



1960

Physician Associates

PCP & INTERNAL MEDICINE

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Marital Status: Married Single Divorced Widowed

Sex: Female Male Transgender

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other Declined

Language: English Spanish Other: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined

Social Security Number: _____ - _____ - _____

RESPONSIBLE PARTY INFORMATION (If not self)

(Information used for patient balance statements)

Responsible party: Another patient Guarantor Self

Check here if address and telephone information is same as patient

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: ____/____/____

Sex: Female Male

Social Security Number: _____ - _____ - _____

Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

Primary Insurance: _____ Member ID: _____ Group Number: _____

Secondary Insurance: _____ Member ID: _____ Group Number: _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____

Emergency contact relationship to patient: _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____



MEDICAL HISTORY

Name: _____ DOB: _____ Date: _____

PAST MEDICAL HISTORY:

- ___ Allergies ___ Blood clots ___ Gallbladder disease ___ MI (heart attack)
___ Anemia ___ Cancer, Type ___ GERD (reflux) ___ Osteoarthritis
___ Angina (chest pain) ___ CVA (stroke) ___ Hepatitis C ___ Osteoporosis
___ Anxiety ___ COPD (emphysema) ___ High cholesterol ___ Peptic ulcer disease
___ Arthritis ___ CAD (heart disease) ___ High blood pressure ___ Renal disease (kidneys)
___ Asthma ___ Crohn's disease ___ Irritable bowel syndrome ___ Seizure disorder
___ Atrial fibrillation ___ Depression ___ Liver disease ___ Thyroid disease
___ BPH (enlarged prostate) ___ Diabetes ___ Migraine headaches ___ AIDS/HIV

SURGERIES: (Indicate the DATE/YEAR if known)

- ___ Angioplasty ___ Colectomy (colon removed) ___ Pacemaker
___ Colostomy ___ Small bowel resection ___ Thyroidectomy
___ Appendix ___ Gastric bypass ___ Tonsillectomy
___ Arthroscopy knee ___ Hernia repair ___ Tympanoplasty
___ Back surgery ___ Hip replacement
___ CABG (open heart surgery) ___ Knee replacement
___ Carpal tunnel release ___ LASIK
___ Cataract ___ Liver biopsy
___ Cholecystectomy (gallbladder) ___ Mastoidectomy
___ Ear tube/BMT

Gender Specific Female:

- ___ Breast augmentation
___ Bilateral tubal ligation
___ Breast biopsy
___ Cesarean section
___ D & C
___ Hysterectomy
___ Mastectomy
___ Breast reduction

Gender Specific Male:

- ___ Prostatectomy
___ TURP
___ Vasectomy

ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY:

FAMILY HISTORY:

Table with 6 columns: Mother, Father, Sister, Brother, Other and 16 rows of medical conditions.

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SOCIAL HISTORY:

Tobacco Use Details

- ___ Current everyday smoker ___ Light tobacco smoker
___ Current some day smoker ___ Never smoker
___ Former smoker ___ Smoker, status unknown
___ Heavy tobacco smoker ___ Unknown if ever smoked

Alcohol Use Details

- ___ Do not drink ___ Hx of alcoholism
___ Drink daily ___ Occasional drink
___ Frequent drink

Illicit Drug Use

- ___ Intravenous drug use ___ Illicit drug use ___ No illicit drug



REVIEW OF SYSTEMS

Name: _____ DOB: _____ Date: _____

<p><u>GENERAL</u></p> <p><input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Chills <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Fatigue <input type="checkbox"/> Daytime drowsiness <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Anorexia</p>	<p><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Difficulty breathing at rest <input type="checkbox"/> Difficulty breathing with activity <input type="checkbox"/> Difficulty breathing when laying down <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Shortness of breath during sleep <input type="checkbox"/> Lower extremity edema <input type="checkbox"/> Varicosities</p>	<p><u>SKIN</u></p> <p><input type="checkbox"/> Dry hair <input type="checkbox"/> Brittle hair <input type="checkbox"/> Hair loss <input type="checkbox"/> Dry skin <input type="checkbox"/> Itching <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Bruising <input type="checkbox"/> New moles <input type="checkbox"/> Skin sores <input type="checkbox"/> Skin lumps</p>
<p><u>EYE, EAR, NOSE, MOUTH & THROAT</u></p> <p><input type="checkbox"/> Change in vision <input type="checkbox"/> Loss of vision <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Eye redness <input type="checkbox"/> Eye pain <input type="checkbox"/> Tearing <input type="checkbox"/> Purulent discharge <input type="checkbox"/> Difficulty hearing <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear pain/earache <input type="checkbox"/> Tinnitus <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Nosebleed <input type="checkbox"/> Sneezing <input type="checkbox"/> Snoring <input type="checkbox"/> Lip/mouth/tongue sores <input type="checkbox"/> Sore throat <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Painful swallowing <input type="checkbox"/> Gum bleeding <input type="checkbox"/> Dental problems <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Change in voice quality</p>	<p><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> Abdominal pain <input type="checkbox"/> Rectal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Flatulence <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fecal incontinence <input type="checkbox"/> Clay-colored stools <input type="checkbox"/> Greasy stools <input type="checkbox"/> Tarry stools <input type="checkbox"/> Blood in stools <input type="checkbox"/> Foul smelling stools</p> <p><u>URINARY</u></p> <p><input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Increased urination <input type="checkbox"/> Decreased urination <input type="checkbox"/> Increased nighttime urination <input type="checkbox"/> Urge symptoms <input type="checkbox"/> Urinary incontinence</p> <p><u>HEMATOLOGIC</u></p> <p><input type="checkbox"/> Easy bruising <input type="checkbox"/> Difficulty stopping blood flow <input type="checkbox"/> Lymph node enlargement <input type="checkbox"/> Lymph node tenderness</p>	<p><u>NEUROLOGICAL</u></p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> Vertigo <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Fainting <input type="checkbox"/> Blackouts <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tremor <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Weakness <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Memory loss <input type="checkbox"/> Difficulty concentrating</p> <p><u>GENITAL/REPRODUCTIVE</u></p> <p><input type="checkbox"/> Changes in libido <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Genial discharge</p> <p><u>MEN ONLY</u></p> <p><input type="checkbox"/> Erectile dysfunction</p> <p><u>WOMEN ONLY</u></p> <p><input type="checkbox"/> Breast lump <input type="checkbox"/> Breast pain <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Menorrhagia <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Excessive pain with menses <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Postmenopausal vaginal bleeding <input type="checkbox"/> Hot flashes</p>
<p><u>NECK</u></p> <p><input type="checkbox"/> Neck pain <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck lumps <input type="checkbox"/> Neck swelling</p> <p><u>RESPIRATORY</u></p> <p><input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Cough <input type="checkbox"/> Cough productive of sputum <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing</p>	<p><u>MUSCULOSKELETAL</u></p> <p><input type="checkbox"/> Muscle pain <input type="checkbox"/> Back pain <input type="checkbox"/> Tender joints <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Decreased muscle strength <input type="checkbox"/> Limp paralysis <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Limp</p>	<p><u>PSYCHIATRIC</u></p> <p><input type="checkbox"/> Change in mood <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Nervousness <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Hopelessness <input type="checkbox"/> Worthlessness <input type="checkbox"/> Delusions <input type="checkbox"/> Hallucinations</p>



WRITTEN NOTICE FOR FINANCIAL OBLIGATIONS

Name: _____ DOB: _____ Date: _____

This clinic is a hospital outpatient department of 1960 Physican Associates. Medicare requires us to inform you that you will incur a coinsurance liability to the hospital that you would otherwise not incur if the services were furnished in an entity that is not hospital-based and to provide you with a notice of your potential financial liability for the hospital service(s).

Financial Agreement

- I acknowledge, that as a courtesy, 1960 Physican Associates may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.
- I understand the actual amount of the coinsurance liability to the hospital may be different from any estimate provided.
- Actual coinsurance liability will be based on services rendered and subject to financial determination by Medicare program.
- Coinsurance liability for hospital services is separate from the Medicare coinsurance liability that may be owed for a physician or professional services rendered in conjunction with hospital services.

Third Party Collection. I acknowledge 1960 Physican Associates may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to 1960 Physican Associates any insurance or other third-party benefits available for health care services provided to me. I understand 1960 Physican Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to 1960 Physican Associates) I agree to forward all health Insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to 1960 Physican Associates by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for 1960 Physican Associates or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe. I expressly agree and consent that 1960 Physican Associates or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or 1960 Physican Associates or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have read the foregoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law and that I have received a copy of this notice.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Mark relationship(s) from list below:

- | | |
|---|--|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Guarantor |
| <input type="checkbox"/> Parent | <input type="checkbox"/> Healthcare Power of Attorney |
| <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Other (please specify): _____ |



ADVANCE DIRECTIVES INFORMATION SHEET

An **advance directive** is a legal document that tells your family, friends and healthcare professionals the care you would like to have if you become unable to make medical decisions. Through advance directives, you can make legally valid decisions about your future medical treatment.

You do not need a lawyer to complete your advance directives. However, you should be aware that each state has its own laws for creating advance directives.

There are three advance directives recognized in Texas:

- The **Texas Medical Power of Attorney** appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Your attending physician must certify in writing that you are unable to make health care decisions and file the certification in your medical record. If you would like more information and a copy of the Texas Medical Power of Attorney form, please ask the front desk staff.
- A **living will**, officially known in Texas as the Directive to Physicians and Family or Surrogates, describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will should be signed, dated and witnessed by two people, preferably individuals who know you well but are not related to you and are not your potential heirs or your health care providers. If you would like more information and a copy of the Directive to Physicians and Family Members form, please ask the front desk staff.
- The **Out-of-Hospital Do Not Resuscitate (DNR) order** provides you with the right to withhold or withdraw cardiopulmonary resuscitation (CPR) or other treatments such as defibrillation and artificial ventilation. If you would like more information and a copy of the Texas Department of Health Services Standard Out of Hospital Do Not Resuscitate form, please ask the front desk staff.

By creating an advance directive, you are making your preferences about medical care known before you are faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

In order to make your directive legally binding, you must sign it, or direct another to sign it, in the presence of two witnesses who must also sign the document.

It is our responsibility to inform all competent adult patients about Advance Healthcare Directives and ask whether they have one in place. The staff is instructed to know the different types of advance directives. All staff members know where to direct patients who have questions or want more information about advance directives. If a patient provides an advance directive to 1960 PHYSICIAN ASSOCIATES Physicians, the physicians and staff should know the patients' decisions related to treatment.



ADVANCE DIRECTIVES CONFIRMATION FORM

Name: _____ DOB: _____ Date: _____

Under Texas law you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas any person age 18 years or old who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

YES, I have an Advance Healthcare Directives (*select which advance directive you have below*).

Texas Durable Medical Power of Attorney

Living Will, officially known as the Directive to Physicians and Family or Surrogates

Out of Hospital Do Not Resuscitate (DNR)

****If you have selected YES, please provide a copy of your advance directive to the front office staff.*

NO, I do not have Advance Healthcare Directives (*select which advance directive you have below*). I understand that I can request more information about advance directives.

I have received the information sheet about advance directives.

I would like additional information about the three advance directives recognized in Texas.

Patient signature: _____ Date: _____



AUTHORIZATION TO COMMUNICATE AND DISCLOSE PROCTED HEALTH INFORMATION

Name: _____ DOB: _____ Date: _____

Notice of Privacy Practice/clinics

_____(Patient/Representative initials) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic 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. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	NAME	RELATIONSHIP	PHONE NUMBER
1			
2			
3			
4			

**This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.**

- I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
- I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.

Communications about My Healthcare

I agree the provider, or an agent of the provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinics health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

Patient signature: _____ Date: _____



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Section A: Required for all Authorizations for Release of PHI or Right to Access					
Patient Name:		Birth Date:		Social Security No. (optional):	
Patient's Address:		Requestor's Name/Phone Number (if patient is not the requestor):			
PHI Recipient Name:	Address/City/State/Zip			Phone Number:	
				Fax Number:	
PHI Sender Name:	Address/City/State/Zip			Phone Number:	
				Fax Number:	
<input type="checkbox"/> Release of Records <input type="checkbox"/> Request of Records					
Purpose of Disclosure:					
<input type="checkbox"/> Continued Care/Treatment <input type="checkbox"/> Disability <input type="checkbox"/> Attorney/Litigation <input type="checkbox"/> Other: _____					
Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in record <input type="checkbox"/> History and Physical <input type="checkbox"/> Consult Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Progress Notes		<input type="checkbox"/> Physician Orders <input type="checkbox"/> Laboratory <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Record		<input type="checkbox"/> Demographics <input type="checkbox"/> Rehabilitation Services <input type="checkbox"/> Special Test/Therapy <input type="checkbox"/> Itemized Bill/Claims <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initials) If not, applicable, check here <input type="checkbox"/>					
I understand that: <ol style="list-style-type: none"> 1. I may refuse to sign this authorization and my treatment will not continued upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings). 2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. 4. I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it. 5. I will receive a copy of this form after I sign it. 					
Section B: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Guardian/Patient Representative:				Date:	
Print Name of Patient's Representative:				Relationship to Patient:	