GILBERT J. CUSTER, JR., M.D.
1101 S. Capital of Texas Hwy., Bldg. A, Suite 200, Austin, TX 78746

INITIAL EVALUATION: PAST, FAMILY, SOCIAL HISTORY (PFSH)

Patient Name:				**Age:**	
Date of service:		**Location of session(s):** Office		**Date of Birth:**	
Height:		**Current Weight:**		**Gender:**	☐ Male ☐ Female

Reason for today's visit:

YOUR PAST MEDICATL HISTORY

Check all that apply:	**Year Diagnosed**		**Year Diagnosed**
☐ Heart Disease		☐ Peptic Ulcer	
☐ Stroke		☐ Gastrointestinal Disorder	
☐ High Blood Pressure		☐ Head Injury, Seizures	
☐ Rheumatic Fever		☐ Migraines	
☐ High Cholesterol Levels		☐ Colon Disorder	
☐ Diabetes		☐ Liver, Hepatitis	
☐ Kidney Disease		☐ Sexually Transmitted Disease (HIV, Gonorrhea, etc.)	
☐ Thyroid or Glandular		☐ Other:	
☐ Asthma/Lung		☐ Other:	
☐ Cancer			
☐ Back or Spine Disorder			

GYN (WOMEN ONLY)
Age menses began: _____ Date of last menstrual cycle: _____ Birth Control method using: _____
Total # of Pregnancies: _____ Full term pregnancies: _____ Living Children: _____ Miscarriages: _____
Abortions: _____ Date of last pap smear: _____ Ever abnormal pap? _____
Date last mammogram: _____ Do you perform regular monthly self breast exams? ☐ Yes ☐ No

List all hospitalization, surgeries or serious illness and give dates:

Type:	**Year**	**Type:**	**Year**

Allergies/Reactions to meds, food, latex, etc: ☐ None ☐ Airborne/Household Only ☐ Allergies:

Current Medications: (Also include vitamins, over the counter, birth control, herbal medications)
(ex: Zoloft 50mg 1 ½ every morning) Prescribed by:

Previous Medications Tried:

Medication:	Dates of Treatment:	Reason Stopped:
(ex: Zoloft 50mg 1 ½ every morning	Jan 2018 – June 2018	ex: didn't work, head ache, increase anxiety, daytime sleepiness)

FAMILY HISTORY

	Age	List medical problems (state "none" if so) and cause of death if deceased	Deceased?
Father			☐ @ age:
Mother			☐ @ age:
Brother			☐ @ age:
Brother			☐ @ age:
Sister			☐ @ age:
Sister			☐ @ age:
Children			☐ @ age:

Has any member of *your family* had (check all that apply):

☐ Diabetes	☐ Sickle Cell Anemia	☐ Heart Disease
☐ Cancer	☐ Glaucoma	☐ High Cholesterol
☐ Rheumatoid Arthritis	☐ Migraine	☐ Asthma / Lung Disease
☐ Stomach Ulcer	☐ Inheritable Disorder	☐ Tuberculosis
☐ Stroke	☐ Mental Illness	☐ Blood Disease
☐ High Blood Pressure	☐ Colon Disease	☐ Thyroid Disease
☐ Epilepsy	☐ Alcohol / Drug Abuse	☐ Osteoporosis
☐ Gout	☐ Kidney Disease	☐ Hepatitis

Please explain any checked above:

SOCIAL HISTORY

What is your occupation? _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use History: ☐ Never ☐ Smoke(d) ☐ Dip/Chew(ed)

If **current** use: Packs/day: _____ How many years? _____ Motivated to quit? ☐ Yes ☐ No

If **previous** use: Quit when? _____ Smoked/dipped how many years? _____

Alcohol use: ☐ Yes ☐ No How many drinks / week? _____

Any **current** drug use: ☐ Yes ☐ No ☐ No Comment Explain: _____

Diet: ☐ Good (low cal, low fat, high fiber) ☐ Average ☐ Below Average (high calorie, high saturated fat, high white flour, white sugar, corn starch)

How many caffeinated drinks/day? _____

Exposure to toxic chemicals: _____

Foreign travel in the past 6 months (where)? _____

Exercise Routine (what, how much and how often): _____

_____

Major changes/stressors: _____

_____

Are you an organ donor? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

REVIEW OF SYSTEMS QUESTIONNAIRE

Are you <u>currently</u> experiencing any of the following (Please check all that apply):

- ☐ Fever
- ☐ Weight Change (☐ up ☐ down)
- ☐ Sleep Problems
- ☐ Drenching sweats at night
- ☐ Unexplained fatigue
- ☐ Problematic headaches
- ☐ Visual changes
- ☐ Wear glasses or contacts
- ☐ Peripheral vision loss
- ☐ Double vision
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Dizziness, spinning
- ☐ Bleeding gums
- ☐ Dentures
- ☐ Allergies
- ☐ Sinus problems
- ☐ Persistent hoarseness/voice change
- ☐ Frequent sore throats
- ☐ Nosebleeds
- ☐ Dental Problems, sores in mouth
- ☐ Excessive sneezing
- ☐ Loud snoring
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Waking abruptly short of breath
- ☐ Leg cramps during walking
- ☐ Fluttering in the chest (palpitation)
- ☐ Swallowing problem
- ☐ Early filling when eating
- ☐ Heartburn
- ☐ Nausea
- ☐ Abdominal pains
- ☐ Vomiting
- ☐ Jaundice
- ☐ Persistent feeling of need to pass stool
- ☐ Bright blood in stools
- ☐ Black tar-like stools
- ☐ Change in bowel habits
- ☐ Rectal pain
- ☐ Change in stool caliber/size
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach pain after fatty foods
- ☐ Indigestion
- ☐ Excessive gas
- ☐ Urine color change
- ☐ Painful urination
- ☐ Increased frequency of urine
- ☐ Loss of urinary control, leaking
- ☐ Blood in urine
- ☐ Change in ☐ sex drive or ☐ performance
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Significant Back Pain
- ☐ Muscle cramps
- ☐ Coldness of extremities
- ☐ Loss of muscle mass
- ☐ Foot pain
- ☐ Varicose veins
- ☐ Rashes
- ☐ Persistent sores
- ☐ Change in moles
- ☐ Itching
- ☐ Numbness
- ☐ Weakness/Paralysis
- ☐ Memory changes
- ☐ Anxiety, nervousness
- ☐ Coordination / balance problems
- ☐ Depression
- ☐ Appetite change ☐ up ☐ down)
- ☐ Passing out, fainting
- ☐ Stress
- ☐ Slurred speech
- ☐ Tremors
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Swollen lymph glands
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Dry skin
- ☐ Change in hair distribution
- ☐ Changes in hand size / feet size

Men:

- ☐ Urinary hesitancy
- ☐ Dribbling after urination
- ☐ Swelling / lump in testicle
- ☐ Awakening to urinate more than twice nightly
- ☐ Weak urine stream

Women:

- ☐ Hot flashes
- ☐ Irregular menses
- ☐ Severe menstrual cramps
- ☐ Heavy periods
- ☐ Pelvic pain
- ☐ Spotting between periods
- ☐ Breast lumps
- ☐ Breast pain
- ☐ Breast discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

History of:

- ☐ Abnormal chest x-ray
- ☐ Abnormal EKG
- ☐ Disability
- ☐ Heart murmur

PLEASE INITIAL: _____

PATIENT CONTACT INFORMATION

Patient First Name: _____ **MI:** _____ **Last:** _____

DOB: _____ Age: _____ Gender: ☐M ☐F Marital Status: ☐S ☐M ☐D

Parent(s) if minor: _____

Student Status: ☐Non-student ☐Full-Time ☐Part-Time School Name: _____

Other Family Members: _____

Employer: _____ Occupation: _____

Email: _____ ☐@gmail.com ☐@yahoo.com ☐Other: @_____

Preferred Contact Phone #: ( ) _____ **Ok to leave message?** ☐Yes ☐No

(circle one) ☐Patient's ☐Mom's ☐Dad's ☐Spouse's ☐Other's: _____

Secondary Contact Phone #: ( ) _____ **Ok to leave message?** ☐Yes ☐No

(circle one) ☐Patient's ☐Mom's ☐Dad's ☐Spouse's ☐Other's: _____

Current Mailing Address: _____ Apt #: _____

City/ST: _____ Zip: _____

New Mailing Address (eff: _____)

Address: _____ Apt #: _____

City/ST: _____ Zip: _____

New Mailing Address (eff: _____)

Address: _____ Apt #: _____

City/ST: _____ Zip: _____

Referred by: _____ Reason for Visit: _____

Family Physician: _____ Allergies: ☐None or _____

Pharmacy Information:

Pharmacy Name: _____

Address (or Intersection): _____

I authorize Dr. Gilbert Custer's office to electronically obtain access to my prescription history from participating pharmacies through the Surescripts Network.

_____ _____

Signed Date

_____ Relationship to Patient:

Printed Name ☐ Patient ☐ Parent / Guardian

_____ _____

Staff Member / Witness Signature Date Staff Member / Witness Printed Name

Emergency Contact Information

Emergency Contact Name: _____

Preferred Contact Phone #: ( ) _____ Ok to leave message? ☐Yes ☐No

Secondary Contact Phone #: ( ) _____ Ok to leave message? ☐Yes ☐No

PATIENT FINANCIAL INFORMATION

Dr. Custer's practice is private pay only. Payment in full is due at the time services are rendered.
We're happy to provide you with a walk out receipt to file for reimbursement from your insurance company.
Insurance companies do not usually cover the entire cost of the fees.
Any financial concerns should be discussed with the Doctor prior to services being rendered.

FEES AND PAYMENTS:

Initial Consultation: Child/Adolescent (2 x 1 hour appointments)		$680.00
Initial Consultation: Adult (1½ hour appointment)		$510.00
Follow up Medication Management with Psychotherapy:	20 – 30 minutes	$170.00
	45 minutes	$255.00
	50 – 60 minutes	$340.00
Other Clinical Services (telephone consults, reports, letters, consultations with family or others)		$85.00 per 15 min
Medical Records Copies (per Texas Medical Board Guidelines, Signed Release required)		$25.00 pg(s) 1 - 20; .50¢ per pg(s) 21+

APPOINTMENTS:

- Courtesy appointment reminder calls are made 2 business days in advance of your appointment.
- Appointments must be cancelled 24 hours in advance to avoid a missed appointment fee.
- **Patients who miss or don't cancel their appointment 24 hours in advance may be financially responsible for the full fee of the appointment.**
- **Missed appointment fees must be paid prior to the next appointment.**
- Patients who are consistently unable to keep their scheduled appointments will receive notification of discontinuation of services via postal service.

Patient Name: _____

Responsible Party Name (please print): _____

Billing Address: _____

City/ST: _____ Zip: _____

Preferred Contact Phone #:(_____) _____ ☐ Home ☐ Cell ☐ Work ☐ Ok to leave message?

If the responsible party will not be present at the time of services (i.e.: parent living out of town or not attending sessions with patient) or to keep a credit card on file for your visits, please provide a credit card number below:

☐ MC ☐ Visa ☐ Amex ☐ Discover CC #: _____

Expiry (MM/YY): ____/____ Billing address for above card: _____

Security Code: _____ City, State: _____ Zip Code: _____

Drivers License #: _____ ☐ Texas DL ☐ Other State: _____

Email (if you'd like a credit card receipt emailed to you**): _____@_____
**Please notify us immediately of any email address changes

By signing below, I acknowledge that I have read the above and agree to be personally responsible for all charges and I give my consent for medical treatment.

In agreement: _____ _____
Responsible Party Signature (Patient or Parent/Guardian) Date

Reviewed by: _____ _____
Office Staff Signature Date

I appreciate the opportunity to be of service to you. If you have questions, concerns, or suggestions regarding my practice, please feel free to discuss them with me. I'm always eager to hear your comments and will gladly answer any of your questions.

Complaints about physicians, as well as other licenses and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners: Attn: Investigation, 1812 Centre Creek Dr., Suite 300, POB 149134, Austin, TX 78714-9134. Assistance in filing a complaint is available by calling the following telephone number: (800)201-9353.
Se pueden presenter quejas acerjas acerca de medicos, asi tambien como de otras personas autorizadas y registradas por la Junata de Examinadores Medicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes medicos y acupenteristas, para su investigacion, en la siguente direccion: Texas State Board of Medical Examiners: Attn: Investigation, 1812 Centre Creek Dr., Suite 300, POB 149134, Austin, TX 78714-9134. Se pueden obtener ayunda para presenter una queja llamando al sigiente numero telefonico: (800)201-9353.

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CLIENT EMAIL & APPOINTMENT REMINDERS VIA TEXT CONSENT FORM
(Please complete if you'd like to correspond via email or receive appointment reminders via text message.)

Patient Name:_____ DOB: _____

Parent(s)/Legal Guardian Name if minor: _____

HIPAA (Health Insurance Portability and Accountability Act) was passed by the U.S. government in 1996 to establish privacy and security protections for health information. In their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. (You can find this information in a pdf (pg. 5634) on the U.S. DHHS website: http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf.)

Per these guidelines, the following are the risks and our policies for sending and/or receiving unencrypted email:

- Emails should include only routine matters that don't require an immediate response (like prescription requests, appointments, billing questions, etc.).
- **EMAILS ARE NOT APPROPRIATE FOR USE IN AN EMERGENCY.**
- Our office will try to reply to all emails within one business day, but we can't be responsible for technical issues or delays in message delivery by the service provider.
- **Please keep in mind that emails are not completely secure.**
- Our office is dedicated to keeping your medical record information confidential; however, due to the nature of email, third parties may have access to messages. Some popular email services (like Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email. (However, when our office sends a document attached to an email with sensitive information, our office will send it as an encrypted pdf protected with a passcode. A separate email will follow with the passcode to open your document.)
- Once the email is received by you, someone may be able to access your email account and read it.
- **When communicating from work (or with a work email), you should be aware that some companies consider email corporate property and your messages may be monitored.**
- Our office staff prints out all emails and files them in the medical record. Office staff may read email messages.
- Our office will not correspond via text message except by way of sending an appointment reminder two (2) business days prior to your scheduled appointment (if consented to below). Any replies to this text message will be converted into an email on our end.

_____I understand the risks of unencrypted email and hereby give permission to Dr. Custer's office to send personal health information via unencrypted email to the following email address:

_____@_____

_____I authorize Dr. Custer's office to send appointment reminders via text message to (and any number forwarded from or transferred to) the following cell phone number:

(_____) _____-_____

I understand that I may terminate this authorization by providing written revocation to Dr. Custer's office. I understand that I am responsible for updating Dr. Custer's office of any changes to my email address and/or cell phone number as listed above.

_____ _____
Signed Date

_____ Relationship to Patient:
Printed Name ☐ Patient ☐ Parent / Guardian

_____ _____
Staff Member / Witness Signature Date Staff Member / Witness Printed Name

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dr. Custer's Office reserves the right to modify the privacy practices outlined in the notice.

You may refuse to sign this acknowledgment

I have received a copy of the "Notice of Privacy Practices" for Dr. Gilbert Custer, Jr., M.D.

Patient Name: _____ DOB: _____

_____
Signature Date

_____
Printed Name

Relationship to Patient:
- ☐ Patient
- ☐ Parent / Guardian
- ☐ Other: _____

_____
Witness Signature Date

FOR OFFICE USE ONLY

Documentation of Attempt to Obtain Acknowledgment of Receipt of Notice of Privacy Practices

We attempted to obtain acknowledgment of receipt of our "Notice of Privacy Practices" on _____.
The acknowledgment was not obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other: _____

Name of Staff Member: _____ Date: _____