Thank you for choosing Hill Country Memorial Medical Group for your healthcare needs. We look forward to seeing you for your upcoming appointment.

HCM Medical Group Offices:

205 W. Windcrest St., ***Fredericksburg***
1009 S. Milam St., Ste 3, ***Fredericksburg***
1331 Bandera Hwy, Ste 1, ***Kerrville***
1580 S. Main St., Ste 101, ***Boerne***
136 Old San Antonio Rd Ste 406, **Boerne (by appointment only)**
2511 US Highway 281, Ste 800, ***Marble Falls***
511 US Highway 281, ***Marble Falls***
405 US Highway 281 South, Ste 101 C, ***Johnson City***

HCM Medical Group Providers:

ENT
Tracy Byerly, II, MD
Carrie Culpepper, FNP-C
Maggie Klein, PA-C

Foot and Ankle Surgery
Podiatry
Bryce Karulak, DPM

Internal Medicine
Julian Falla, MD
Paola Forero, MD

Physical Therapy
Mindy Eckert, PT, DPT

Gastroenterology
Lindy T. Rachal, MD FACP

Vascular
Andrew Bowser, MD, FACS
Joseph Vinas, MD, FACS
Maggie Klein, PA-C

Pain Management
Ralph Menard, MD
Kaleb Shaw, MD

OB/GYN
Blair Tull, MD

Pulmonology
Dure Fernandez, MD

Orthopedic Surgery
Daniel B. Robertson, MD
Paul Phillips, MD
Kristina Crawford, PA-C

Primary Care/ Family Medicine
Jovawna D. Hubbard, FNP-C
Shannon Klump, DO
Rebecca Turbeville, MD

General Surgery
Greg D. Andreassian, MD

Urology
Michael C. Speck, MD

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Please bring your driver's license and insurance cards to all of your appointments. In order to ensure that our records are current, we will ask you to present these cards upon checking in for every appointment.

We have enclosed paperwork for you to complete prior to your appointment. If possible, return the completed paperwork to any of our office locations prior to the day of your appointment. This saves you time on the day of your appointment and helps us keep on schedule.

If you are unable to return the completed paperwork prior to the day of your appointment, please plan to arrive 15 minutes early with paperwork completed for your appointment in order to allow our front desk time to input your information into your record prior to you seeing the doctor. If you are unable to complete the paperwork until arrival to our office, please plan to arrive 45 minutes early for your appointment.

You may receive a confirmation call and/or text prior to your appointment. It is important that you confirm this appointment by responding to the automated message or returning our phone call. Please give our office at least a 24 hour notice if you need to cancel or reschedule your appointment.

Enclosed you will also find a records release authorization form. If you would like for us to obtain your records from a previous doctor, please complete and return along with your paperwork.

If you have any questions or concerns, do not hesitate to call us at (830) 990-1404.

Thank you so much and we greatly look forward to providing you with Remarkable Healthcare!

Sincerely,

Hill Country Memorial Medical Group

Patient Paperwork

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Patient Contact

Patient Last Name		First Name	Middle Name	
Mailing Address		City	State	Zip
Physical Address		City	State	Zip
Home Phone #	Work Phone #		Cell Phone #	

Patient Info

Date of Birth	Sex □ Male □ Female	Social Security #	Marital Status	Student Status □ Full □ Part Time
Employer Name		Address		
Work Phone		May we leave a message with this work phone number? □ Yes □ No		
Is this a work related injury? □ Yes □ No				

Confirmations

How would you like to receive your appointment confirmations?

□ Please confirm my appointments via text to cell phone number:

□ Please confirm my appointments via voice phone call to phone number:

Guarantor/Parent (if patient is a minor)

Guarantor Last Name		Guarantor First Name	Middle Name	
Date of Birth	Social Security #	Phone #	Email Address	Sex (check one) □ Male □ Female
Mailing Address		City	State	Zip
Physical Address (if different from mailing address)		City	State	Zip
Employer Name		Address		
Work Phone		May we leave a message with this work phone number? □ Yes □ No		

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes to foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Physicians

Primary Care Physician	Phone #	Address
Referring Physician	Phone #	Address

Emergency

Emergency Contact Last Name		Emergency Contact First Name	Middle Name		
Address		City	State	Zip	
Phone					

Patient Paperwork

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Insurance				
	Please provide insurance cards for our office to scan into your record*			
	Primary Insurance Company	Effective Date	Policy ID Nuimber	Group ID Number
	Subscriber Name (policy holder)	Date of Birth	Subscriber Social Security #	Relationship to Patient
	Secondary Inurance Company	Effective Date	Policy ID Nuimber	Group ID Number
	Subscriber Name (policy holder)	Date of Birth	Subscriber Social Security #	Relationship to Patient

Patient Portal

Please provide an email address so that we may set you up for a secure patient portal. With the patient portal, you will have access to:

* Appointments (Book and Keep Track of Appointments)
* Medications (Request Prescription Refills)
* Medical Records (View Your Personal Health Record)
* Education (Received Educational Materials)
* Messages (Send and Receive Messages from Staff)

By providing your email address, you authorize HCM Medical Group to set up a patient portal for you.

Email Address:

Patient

□ White/Caucasian □ Hispanic/Latino □ Black/African American □ Asian □ Other _____

Preferred Laungauge: □ English □ Spanish □ Other _____

Hill Country Memorial Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Pharmacy				
	Primary Pharmacy	City	State	Phone
	Secondary Pharmacy	City	State	Phone

Legal		
	Do you have an Advance Directive or Living Will?	□ Yes □ No
	Would you like information on the preparation of these?	□ Yes □ No
	Do you have a Durable Power of Attorney? (Please provide a copy to our office)	□ Yes □ No
	If so, who? _____	

Skilled Nursing Facility		
	Do you reside in a skilled nursing or retirement facility?	□ Yes □ No
	Name of Facility	
	Address	
	Phone	

_____ _____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN DATE

Patient Paperwork

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Patient's Name _____

Consent to Treat / Financial Responsibility / HIPAA

I hereby authorize employees and agents of Hill Country Memorial Medical Group (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and other plans to Hill Country Memorial Medical Group for medical services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that I am financially responsible for the total charges for the services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Hill Country Memorial Medical Group.

I acknowledge that I have received Hill Country Memorial Medical Group's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I understand that any payments that are due should be paid at the time of service unless arrangements have been made in advance, this includes copays, coinsurance, deductible and self-pay. I understand that HCM Medical Group will make every effort to file and collect payment from my insurance when applicable, but ultimatly I am responsible for charges that incur. I understand that sometimes unforeseen charges may incur in order to provide me the treatment that is medically necessary and that I may receive a bill for these services, tests and/or treatments.

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient or legal guardian.

If you would like to add additional contacts (other than the patient or legal guardian) that HCM Medical Group is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like HCM Medical Group to list as your Emergency Contact in the event an emergency situation was to take place at our office.

Name:	Relationship:	Authorized Access (Check all that apply) □ Billing Information
Phone:	Address:	□ Medical Condition Information
Name:	Relationship:	Authorized Access (Check all that apply) □ Billing Information
Phone:	Address:	□ Medical Condition Information
Name:	Relationship:	Authorized Access (Check all that apply) □ Billing Information
Phone:	Address:	□ Medical Condition Information

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

Patient Paperwork

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Patient Name: _____

Date: _____

Current Weight:
Current Height:

MEDICATIONS - List all medications you take, prescription and non-prescription, and the dosage

□ I do not take any medications □ I have a list I will provide separately

Medication Name	Dosage	Frequency	For	Prescibed by

If more space is needed, please attach full list of medications on a separate sheet of paper.

MEDICAL HISTORY - Check if you are or have ever experienced the following conditions

	Condition		Condition		Condition
□	Alcoholism	□	Depression	□	Learning Disability/Delay
□	Anemia	□	Diabetes	□	Liver Disease
□	Anxiety	□	Diverticulitis/Diverticulosis	□	Neuropathy
□	Arthritis	□	Eye Disease	□	Obesity
□	Asthma	□	Fibromyalgia	□	Osteoporosis
□	Atrial Fibrillation	□	GERD	□	Pancreatitis
□	Autoimmune Disease	□	Gout	□	Peripheral Vascular Disease
□	Bleeding Disorder	□	Hearing Loss	□	Prostate/BPH
□	Cirrhosis	□	Heart Attack	□	Renal Disease
□	Colon Cancer	□	Hepatitis A / B / C	□	Rheumatoid Arthritis
□	Colon Polyps	□	High Cholesterol	□	Sleep Apnea
□	Congestive Heart Failure	□	Hitatal Hernia	□	Stroke/TIA
□	COPD/Emphysema	□	HIV/AIDS	□	Thyroid Disease
□	Coronary Artery Disease	□	Hypertension	□	Ulcerative Colitis
□	Crohn's Disease	□	Irritable Bowel Syndrome	□	Other

MEDICATION AND FOOD ALLERGIES - List all known allergies and intolerances (drugs, food, animals, latex, etc.)

□ No Known Allergies

Allergy	Reaction

Patient Name: _____

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SURGICAL HISTORY - List any serious injuries or surgical procedures, and approximate year.							
Procedure		Year	Procedure	Year	**Procedure**		Year
□	Appendectomy		□	Heart Surgery (Type):	□	Pacemaker	
□	Aneurysm				□	Prostate	
□	Bladder				□	Reflux Surgery	
□	Bowel Surgery		□	Hemorrhoid Surgery	□	Skin Surgery	
□	Brain		□	Hernia Surgery	□	Spinal Surgery	
□	Breast		□	Hysterectomy	□	Stent Placement	
□	CABG		□	Joint replacement:	□	Sterilization; Type	
□	Carotid				□	Testicles	
□	Carpal Tunnel				□	Thyroidectomy	
□	Colonoscopy		□	Kidney	□	Tonsillectomy	
□	Cosmetic Surgery		□	Liver Biopsy	□	Transplant Surgery	
□	C-Section		□	Liver Surgery	□	Upper Endoscopy (EGD)	
□	ERCP		□	Lung Surgery	□	Valve Replacement	
□	Eye Surgery		□	Orthopedic Surgery:	□	Varicose Veins	
□	Gallbladder Surgery				□	Other	
□	Gastric Surgery				□	Other	

HOSPITALIZATIONS - Non-surgical, please provide reason	
Date_____	Reason: _____
Date_____	Reason: _____
Date_____	Reason: _____
Date_____	Reason: _____

FAMILY MEDICAL HISTORY							
□ Adopted	Mother	Father	Sibling:	Sibling:	Sibling:	Child	Child
Living	□	□	□	□	□	□	□
Deceased	□	□	□	□	□	□	□
Deceased Age:							
Barrett's Esophagus	□	□	□	□	□	□	□
Colon Polyps	□	□	□	□	□	□	□
Inflammatory Bowel Disease	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□
High Cholestrol	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□
Liver Disease	□	□	□	□	□	□	□
Mental Disorder	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□
Other	□	□	□	□	□	□	□
Cancer:	□	□	□	□	□	□	□
Breast	□	□	□	□	□	□	□
Esophagus	□	□	□	□	□	□	□
Lung	□	□	□	□	□	□	□
Uterine, Bladder, Ureter	□	□	□	□	□	□	□
Pancreas	□	□	□	□	□	□	□
Prostae	□	□	□	□	□	□	□
Stomach	□	□	□	□	□	□	□
Other	□	□	□	□	□	□	□

Patient Name: _____

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Caffeine/Tabacco/Drug/Alcohol Use	Do you currently use tabocco products? □ Yes □ No			For how long? _____	
	□ Cigarettes ____ packs per day	□ Cigar/Pipe ____ amount per day		□ Chewing ____ amount per day	
	Have you ever tried to quit? □ Yes □ No				
	Have you previously used tobacco products? □ Yes □ No			For how long?	
	□ Cigarettes	□ Cigar/Pipe	□ Chewing	When did you quit?	
	Alcohol Use:	□ Yes □ No			
	Beer:	□ Occasional	□ Weekly	□ Daily	□ Never
	Wine:	□ Occasional	□ Weekly	□ Daily	□ Never
	Liquor:	□ Occasional	□ Weekly	□ Daily	□ Never
	Do you consume drinks containing Caffeine? □ Yes □ No				
	If yes, how many drinks do you consume per day _____				
	Drug use:	□ Yes □ No	Type _____	Last Usage _____	
	Have you ever been treated for addiction?		□ Yes □ No		

Personal	Education			
	How many children do you have?	How many children at home?		
	Type of Exercise? _____	□ Daily	□ Weekly	□ Monthly □ Yearly
	Lives With			
	Occupation	□ Full Time □ Part time		
	Religious Preference			

Vaccines	Last Flu Vaccination	Date
	Last Pneumonia (Circle: Prevar 13 and/or Pneumovax 23) Vaccination(s)	Date
	Last Shingles (Zostavax) Vaccine	Date
	Last Tetnus (Circle: Tdap or Td) Vaccine	Date
	HepatitisB Vaccine, Did you complete the series? □ Yes □ No	Dates:

Screenings	Last Breast Cancer Screening (Mammogram)	Date
	Last Abdominal Aortic Aneurysm (AAA) Screening	Date
	Last Lung Cancer Screening	Date
	Last Bone Density Screening (DEXA)	Date
	Last Prostate Cancer Screening (PSA)	Date

Testing	Diagnostic Testing - List any imaging you have had pertaining to the curent issues					
		Ultrasound	CT Scan	MRI	Labs	Other
	Date					
	Where					

Specialists	Please list all doctors you currently see			
	Name	Specialty	Address	Phone

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Authorization for Release of Information

Patient's Name:	Date of Birth:
I hereby authorize the following providers to disclose my protected health information to the provider(s) of HCM Medical Group:	

Provider's Name:	Phone:
Address:	
Fax:	Specialty:

Provider's Name:	Phone:
Address:	
Fax:	Specialty:

Disclose the following information:
□ Any and all information inmy medical record my physican thinks is appropriate
□ Information limited to dates of service:
□ Services related to the following:

Reason for request:		
□ Continued Care	□ Personal	□ Legal
□ Transferring Care	□ Health Insuarnce	□ Life/Disability Insurance
□ Other		

Do NOT send any information related to:		
□ AIDS, ARC, or HIV Infection	□ Alcohol or Drug Abuse	□ Mental Health Disorder

This authorization shall be in force and until:	
□ Revoked by me	□ The following specific date
□ One year after signature date	

I understand that I have the right to revoke this authorization in writing at any time by sending such written notice to : HCM Medical Group, 205 W. Windcrest, Ste 130, Fredericksburg, TX 78624. I understand that a revocation is not effective to the extent that HCM Medical Group has already relied on this authorization to use and disclose the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to the re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Representive	Date
□ Fax records to:	
□ Mail records to:	

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No-Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment

"No-Show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to the other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "no-Show"

1. **Confirm** your appointment
2. **Arrive** 5-10 min early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

Hill Country Memorial Medical Group (HCMMG) will attempt to contact you 3 business days before your appointment to confirm your appointment. If we are unable to speak with you and have to leave a message, you will need to contact HCMMG, no later than 24 hours before your scheduled appointment time, to confirm, cancel or reschedule your appointment – otherwise the appointment will be canceled and marked a "no-show.

2. Always arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 min prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-show" Appointments

If you miss 3 or more appointments within a year, you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your medical provider
2. **If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled**
3. Only emergency medical treatment will be offered within the first 30 days of dismissal
4. Reapplication to the clinic after a six month period after initial dismissal letter will be considered by your medical provider.

I have read and understood the HCM Medical Group "No Show" Policy as described above.

_____

Printed Patient Name

_____ _____

Patient Signature Date