McCart Medical Assoc.

Ronald Stewart, D.O., P.A.
Internal Medicine

Angelene Stewart, D.O.
Internal Medicine

We at McCart Medical Associates are pleased that you have selected us for your medical care. Currently we have 4 providers that are available to you to help manage and direct your health care needs. Your health care providers are, Dr. Ronald Stewart and Dr. Angelene Stewart along with our Nurse Practitioners, Angelita Nwaokelemeh, FNP-C , Vimala Ravi, FNP-BC, and LaKeisha Alexander, FNP-C.

Our Nurse Practitioners are board certified, licensed providers that were personally selected by Dr. Ronald Stewart and Dr. Angelene Stewart to provide and manage your medical care.

What is a Nurse Practitioner?

A Nurse Practitioner is a board-certified medical professional who is licensed to provide and manage your medical care. A nurse practitioner begins their career as a registered nurse where they gain valuable experience in a range of healthcare settings, then progresses into a rigorous advanced training program to attain both the education and the licensing to become a nurse practitioner. In the state of Texas, nurse practitioners practice independently in collaboration with physicians in the office. Nurse Practioners are able to write and refill prescriptions, order and interpret tests as well as make diagnoses and treat acute and chronic conditions.

McCart Medical Associates looks forward to creating a bond to work collaboratively with you to improve and meet your health care needs.

I have read and understand the above:

_____

Signature Date

7120 McCart Avenue • Fort Worth, Texas 76133 • (817) 294-5624 • Fax (817) 294-4711

McCart Medical Associates

Patient Name:_____ DOB:_____ Sex:_____

Address:_____ City:_____ Zip:_____

Primary Phone#:_____ Secondary Phone#_____

Employer Name:_____ SS#:____-____-____ MaritalStatus:_____

DL#_____ _____ Expiration Date:_____ Race:_____
(State)

Pharmacy Name: _____ Phone#:_____

****

In Case of an Emergency Contact:_____

Phone:_____ Relationship:_____

****

Primary Insurance:_____Phone:_____

ID#_____ Group#_____ Subscriber Employer:_____

Subscriber Name:_____ DOB:_____ SS#____-____-____
(insured or card holders name)

Claims Address:_____ City_____ Zip:_____

Secondary Insurance:_____ Phone:_____

ID#_____ Group#_____Subscriber Employer:_____

Subscriber Name:_____ DOB:_____ SS#____-____-____
(insured or card holders name)

Claims Address:_____ City:_____ Zip:_____

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Release of Medical Information: I hereby consent and authorize McCart Medical Associates to release any medical information in connection with the services rendered for determination of benefits/ or collection of said benefits from my health insurance carrier. **I understand that if my insurance does not pay due to incorrect or lack of information I have given on this form, I will be fully responsible for the amount billed.**

****MISSED APPOINTMENTS:** As a courtesy to the patients that need to be seen, please give 24 hour notice if you need to cancel your appointment. A $35 fee will be charged to you for appointment cancellation with less than 24 hour notice or a no show. **This fee is NOT covered by your insurance** and will be due before your next date of service.

Signature:_____ Date:_____

OFFICE POLICIES

MISSED APPOINTMENTS: As a courtesy to the patients that need to be seen, please give 24 hour notice if you need to cancel your appointment. If you do not give 24 hours notice you will be charged a **NO SHOW FEE OF $35** that is **NOT covered by your insurance** and will be due before your next date of service.

CALLS TO THE OFFICE: Our nursing staff will handle your questions regarding your medical care and/or test results as time permits between patients. Please remember that on clinic days our priority is to see patients in the office promptly and without interruption. Emergency calls will be handled on first priority basis. If you have an emergency that can not wait, we ask that you go to the nearest emergency room or call our office for an appointment.

PRESCRIPTION REFILLS: Please call your pharmacy for refills. **Allow 5 to 7 business days for nursing staff to respond.** NO PRESCRIPTIONS WILL BE GIVEN AFTER HOURS OR ON THE WEEKENDS WITHOUT AN EMERGENCY ROOM VISIT.

PROFESSIONAL FEES: The office will bill your primary insurance company for services provided, collecting only your co-pay or outstanding deductibles. The patient is ultimately responsible for filing any secondary insurance (except medicare). Payment of co-payments, deductibles, and services rendered to non insured patients are due at the time of service. Procedure co-pays and deductible amounts are collected at the time of your pre-op visit. Our staff can give you an estimate of the approximate fee for the procedure. Please keep in mind that this is only an estimate.

EMERGENCY CALLS: If you have an emergency after hours you may call the regular office number. My staff or the answering service will reach me and your call will be returned as soon as possible. Since we do not have access to your chart after hours, the more detail that you can give the more we will be able to help you.

MEDICAL RECORDS: Copies of your medical records will be furnished to another physician at no charge upon the receipt of a proper medical release form. Copies of your medical records for your personal, legal or insurance use are furnished upon receipt of a proper medical release form and pre-payment of $35. Please allow 15-30 days for completion of these requests.

Ronald A. Stewart, D.O.
Angelene M. Stewart, D.O.

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

_____

Patient Signature Date

Authorization for the release of medical records

Patient Name (print): _____

Date of Birth: _____

I, the undersigned, hereby authorize the release of my medical records from

Doctor, Clinic Name or Hospital: _____

Address: _____

Phone: _____ _____ Fax: _____

Medical Information covering the period of:

_____ to _____

Please release:

Copy of Entire Record: _____

Doctor's Notes: _____

Lab/X-Ray results: _____

Other (Specify): _____

_____

Reason for Release:

_____

The above information to be released to

McCart Medical Associates
Dr. Ronald Stewart
Dr. Angelene Stewart
7120 McCart Ave
Fort Worth, TX 76133
817-294-5624 (phone)
817-294-4711 (fax)

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. I also understand that I may revoke this authorization at any time to the extent that action has been taken in reliance on it and that, in any event, this authorization will expire sixty days from the date of my signature unless otherwise specified by date, event or condition as follows:

_____

_____ _____

Date Signature

Revised 9/12 AM

Ronald Stewart, D.O., P.A.

Angelene Stewart, D.O.

Consent to Release Information

This consent is to authorize that McCart Medical to release my personal health information to

(Name)	(Relationship)	(Number)
(Name)	(Relationship)	(Number)
(Name)	(Relationship)	(Number)

Signature of patient

Print Name

Today's Date

Insurance Waiver

This notice is to inform you(the beneficiary) that the following services, such as new patient establishment, new insurance with pre-existing clause, Physical Exams, Well Woman Exams or procedures may **or** may not be covered by your medical insurance benefits.

** **Services not covered by your medical insurance** **
will be the sole responsibilty of the patient.

I understand the above statement and agree that I will be responsible for the payment of the following services if not covered by my medical insurance.

Patient Signature/Guardian

Date

Print Name

Patient Name: _____ **Date of Birth** _____

Phone Number: _____ **Address** _____

Any recent hospitalizations? _____ **If so where and when?** _____

General/Constitutional

Patient complaining of

O Chills O Depression O Dizziness O Faintness O Fever
O Forgetfulness O Headaches O Sleep Loss O Weight Loss
O Nervousness O Numbness O Sweats O None

Gastrointestinal

Patient complaining of

O Poor Appetite O Bloating O Bowel Changes
O Constipation O Diarrhea O Excessive Hunger
O Excessive Thirst O Gas O Hemorrhoids
O Indigestion O Nausea O Rectal Bleeding
O Stomach Pain O Vomiting O Vomiting Blood
O None

ENT

Patient complaining of

O Bleeding Gums O Blurred Vision O Crossed Eyes
O Difficulty swallowing O Double vision O Ear ache
O Ear discharge O Hay fever O Hoarseness
O Loss of hearing O Nosebleeds O Persistent cough
O Ringing in ears O Sinus problems O Vision-flashes
O Vision-halos O None

Men Only

Patient complaining of

O Breast lump O Erection difficulties O Lump in testicles
O Penis discharge O Sore on penis
O Dribbling after urinating O Other O None

Women Only

Patient complaining of

O Abnormal Pap Smear O Bleeding between periods O Breast lump
O Extreme menstrual pain O Hot flashes O Nipple discharge
O Painful intercourse O Vaginal discharge O Pelvic pain
O Other O None

Musculoskeletal

Patient complaining of pain, weakness or numbness in

O Arms O Hips O Back
O Legs O Feet O Neck
O Hands O Shoulders
O Knees O None

Genitourinary

Patient complaining of

O Blood in Urine O Frequent Urination
O Lack of bladder control O Painful urination
O Difficulty urinating O incomplete emptying O None

Cardiovascular

Patient complaining of

O Chest pain O Irregular heart beat O Low blood pressure
O Poor circulation O Rapid heartbeat O Swelling of ankles
O Varicose veins O None

Skin

Patient complaining of

O Bruise easily O Hives O Itching
O Change in moles O Rash O Scars
O Sore that won't heal O Spider veins O Keloid scar
O None

Respiratory

O Shortness of breath O Cough O Coughing up blood O Sputum production
O wheezing O Shortness of breath on exertion

Patient Name: _____ **Date of Birth:** _____

Family History

Father: O Alive O Deceased O Diabetes O High Blood Pressure
O High Cholesterol O Cancer O Stroke O Lung Disease
O Fatal Heart Attack O Kidney Disease O Thyroid Disease
O Dementia O Other

Mother: O Alive O Deceased O Diabetes O High Blood Pressure
O High Cholesterol O Cancer O Stroke O Lung Disease
O Fatal Heart Attack O Kidney Disease O Thyroid Disease
O Dementia O Other

Maternal Grand Parents: O Alive O Deceased O Diabetes O High Blood Pressure
O High Cholesterol O Cancer O Stroke O Lung Disease
O Fatal Heart Attack O Kidney Disease
O Thyroid Disease O Dementia O Other

Paternal Grand Parents: O Alive O Deceased O Diabetes O High Blood Pressure
O High Cholesterol O Cancer O Stroke O Lung Disease
O Fatal Heart Attack O Kidney Disease
O Thyroid Disease O Dementia O Other

Brother(s): O Alive O Deceased O Diabetes O High Blood Pressure
O High Cholesterol O Cancer O Stroke O Lung Disease
O Fatal Heart Attack O Kidney DiseaseO Thyroid Disease
O Dementia O Other

Sister(s) : O Alive O Deceased O Diabetes O High Blood Pressure
O High Cholesterol O Cancer O Stroke O Lung Disease
O Fatal Heart Attack O Kidney DiseaseO Thyroid Disease
O Dementia O Other

Surgical History

Appendectomy	O Yes	O No
Back Surgery	O Yes	O No
Bladder surgery	O Yes	O No
Breast augmentation	O Yes	O No
Cataracts	O Yes	O No
Colon Surgery	O Yes	O No
Fractures	O Yes	O No
Gallbladder Surgery	O Yes	O No
Heart Surgery	O Yes	O No
Hernia Surgery	O Yes	O No
Hysterectomy	O Yes	O No
Knee Surgery	O Yes	O No
Prostate Surgery	O Yes	O No
Thyroid Surgery	O Yes	O No
Tonsillectomy	O Yes	O No
Tubal ligation	O Yes	O No
Vasectomy	O Yes	O No
Other	O Yes	O No

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7120 McCart Ave.
Fort Worth, Texas 76133
(Ph) 817-294-5624 (Fax) 817-294-4711

Acknowledgement and Acceptance of Privacy Notice and Practices (HIPAA)

You agree to permit your protected health information to be used and disclosed for purpose of treatment, payment and health care operations. For more details about the uses and disclosure please see our Privacy Notice.

We reserve the right to change our privacy policies described in the Privacy Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree with your request, but if we do, we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use or disclosures of your information.

I have read the Notice Of Privacy Practices and acknowledge it's contents.

I wish to be contacted in the following manner: (Check all that apply)

Home Phone#_____ Cell Phone#_____

□O.K. to leave message with detailed information.
□Leave message with call back number only.

Work Phone#_____

□O.K. to leave message with detailed information.
□Leave message with call back number only.

Patient (or guardian) signature:_____ Date:_____