# Murray Fershtman, M.D.

**3115 College Park Dr Ste 104**
**Conroe, TX 77384**

## PATIENT INFORMATION

*(please print clearly)*

Patient Full Name: _____ Date of Birth: ____/____/____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Mother's Cell: (_____) _____-_____ Father's Cell: (_____) _____-_____

Mother's Name: _____ Father's Name: _____

DOB: ____/____/____ DOB: ____/____/____

Patient lives with: _____ Email Address: _____

How did you hear about Murray Fershtman, M.D.? _____

## EMERGENCY CONTACT INFORMATION

*(other than persons listed above)*

Name: _____ Phone: (_____) _____-_____ Relationship to patient: _____

## PREFERRED PHARMACY INFORMATION

*(This information will be kept on file, please notify our office of any changes to this information)*

Pharmacy Name: _____ Phone: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

## INSURANCE INFORMATION

*Insurance information is a necessary part of yours or your child's medical record. We will do our best to direct yours or your child's care and need for any specialist consults, lab work, and other medically necessary testing according to your managed care guidelines. However,* ***it is the ultimate responsibility of the parent/policy holder to verify that all facilities and specialists that our provider refers you to are within your health plan network.***

### PRIMARY INSURANCE

Policy Holder: _____
Date of Birth: ____/____/____ SS# _____
Relationship to Patient: _____
Insurance Company: _____
Claims Address: _____
ID# _____
Group# _____
Address of policy holder: ☐ ***check here if same as patient***
_____

### SECONDARY INSURANCE

Policy Holder: _____
Date of Birth: ____/____/____ SS# _____
Relationship to Patient: _____
Insurance Company: _____
Claims Address: _____
ID# _____
Group# _____
Address of policy holder: ☐ ***check here if same as patient***
_____

***By signing below, I hereby authorize Murray Fershtman, M.D. to treat the above-named patient. I also authorize payment of medical benefits, and release of correspondence and/or medical records to other medical providers involved in my child's care. I have read and understand the Murray Fershtman, M.D. Office and Financial Policy.***

Patient or Parent/Legal Guardian Printed Name: _____ Relationship to Patient: _____

Signature of Patient or Parent/Legal Guardian: _____ Date: ____/____/____

# MEDICAL HISTORY

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

**Medication Allergies:**

_____

_____

**Surgeries:** *(list with month & year of procedure)*

_____

_____

_____

**Current Medications:**

_____

_____

_____

**Hospitalizations:**

_____

_____

_____

**Family History** *(check all that apply)*

| | Mom | Dad | MGP | PGP |
|---|---|---|---|---|
| ☐ Diabetes | — | — | — | — |
| ☐ Heart Issue | — | — | — | — |
| ☐ Stroke | — | — | — | — |
| ☐ Cancer | — | — | — | — |
| ☐ Tuberculosis | — | — | — | — |
| ☐ Ulcer | — | — | — | — |
| ☐ Arthritis | — | — | — | — |
| ☐ Asthma | — | — | — | — |
| ☐ Eczema | — | — | — | — |
| ☐ Obesity | — | — | — | — |
| ☐ Thyroid Disorder | — | — | — | — |
| ☐ Sickle Cell | — | — | — | — |
| ☐ Seizures/Epilepsy | — | — | — | — |
| ☐ Bedwetting | — | — | — | — |
| ☐ Allergies | — | — | — | — |
| ☐ Hay Fever | — | — | — | — |
| ☐ Mental Illness | — | — | — | — |
| ☐ Suicide | — | — | — | — |

# Murray Fershtman, M.D.

## OFFICE AND FINANCIAL POLICY

Welcome and thank you for choosing Murray Fershtman, M.D. for you or your child's medical needs. We are dedicated to providing the best possible care for you or your child, and we want you to completely understand our office and financial policies. Our professional fees have been determined through careful consideration, in addition to being reasonable and customary within our geographical area. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your child's visit as pleasant as possible. **Please review and initial the following statements:**

____**Co-payments, unmet portions of your deductible, coinsurance, and previous balances are due at time of service.**

____**Appointments:** Please inform our receptionist at the time of making your appointment of any demographic changes (e.g. address, telephone number, insurance, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any service not covered by your insurance carrier.

____ **Child Custody/Divorced Parties:** Murray Fershtman, M.D. does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. Payment is the responsibility of the parent who brings the child in the office for treatment. This is regardless of the terms outlined in a divorce decree. This is a matter between the divorced parties and the courts and we cannot be placed in the middle.

_____**Consent to Seek Treatment of a Minor:** We understand that there will be times when a person who does not hold legal guardianship of a child must bring them in to be evaluated/treated by our physicians. Should this occur, our office will require written consent from a parent/legal guardian giving said non-guardian permission to seek treatment of their minor child without the parent/guardian being present.

____**Self-pay Accounts:** Patients with no insurance will be expected to pay at the time of service.

____**Insurance:** The patient is expected to present an insurance card at each visit. If we participate with your plan, we will directly bill your insurance. Keep in mind that your insurance policy is a contract between you and your insurance company. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for those charges. Any non-covered charges are due upon receipt of a statement from our office within 30 days.

**It is the patient or parent/guardian's responsibility to contact the insurance company and confirm that the doctor is "In Network" with your or your child's specific insurance plan. If our doctor is "Out of Network", the patient or parent/guardian will be responsible for any charges not covered by their "Out of Network" benefits.**

____**Late Arrival:** As a courtesy, please arrive at least 5 minutes prior to your appointment. If you are ***more than 15 minutes late***, it may be necessary to re-schedule your appointment to another day in order to prevent inconveniencing other patients.

____**No-Shows or Missed Appointments:** When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not canceled in advance and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. We wish to advise you that all appointments will require a 2-hour notice of cancellation by you. ***If an appointment is missed without at least 2-hours prior notice, you will be charged the full office visit.*** This fee is not payable by your insurance company and will be your responsibility.

**Responsible Party:** In order to be HIPPA compliant, we must have the responsible party sign this form. If the responsible party is anyone other than the Primary Insurance carrier, we must have the following:

Responsible Party's DOB: ____/____/____ Responsible Party's SS# _____

I have read, understand and agree to the above Murray Fershtman, M.D. Financial Policy. I also understand and agree that such terms may be amended by the practice at any given time.

Responsible Party's Printed Name: _____ Signature: _____ Date: ____/____/____

Name of Patient: _____ Patient D.O.B.: ____/____/____

*Rev 01/18*

## PRIVACY INFORMATION

Murray Fershtman, M.D.s' personnel must have permission from the patient or parent/legal guardian to relay a patient's medical information over the phone. Please let us know how you, (the patient or parent/legal guardian), would like to be contacted, list the names of who we may relay information to in the event that you are unavailable, and confirm or deny permission for us to leave normal/benign laboratory/imaging results on your voicemail. If you do not give specific permission for us to speak to family members, we will assume that you do not want any information relayed to anyone else in your household.

**HOME PHONE** **MOM CELL PHONE** **DAD CELL PHONE** **WORK PHONE**

Please list the name of each individual with whom we are authorized to discuss you or your child's medical care or test results:

_____

_____

**May we leave normal lab/imaging results on home voicemail?** ***(circle one)*** **YES NO**

**May we leave normal lab/imaging results on cell voicemail?** ***(circle one)*** **YES NO**

_____ _____

*Signature of Patient or Parent/Guardia* *Date*

# Murray Fershtman, M.D.

## Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as a part of mine or my child's healthcare, Murray Fershtman, M.D., originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnosis, treatments, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among the many health professionals who contribute to their care
- A source of information for applying my diagnosis and/or surgical information to my bill
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that a more complete description of information uses and disclosures is available within Murray Fershtman, M.D.s' HIPAA Notice of Privacy Practices which is available for review upon my request. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that Murray Fershtman, M.D., is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Murray Fershtman, M.D., reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Murray Fershtman, M.D. change their notice, I will be notified of such.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as a part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____ _____

*Patient Name* *Patient DOB*

_____ _____

*Parent/Guardian Printed Name* *Relationship to Patient*

_____ _____

*Signature of Patient or Parent/Guardian* *Date*

# Murray Fershtman, M.D.

3115 College Park Dr Ste 104
Conroe, TX 77384

## Authorization for Disclosure of Confidential Information

Patient Full Name: _____ DOB: ____/____/____
Patient Full Name: _____ DOB: ____/____/____
Patient Full Name: _____ DOB: ____/____/____

***I hereby authorize my child/children's medical records to be released from:*** _____
*Name of Medical Practice, Physician, Clinic, or Hospital*

Address: _____
City, State, Zip: _____
Ph: _____ Fax: _____

***To be released to:***

☐ **Murray Fershtman, M.D.**
3115 College Park Dr. Suite 104
Conroe, TX 77384
**Fax:** (936) 271-5033

☐ **Name:** _____
**Address:** _____
**City, State, Zip:** _____
**Phone:** _____ **Fax:** _____

***For the purpose of:***

☐ Continuing or transfer of medical care
☐ Legal Matters
☐ Proof of Immunization
☐ Insurance Review or Underwriting

Release information concerning the following dates: **From** _____ **to** _____, and to include:

☐ Complete Medical Record
☐ Lab Reports Only
☐ Other: _____
☐ Immunizations Only
☐ Progress Notes Only

Also, I ☐ **DO** or ☐ **DO NOT** (*check one & initial* _____) consent to release of information pertaining to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing.

***I, the patient or parent/legal guardian, agree that a photocopy or facsimile (fax) of this authorization may be considered valid, this authorization shall be valid for 120 days from the date of signature, and that this authorization can be revoked in writing at any time prior to the expiration date.***

***I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above-named medical practices, physician, or facility from all liability and damage resulting from the lawful release of my protected health information.***

_____ _____
*Signature of Patient or Parent/Legal Guardian* *Date*

*Rev 1/18*