VALLEY VIEW
FAMILY MEDICAL CLINIC

Krystal Bewley, FNP-C
Polly Klement, FNP-C
Jill Buck, FNP-C
Lindsay Kirkwood, FNP-C
Chance Dingler, MD

909 North Frontage Rd
Valley View, TX 76272
Phone: 940-726-5750 | Fax: 940-726-5721

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

City and State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Gender: _____ Age: ____ SSN: _____

Email Address: _____ (required for patient portal account)

Ethnicity/Race: _____ Preferred Language: _____

Previous Physician (including location): _____

Preferred Pharmacy (including location): _____

Employer: _____ Employer Phone: _____

Parent/Guardian: _____ Parent/Guardian Date of Birth: _____

Emergency Contact Name & Phone: _____

How did you hear about Valley View Family Medical Clinic?: _____

I hereby authorize the release of medical information necessary to process my insurance claim and assign the doctor all payments from Medicare and other insurance carriers for services rendered. I also understand that I am responsible for the balance of my account. I understand and agree to the above conditions.

Patient Signature: _____ Date: _____

VALLEY VIEW
FAMILY MEDICAL CLINIC

Krystal Bewley, FNP-C
Polly Klement, FNP-C
Jill Buck, FNP-C
Lindsay Kirkwood, FNP-C
Chance Dingler, MD

909 North Frontage Rd
Valley View, TX 76272
Phone: 940-726-5750 | Fax: 940-726-5721

Patient Name: _____ Date of Birth: _____

ACKNOWLEDGE OF REVIEW OF PRIVACY PRACTICES

I hereby certify that I have been given the opportunity to review Valley View Family Medical Clinic's NOTICE OF PRIVACY PRACTICES, which explains how my protected health information will be used and disclosed. I understand that I am entitled to a copy of this document if I chose to have one.

COMMUNICATION AUTHORIZATION
and RELEASE OF INFORMATION TO AUTHORIZED REPRESENTATIVES

I give Valley View Family Medical Clinic permission to:

Leave a message on your voicemail / home messaging system regarding appointments, lab results, imaging reports or other such diagnostic reports? ☐ YES ☐ NO

Contact me at work (in emergency circumstances only) with lab results, imaging reports, other diagnostic test results or urgent health issues? ☐ YES ☐ NO

Discuss your health care issues with any member of your family or other authorized persons that I chose and have listed below? ☐ YES ☐ NO

If yes, please list the person(s) that are authorized below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient or Representative: _____ Date: _____

VALLEY VIEW
FAMILY MEDICAL CLINIC
Rooted in Family. Focused on You.

940-726-5750
vvfmc.com
909 Frontage Rd.
Valley View, TX 76272

HEALTH HISTORY FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Today's Date: _____

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

Phone: _____ Email: _____ Preferred Pharmacy: _____

Occupation: _____ Employer: _____

1. PAST MEDICAL HISTORY

Please check any of the following conditions you have been diagnosed with:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Stroke / TIA
- ☐ Diabetes (Type 1 / Type 2)
- ☐ Thyroid Disorder
- ☐ Asthma / COPD
- ☐ Sleep Apnea
- ☐ GERD / Acid Reflux
- ☐ IBS / Digestive Disorder
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Chronic Pain
- ☐ Anxiety
- ☐ Depression
- ☐ ADHD
- ☐ Migraines / Headaches
- ☐ Seizure Disorder
- ☐ Cancer (Type: _____)
- ☐ Anemia
- ☐ Autoimmune Disorder
- ☐ Gout
- ☐ Allergies (Seasonal)
- ☐ Other: _____

Please list any other medical conditions not listed above:

_____

_____

Past Surgeries / Procedures (include date):

_____

_____

Hospitalizations (include date and reason):

2. FAMILY MEDICAL HISTORY

Please check any of the following that apply to your immediate family (parents, siblings, children):

CONDITION	MOTHER	FATHER	SIBLINGS	CHILDREN
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Mental Health Disorder	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

Additional family history information:

_____

_____

_____

CURRENT MEDICATIONS (Prescription, OTC, Vitamins, Supplements)

	MEDICATION NAME	DOSAGE (How much do you take)	FREQUENCY (How often)	QUANTITY (How much do you have)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Medication Allergies (please list medication and reaction): _____

Other Allergies (food, environmental, etc.): _____

Thank you for providing this information.
It helps us provide you with the best possible care.

VALLEY VIEW
FAMILY MEDICAL CLINIC
Rooted in Family. Focused on You.

940-726-5750
vvfmc.com
909 Frontage Rd.
Valley View, TX 76272

HEALTH HISTORY FORM

3. PREVENTATIVE SCREENINGS

SCREENING	DATE (MO/YR)	RESULTS	WHERE DONE
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Colonoscopy	_____	_____	_____
Bone Density (DEXA)	_____	_____	_____
Prostate Screening (PSA)	_____	_____	_____
Eye Exam	_____	_____	_____
Dental Exam	_____	_____	_____
Immunizations	_____	_____	_____

4. SOCIAL HISTORY

TOBACCO USE

- ☐ Never
- ☐ Former (Quit date: _____)
- ☐ Current
  - Type: _____
  - How much: _____

DRUG USE

- ☐ Never
- ☐ Former
- ☐ Current
  - Type(s): _____

ALCOHOL USE

- ☐ Never
- ☐ Occasional
- ☐ Moderate ( ) drinks per week
- ☐ Heavy ( ) drinks per week

CAFFEINE USE

- ☐ Never
- ☐ Occasional (1–2 servings per day)
- ☐ Moderate (3–4 servings per day)
- ☐ High (5+ servings per day)

Type: _____

DIET

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent

EXERCISE

- ☐ None
- ☐ 1–2 times per week
- ☐ 3–4 times per week
- ☐ 5+ times per week

Type of exercise: _____

How often: _____

LIVING SITUATION

- ☐ Live alone
- ☐ Live with spouse/partner
- ☐ Live with family
- ☐ Other: _____

SAFETY

Do you feel safe at home?

☐ Yes ☐ No

Do you have any concerns about:

- ☐ Falls
- ☐ Depression / Stress
- ☐ Other: _____

MARITAL STATUS

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Other: _____

5. ADDITIONAL INFORMATION

Is there anything else about your health that you would like us to know?

_____

_____

_____

FOR OFFICE USE ONLY

Reviewed by: _____ Date: _____

Thank you for providing this information.
It helps us provide you with the best possible care.

Rooted in Family. Focused on You.

VALLEY VIEW
FAMILY MEDICAL CLINIC

Polly Klement, FNP-C • Krystal Bewley, FNP-C • Jill Buck, FNP-C • Lindsay Kirkwood, FNP-C • Chance Dingler, MD

909 N. Frontage Rd, Valley View, TX 76272
Phone: 940-726-5750 • Fax: 940-726-5721

2026 TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Valley View Family Medical Clinic at 940-726-5750.
5. I understand that the laws that protect privacy and the confidentiality of healthcare information apply to telemedicine.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurance that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.
8. I understand my consent includes authorization for my provider to take a photograph/video of my visit to save in my file.

Patient Printed Name

Patient/Parent/Guardian Signature

Patient Date of Birth

Witness Signature

Date

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand, and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

VALLEY VIEW
FAMILY MEDICAL CLINIC

909 N Frontage Rd
Valley View, TX 76272
Phone: 940-726-5750
Fax: 940-726-5721

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I understand that my medical records are confidential and cannot be disclosed without my written authorization, except as otherwise provided for by law. I hereby voluntarily authorize Valley View Family Medical Clinic to obtain my medical information on my behalf. I understand that I may revoke this authorization at any time by notifying Valley View Family Medical Clinic in writing of my intent to revoke this authorization, and understand that such revocation will not have any effect on the actions taken by the office prior to the revocation. I understand that once my information is received that it may be disclosed by Valley View Family Medical Clinic to those with similar authorization. I understand that I may be asked to show proof that I have the authority to sign an authorization of this nature. I understand that I may be charged for copies of my records which I have requested for my personal use. I also understand that fees for copies are due and payable prior to copies being released. I understand that a photocopy or facsimile of this authorization is as valid as the original.

Patient Name: _____ Date of Birth: _____

Signature of Patient or Legally Authorized Representative: _____

Relationship to the Patient: ☐ self ☐ parent / legal guardian ☐ other (specify) _____

INFORMATION TO BE OBTAINED

From: _____

Fax: _____ Address: _____

Dates of Records: _____

Types of Information:

- ☐ All previous medical records
- ☐ Records from recent hospital stay / ER visit
- ☐ Office note from most recent visit
- ☐ Imaging
- ☐ Lab reports
- ☐ Other

Request processed by: _____ Date: _____

VALLEY VIEW
FAMILY MEDICAL CLINIC

Valley View Family Medical Clinic - Office Policies

Prescription Refill Policy-

- When you require a refill of your medication, please call your pharmacy and have them send us a prescription refill request to our office, even if you are out of refills. This is the most efficient way to process a refill.
- Please allow 48 hours for refills to be processed. To ensure that you do not run out of your medication, please plan ahead and do not wait until you are out of medication to request a refill.
- If you are due for a follow up appointment or have missed a scheduled appointment, we are not obligated to refill your medication. Please discuss with your provider at each visit about when you are due back in the office for a follow up visit.

Telephone Message Policy-

- When leaving a message for our office staff we must pull your chart, review your records, discuss a plan of action with the provider, and create legal documentation for the phone call. Please allow an adequate amount of time to return your call so that we may provide the best possible care. If you are experiencing an emergency, please do not hesitate to call 911 or go to the nearest emergency room.

Outpatient Testing and Referrals Policy-

- Please allow 24 to 48 hours for our staff to arrange non-emergency testing / imaging and to process any referrals to specialists. This time is needed to send your records and for the facility receiving your orders to make arrangements with your insurance company. If you have an HMO insurance plan, referrals require prior authorization. This process can take up to 5 business days to complete.
- We often send orders directly to outside facilities so that they may contact you to make appointment arrangements. If you have not heard from their office / facility in 48 hours, please contact us so that we can check on the status of your appointment.
- When we receive your test results you will receive a phone call from our office staff with a preliminary report. Please remember that this courtesy call should not be considered a follow up and does not take the place of a face to face appointment with the provider if indicated.

Lab services-

- As a convenience for our patients, we act as a draw site for CPL, Labcorp, and Quest. We will send your insurance information to the lab and they will bill for your lab testing. It is your responsibility to be aware of your lab benefits through your insurance policy. Self pay rates are available for those without insurance. If you have any questions regarding the cost of labs, please speak to our office staff.

Financial Policy-

- If you have an insurance policy that we are in network with, we will be glad to file a claim on your behalf. If you are self pay or your insurance requires a copay, coinsurance, or deductible payment, the full amount due as well as any past due balances are due at the time of service and will be collected before seeing the provider. If you have any questions or concerns regarding billing please let us know so that we may get you in contact with Byrum Medical Solutions, LLC, as they are our billing company.
- There is a $25 fee payable by patient for all NO CALL/NO SHOW appointments.

Controlled Substance Policy-

- In order to provide safe medical care as well as conform to the guidelines of the Drug Enforcement Agency, all controlled substance medication will require routine face to face follow up appointments for prescription refills. Examples of these types of medications include, but are not limited to: pain medication, sleep medication, benzodiazepine anxiety medications, testosterone, and stimulant medications such as diet medication and medications that treat ADD/ADHD. Some of these types of medications may also require additional medication specific consents to be signed as well.

I hereby certify that I have read the policies of Valley View Family Medical Clinic, have been given the opportunity to ask questions, and I fully understand and agree to the policies as stated above.

Patient Name: _____ Signature: _____ Date: _____