense some prescription medications necessary to treat my medical condition(s). I understand that my insurance will not be billed for medications dispensed and that my pharmacy benefits DO NOT apply to this service. **Any medication(s) dispensed in the office are my responsibility and are an additional charge to my office visit charge.** I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

Personal Valuables: Fusion Primary Care and Wellness shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.
Fusion Primary Care and Wellness, A medical corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature: ______________________________ Date: ____________

Fusion Primary Care and Wellness
Authorization to Release Medical Records

Name of Patient: ____________________ Date(s) of Service: ________________

Date of Birth: ___________________ Social Security Number: _______________

I, the undersigned, authorize to release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other: _________________
Legal Purposes	School	_______________________

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report(s)	Emergency Room Record(s)
Operative Report(s)	Discharge/Death Summary	Face Sheet
Lab/Pathology Report(s)	X-Ray Report(s)/Images	Other: __________________

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address)

TO: Dr Zunaira Gul

(832) 446-9444/ (832) 482-1700
____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number / Fax Number

10310 W Grand Pwky S Suite 103, Richmond, Texas 77406
____

Address (Street, City, State and Zip)

FROM:

____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number / Fax Number

____

Address (Street, City, State and Zip)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of signature unless I revoke the authorization prior to that date.

Date: _________________ Signature: ____

Patient or Legally Authorized Representative

____

Printed Name of Patient or Legally Authorized Representative

____

Relation to Patient