Welcome to Peterson Medical Associates. We are honored that you have chosen us as your healthcare provider. Our goal is to provide exceptional, compassionate, patient-centered care for all of our patients.

Your new patient paperwork is enclosed. Please complete each form in its entirety and return to the clinic in-person, by mail or by facsimile (833-905-2454) a minimum of 1 day prior to your appointment. You also have the option of checking-in online up to 10 days prior to your appointment at https://www.petersonhealth.com/peterson-patient-portals/. You can now email this packet to primarycare@petersonhealth.com

On the day of your appointment, you will need to arrive 20 minutes prior to your scheduled appointment time. This will allow the necessary time to get you checked-in, have your chart ready by your appointment time and eliminate the possibility of having to reschedule your appointment. If you do not arrive at least 20 minutes prior to your scheduled appointment time, you may be rescheduled.

Please bring all of the following with you to your appointment:

- ❑ A photo identification card (preferably a driver's license or state-issued identification card)
- ❑ All current (non-expired) insurance cards; and,
- ❑ All prescriptions medications (in their original packaging) or a formulary list from your mail-in pharmacy; and,
- ❑ All over-the-counter supplements and/or medications; and,
- ❑ Payment for your co-payment, deductible or co-insurance (due at the time of service)

Our office policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment will not be rescheduled;
- Three (3) no-show appointments may result in dismissal from the practice.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Peterson Medical Associates does not offer chronic pain management and will not dispense pain medication (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.

Again, thank you for choosing Peterson Medical Associates. We look forward to serving you.

Sincerely,
Tim Clark, MBAHM
Practice Manager

Peterson Health Medical Plaza

Adriana Arguello, MD
Pamela Cantu, MD
William Garre III, MD
Sandra Garred, MD
David Peters, MD
Bridget Robledo, MD
Klaus Schroeder, MD
Michael Shaffer, DO
Laura Teveni, MD
Tyler Ulmer, DO
Jarrod Wiggins, MD
Stephanie Calderon, FNP
Maria Garcia, FNP
Carrie Watson, FNP

1331 Bandera Highway | Kerrville, Texas 78028
Office: 830.258.7762 | Fax: 833.905.2454

Bandera Clinic
Fred Salley, MD
Kaleigh Pruett, FNP

3540 TX-16, Ste. 1D | Bandera, TX 78003
Office: 830.522.2002 | Fax: 833.905.2453

Comfort Clinic
Shannon Klump, DO

203 US-87, Ste. 204 | Comfort, TX 78013
Office: 830.258.7654 | Fax: 833.944.2108

Fredericksburg Clinic
Derrick Borecky, MD
Michael Shaffer, DO / Pamela Cantu MD
97 Hitchin Post Trail | Fredericksburg, TX 78624
Office: 830.307.5002 | Fax: 833.344.1380

PETERSON
MEDICAL ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT INFORMATION (please print)

Last Name:	First Name:	Middle Initial	Date of Birth:
Address:		City:	State: / Zip:
Home Phone:	Cell Phone:	Work Phone:	SSN: / Gender: ❑ M ❑ F
E-Mail Address:		❑ No e-mail address ❑ Prefer not to share e-mail address	Preferred method of contact: ❑ Home ❑ Cell ❑ Work ❑ E-mail

Race:	❑ Asian	❑ Black/African American	❑ White	❑ American Indian	❑ Pacific Islander	❑ Multi-racial	❑ Hispanic or Latino	❑ Prefer not to answer
Ethnicity: (Ethnicity is your ancestral or culture background)			❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑ Unknown	❑ Other		

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Occupation:
Preferred Language:	
Primary Care Doctor:	Preferred Pharmacy:

RESPONSIBLE PARTY INFORMATION

Last Name:	First Name:	Initial	Date of Birth:
Address:		City:	State: / Zip:
Home Phone:	Cell Phone:	Work Phone:	SSN: / Gender: ❑ M ❑ F
Occupation:		Relationship:	

INSURANCE INFORMATION

Primary Insurance:		
Policy Holder:	Insured's Date of Birth:	Insured's SSN:
Insured Employer's Name:	Policy #:	Group #:
Secondary Insurance:		
Policy Holder:	Insured's Date of Birth:	Insured's SSN:
Insured Employer's Name:	Policy #:	Group #:
If you are over 65 years old and Medicare is your SECONDARY policy, please list reason:		

WORKER'S COMPENSATION INFORMATION

Is this visit related to a worker's compensation injury? ❑ No ❑ Yes	If so, Name of Employer:		
Name of Supervisor:	Supervisor Phone:	Name of Case Worker:	Case Worker Phone:
Case #:	Date of Injury:	Name and Address of Company Responsible for Bill:	

EMERGENCY CONTACT INFORMATION

First Contact Name:	Phone:	Relationship:
Second Contact Name:	Phone:	Relationship:

CONSENT TO TREAT

I give permission for Peterson Medical Associates (PMA) to render to me (and/or my named dependent above) medical treatment. I also understand I have the right to refuse any procedure or treatment and to discuss all medical treatments with my provider.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Peterson Medical Associates for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine the benefits payable for related and/or provided services. **I understand that I must pay my share of the costs, including co-pays and deductibles at each visit. Furthermore, if my insurance does not pay or I do not have insurance, I must pay for the cost of these services.**

_____ Patient Signature for Consent to Treat and Assignment of Benefits _____ Date Signed	_____ Signature of Patient Representative (if patient unable to sign)	
	Relationship to Patient:	Reason Patient Unable to Sign:

PRACTICE POLICIES AND GUIDELINES AGREEMENT

PETERSON
Medical Associates

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Thank you for your cooperation.

1. **First Time Visit** - Please arrive at least 15 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all of your medications in their original containers. If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. If you are a self-pay patient, payment will be due at the time of service.

2. **Follow-Up Visits** - Please arrive 5 – 10 minutes before your scheduled appointment time. It is our goal for you to be ready to see your physician on time. Follow-ups are scheduled based on the particular needs of specific disease processes. If you have multiple chronic illnesses, you may be scheduled for multiple follow-up visits.

3. **Late Arrivals** - We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

4. **Appointment Cancellations** - We understand that sometimes plans change. We ask that you reschedule appointments at least 24 hours in advance. Although unexpected events may necessitate missing an appointment, if you miss 2 appointments without following the cancellation protocol then you may be charged $25.00. If you miss 3 appointments without following the cancellation protocol, you may be dismissed from the practice.

5. **Sick Visits** - Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to see another provider.

6. **Medication Refills** - For non-emergency, and routine medication refills, ask your pharmacy to send us a refill request and please allow 48 hours. If you need a 90-day prescription for routine medication refills, please notify the nurse or your physician. Any and all narcotic medications (ex. Norco, ADD meds) require a 5-day notice prior to refill. Narcotic medications will only be written for a 30-day supply at a time. Additional refills to the original prescription will be at the doctor's discretion. Early refills will not be given. You may be requested to contact your pharmacy to ask them to fax a refill request to our office to assure that exact fill dates are documented accurately. You may also be asked for a follow-up appointment for certain refill requests.

As a courtesy, please turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

_____	_____	_____
Patient Printed Name	Last 4 of Social Security Number	Patient Date of Birth
_____	_____	
Patient Signature	Signature Date	
_____	_____	
Patient Representative (if patient unable to sign)	Signature Date	
_____	_____	
Printed Name of Patient Representative	Relationship to Patient	

PATIENT HIPAA ACKNOWLEDGEMENT/DISCLOSURE

PETERSON Medical Associates

I understand Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected health information ("PHI"). This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the person(s) designated below in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends. Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) Peterson Medical Associates, a covered entity (being a healthcare provider as defined by HIPAA), is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR §164.508.

I,_____ , hereby authorize Peterson Medical Associates to disclose the following information:
Print Patient Name

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future, and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person(s) or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give full authorization to ANY protected medical information to the person(s) named in this authorization.

By signing this authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person(s) whose name(s) are written below, and the information, once disclosed, will no longer be protected by the rules created in HIPAA. This authorization shall remain in effect until my WRITTEN MODIFICATION and/or REVOCATION is received by Peterson Medical Associates.

AUTHORIZED INDIVIDUALS TO RECEIVE MY PROTECTED HEALTH INFORMATION (PHI)

COMPLETION OF THIS BOX REQUIRED

Approval to leave detailed message on my home (❑Yes ❑No), cell (❑Yes ❑No), work phone (❑Yes ❑No) listed below:

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

1ST Contact:	Last Name:	First Name:	Relationship:
Home Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No		Cell Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No	
Work Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No		Other Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No	
2nd Contact:	Last Name:	First Name:	Relationship:
Home Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No		Cell Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No	
Work Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No		Other Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No	
3rd Contact:	Last Name:	First Name:	Relationship:
Home Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No		Cell Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No	
Work Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No		Other Phone: *Approval to leave detailed message on voice mail?* ❑Yes ❑No	

SIGNATURE OF CONSENT - COMPLETION OF THIS BOX REQUIRED

X _____
Patient/Legal Guardian Printed Name

_____
Patient/Legal Guardian Signature

_____
Patient Date of Birth

_____
Date Signed

PETERSON
Medical Associates

PATIENT CONSENT & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as a part of the provision of healthcare services, Peterson Medical Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnosis(es), treatment, and any plan(s) for future care or treatment.

The Notice of Privacy Practices which provides a more complete description of the uses and disclosures of certain health information is posted on the first floor at 575 Hill Country Drive in the foyer. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy of facsimile of this consent is as valid as the original
3. I have the right request that the use of my protected health information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my protected health information which have been previously agreed upon.

_____	_____	_____
Patient Printed Name	Last 4 of Social Security Number	Patient Date of Birth
_____	_____	
Patient Signature	Signature Date	
_____	_____	
Patient Representative (if patient unable to sign)	Signature Date	
_____	_____	
Printed Name of Patient Representative	Relationship to Patient	

PATIENT MEDICATION LIST

PETERSON
Medical Associates

Patient Printed Name	Patient Date of Birth	Today's Date

Allergic to: _____

_____

_____

Medication Name	Dose (i.e., mg or mcg)	How taken? (mouth, injection)	How many times taken per day?

PETERSON
Medical Associates

NEW PATIENT HEALTH HISTORY

PATIENT NAME (IN FULL) DATE OF BIRTH: TODAY'S DATE:

YOUR FIRST VISIT

With which provider are you seeking to establish care?

What will we be seeing you for at your first visit?

ALLERGIES AND REACTIONS TO MEDICATIONS

Please list any allergic reactions or other adverse reactions you have had to any medications, including over-the-counter medications. Please specify what kind of reaction you had. (If you have had a reaction to penicillin, did it involve collapsing, difficulty breathing, or did it occur in less than an hour of taking penicillin?

❑ **Please check this box if you have had NO medication allergies or reactions**

ALLERGIES AND REACTIONS TO FOODS, LATEX, BEE STINGS, BITES, OR SUBSTANCES OTHER THAN MEDICATIONS

Please write down any reactions or allergies you have had to things other than medications. Please specify what kind of reaction(s) you have had.

NAME OR TYPE OF SUBSTANCE	KIND OF REACTION	SEVERE (YES or NO)	YEAR

DISEASE PREVENTION

VACCINE	YES	NO	YEAR	VACCINE	YES	NO	YEAR
Chickenpox (Varicella)				Mumps, Measles, Rubella (MMR)			
COVID-19 Initial Dose				Pneumonia 13			
COVID-19 Booster				Pneumonia 23			
Flu				Polio			
Gardasil				Shingles			
Hepatitis A				Tetanus			
Hepatitis B				Other Vaccine:			
Meningococcal				Other Vaccine:			

HEALTH MAINTENANCE

SCREENING TEST	YES	NO	YEAR	SCREENING TEST	YES	NO	YEAR
Eye exam				Chest x-ray			
Colonoscopy				Bone Density (Dexascan)			
Pap Smear				Mammogram			
EKG				Prostate Exam			
Endoscopy (EGD)				Heart Catheterization			
Cardiac Stress Test				HIV Test			

MAJOR INJURIES ~ Include any head trauma and Fractures

TYPE OF INJURY	WHERE IT WAS TREATED	COMPLICATIONS	YEAR

HOSPITALIZATIONS FOR REASONS OTHER THAN SURGERY

REASON FOR HOSPITALIZATION	YEAR	REASON FOR HOSPITALIZATION	YEAR

SURGICAL OPERATIONS YOU HAVE HAD IN THE PAST					
SURGERY	WHO/WHERE PERFORMED	YEAR	SURGERY	WHO/WHERE PERFORMED	YEAR
❑ Gallbladder Surgery			❑ Spine/Neck surgery		
❑ Appendectomy			❑ Hip or knee surgery		
❑ Hernia (what kind?)			❑ Vasectomy		
❑ Hysterectomy			❑ Tubal Ligation		
❑ Remove ovary(ies)			❑ Cataract Surgery		
❑ Cancer Surgery (specify):					

OTHER PHYSICIANS AND SPECIALISTS

List any other physicians below (i.e., Gynecologist, dermatologist, orthopedics, urologist, psychiatrist, etc.

PERSONAL & FAMILY HEALTH HISTORY

Place a check mark in the appropriate column if YOU or any of your IMMEDIATE RELATIVES (parents, children, brothers or sisters) currently have or have had any of these conditions:

CONDITION	SELF	FAMILY MEMBER	CONDITION	SELF	FAMILY MEMBER
AIDS			Hepatitis (If so, what type: A, B, C, other?)		
Alcohol addiction or other alcohol problems			High blood pressure		
Any other cancer, lymphoma, leukemia, etc.			High Cholesterol		
Asthma, COPD or emphysema			HIV positive		
Attention deficit hyperactivity disorder (ADHD)			Hormone replacement therapy		
Bipolar disorder			Kidney failure		
Bleeding or hemophilia			Kidney stones		
Bleeding ulcers or stomach ulcers			Low or high thyroid levels		
Blood clots			Migraines		
Breast cancer			Obesity		
Cervical cancer			Ovarian cancer		
Chemical dependence or substance abuse			Polycystic kidneys		
Colitis or inflammatory bowel disease			Positive test for syphilis/STI (herpes, gonorrhea)		
Colon cancer			Prostate cancer		
Colon polyps			Rheumatoid arthritis or lupus		
Depression requiring counseling or treatment			Schizophrenia		
Diabetes			Skin cancer (any type)		
Epilepsy or seizure disorder			Sleep apnea		
GERD			Tuberculosis		
Gout			Other:		

Heart attack, coronary bypass surgery, abnormal treadmill or stent placement			Any other disorder which may be inherited, specify:		

YOUR HOME AND YOUR SOCIAL SYSTEMS		
Do you live in an apartment or other multiple-family dwelling (assisted living, nursing home, etc.)?	❑ No	❑ Yes
Do you live by yourself?	❑ No	❑ Yes
Are you (check one) ❑ Married ❑ Single ❑Divorced ❑Widowed ❑ in a Civil Union		
What is your highest level of education?		
What type of exercises do you perform? Frequency? Duration?		
What are your hobbies?		
Do you have stairs in the home?	❑ No	❑ Yes
Do you have a living will?	❑ No	❑ Yes
(OPTIONAL) Do you have a religious preference? ❑ No ❑ Yes, specify:		

Do you drink alcohol?	If so, what type?	If so, # of drinks per week:
Do you use tobacco?	If so, what type?	If cigarettes, how many packs per day?
Did you previously use tobacco?	If so, what year did you quit?	If so, number of years smoked?
Have you ever used illicit drugs?	If so, what did you use?	If so, when was the last time you used?
Are you sexually active?	Do you have sex with ❑Men ❑Women ❑Both	How many partners in last 12 months?

REVIEW OF SYSTEMS (Please check any of the following symptoms you are currently experiencing)				
❑ Vision problems	❑ Hearing problems	❑ Sinus trouble	❑ Hay fever	❑ Nosebleeds
❑ Sore throat	❑ Hoarseness	❑ Lumps in neck	❑ Tooth problems	❑ Cough
❑ Coughing up blood	❑ Wheezing	❑ Asthma/COPD	❑ Emphysema	❑ Bronchitis
❑ TB Exposure	❑ Chest pain	❑ Chest discomfort	❑ Shortness of breath	❑ High blood pressure
❑ Diabetes	❑ High cholesterol	❑ Lumps in breast	❑ Breast discharge	❑ Trouble swallowing
❑ Nausea	❑ Vomiting	❑ Abdominal pain	❑ Hepatitis/Jaundice	❑ Gallstones
❑ Diarrhea	❑ Constipation	❑ Blood in stool	❑ Frequent urination	❑ Incontinence
❑ Blood in urine	❑ History of STD/STI's	❑ Anemia	❑ Easy bruising	❑ Pain in legs
❑ Joint pain/stiffness	❑ Blood clot(s)	❑ Weight loss	❑ Weight gain	❑ Heat intolerance
❑ Cold intolerance	❑ Excessive hunger	❑ Excessive thirst	❑ Weakness	❑ Fatigue
❑ Fever	❑ Sweating	❑ Fainting	❑ Seizures	❑ Tremors
❑ Headaches	❑ Numbness/Tingling	❑ Anxiety/Depression	❑ Difficulty sleeping	❑ Other:

PETERSON
MEDICAL ASSOCIATES

Authorization to Use or Disclose Medical Records

Patient Name:		Patient Date of Birth:	
Patient Address:	City:	State:	Zip Code:

Person or Entity Authorized to **RELEASE INFORMATION**:	Person or Entity Authorized to **RECEIVE INFORMATION**:
Name: _____ Address: _____ City, State, Zip Code: _____ Phone Number: ( ) _____ Fax Number: ( ) _____	Name: _____ Address: _____ City, State, Zip Code: _____ Phone Number: ( ) _____ Fax Number: ( ) _____

Specific information to be disclosed:
❑ Medical record from (insert date) _____ to (insert date) _____
❑ **ENTIRE** medical record, **INCLUDING** patient histories, office notes (except psychotherapy notes and inclusions not chosen below), test results, radiology studies, referrals, consults, and records received from other providers.
❑ Other medical records (specify): _____

Include (Indicate by checking **AND** initialing):	Reason for release of information (check all that apply):
❑ _____ Drug/alcohol/substance abuse records ❑ _____ Mental health records (except psychotherapy notes) ❑ _____ HIV/AIDS information (Including HIV/AIDS tests and/or results) ❑ _____ Genetic information	❑ Continuation of medical care ❑ Personal use ❑ Legal purposes ❑ Insurance purposes ❑ Other (specify): _____

This authorization shall remain in effect until for 12 months from the date signed or on the following specified date:
Month: _____ Day: _____ Year: _____

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

My signature indicates I have read and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ Patient Signature/Legally Authorized Representative	_____ Relationship to Patient	_____ Today's Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ Signature of Minor Patient	_____ Printed Patient Name	_____ Today's Date
_____ Witness Signature	_____ Printed Witness Name	_____ Today's Date