

PATIENT INFORMATION AND CONSENT

Patient Name

Legal First Name Legal Last Name Suffix Preferred Name

Today's Visit

What is the reason for your visit today?

Have you been treated at this office location before? Yes No

Have there been any changes to your information in the past 6 months? Yes No

Patient Demographics

Permanent Address Apt.# City State Zip

Phone # Social Security # Gender Birth Date

Language Marital Status Email Address (We will never rent or sell your email address—we value your privacy.)

Mailing/Alternate Address Alternate Phone #

Race: African American American Indian/Alaska Native Asian Hispanic Mixed Race White Other Refuse to Report

Ethnicity: Hispanic Not Hispanic Refuse to Report

Emergency Contact Information

Contact Name Phone # Relationship to Patient

Name of a Relative not Residing With You Phone #

Responsible Party's Information (if someone other than patient)

Legal Name of Responsible Party Address City State Zip

Primary phone number _____ SS# _____

Medical Insurance Information SELF PAY _____

Insurance Company Policy Holder's Name Policy Holder's Relationship to Patient

Policy Holder SSN Policy Holder DOB

Policy Holder's Address City State Zip

Patient Consent for Treatment

1. I voluntarily consent to all health care treatment and diagnostic procedures provided by Eventide Family Practice Clinic and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Eventide Family Practice Clinic.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Eventide Family Practice Clinic Notice of Privacy Practices.
3. I authorize payment of medical benefits to Eventide Family Practice Clinic physicians or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice, Financial Policy Notice and the Release of Information.

Yes
 No Initial _____

X _____ Date _____
 Patient or Authorized Person's
 Signature

Authorization for Release of Information

Eventide Family Practice Clinic is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Individual to Receive Information:
 (Check those that are ok to leave information with/to)

Information to be released

Name _____
 Name _____

Lab/Test results ___ yes ___ no
 Financial ___ yes ___ no
 Medical ___ yes ___ no

I authorize the use of any home answering machine or voice mail for any medical information and correspondence in reference to my medical records. I authorize the discussion of my symptoms or complaints with the medical staff. I authorize the discussion of treatment along with directions and instructions. (initial) _____

Patient Information

I understand that 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 as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

X _____ Description of Personal
 Signature of Patient or Personal Representative Representative's Authority

Eventide Family Practice Clinic
14026 FM 2100 Suite E, Crosby, Texas 77532
Office: 281-328-4888 Fax: 281-328-8345

Date _____

MEDICAL HISTORY FORM

Name _____ Sex M F DOB _____ Age _____

Previous surgery: (type and date) _____ **No surgery history to disclose** _____

PAST MEDICAL HISTORY: NONE TO DISCLOSE _____ **Yourself** _____ **Mother** _____ **Father** _____

		Living <u> </u> Y <u> </u> N	Living <u> </u> Y <u> </u> N
Heart Disease (heart attack, heart failure, abnormal rhythm)	___ Y ___ N	___ Y ___ N	___ Y ___ N
Hypertension (High blood Pressure)	___ Y ___ N	___ Y ___ N	___ Y ___ N
Mitral Valve Prolapse	___ Y ___ N	___ Y ___ N	___ Y ___ N
Pacemaker/defibrillator	___ Y ___ N	___ Y ___ N	___ Y ___ N
COPD	___ Y ___ N	___ Y ___ N	___ Y ___ N
Asthma	___ Y ___ N	___ Y ___ N	___ Y ___ N
Diabetes	___ Y ___ N	___ Y ___ N	___ Y ___ N
If yes insulin dependent	___ Y ___ N	___ Y ___ N	___ Y ___ N
Hepatitis	___ Y ___ N	___ Y ___ N	___ Y ___ N
If yes type	___ B ___ C	___ B ___ C	___ B ___ C
Jaundice	___ Y ___ N	___ Y ___ N	___ Y ___ N
Seizures	___ Y ___ N	___ Y ___ N	___ Y ___ N
Bleeding Tendency	___ Y ___ N	___ Y ___ N	___ Y ___ N
Deep Vein Thrombosis	___ Y ___ N	___ Y ___ N	___ Y ___ N
Glaucoma	___ Y ___ N	___ Y ___ N	___ Y ___ N
Cancer	___ Y ___ N	___ Y ___ N	___ Y ___ N
Arthritis	___ Y ___ N	___ Y ___ N	___ Y ___ N
Anesthesia reactions (If yes, please give details) _____			

Others: _____

Please list any other illness that required surgery, hospitalization or chronic treatment _____

SOCIAL HISTORY _____ **If child? Second hand exposure** _____ y _____ n

Do You Smoke? ___ Y ___ N If yes, How many per day? _____ Would you like to quit? ___ Y ___ N If Quite, When _____

Do you drink Alcoholic Beverages? ___ Y ___ N If yes how much _____ day/week.

Do you have a history of drug or alcohol abuse? ___ Y ___ N If yes, please describe. _____

FEMALES ONLY: Breast Cancer History: Self ___ Y ___ N **Mother or Sister** ___ Y ___ N
Pregnancy: How many? _____ **Live births** _____ **Type of delivery** _____ **Miscarriages** _____
Ages of children _____ **Onset of menses** _____ **Date of last menstrual cycle** _____

I attest that the information I have provided above is correct, complete and current, realizing that the medical care provided to me may be based on this information.

Signature Required _____ Date _____

How did you hear about us: Ad Mailing Friend/Family Other _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from a third party.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound and abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

Person whom information can be released to _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement of this *Notice of Privacy Practices* acknowledgement but was unable to do so as documented below.

Date	Initials	Reason
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Financial Policy and Disclosure

Please Sign and Date

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by Eventide Family Practice Clinic.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at discharge.

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- **If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due.**
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Overdue and Credit Balances

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a \$25 collection fee in addition to the account balance.

Divorce or Custody Case Policy

- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check-out associate or front desk.

Responsible Party's Signature _____

Date _____

Your cooperation is greatly appreciated.

CONSENT FOR TREATMENT BY A NURSE PRACTITIONER

I understand that this clinic is staffed by a full time Nurse Practitioner, Sandra Rasbeary, FNP-C. I understand that a Nurse Practitioner is not a licensed physician, but instead a specially trained, licensed, healthcare professional who works in collaboration and under the supervision of a physician to diagnose and treat patients. I hereby authorize Dr. Todd Husby, MD of Eventide Family Practice Clinic to instruct and assist Sandra Rasbeary FNP-C in certain aspects of my medical care. I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination and treatments.

Patient Signature (or authorized representative)

Date

Eventide Family Practice Patient Medication List

Date: _____

Update _____

Patient Name _____ DOB _____

Pharmacy of Choice _____ Phone Number _____

I do not take any medications

I am not allergic to any medications

Medication allergies: PCN Sulfa Morphine Codiene Latex

Others: _____

Medication List:

Medication Name	Dose	Times per day	Prescriber
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new right to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- * Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- * Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- * Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except in the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 21, 2008 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For more information about HIPAA or
To file a complaint:

Services

The U.S. Department of Health & Human

Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-675