**PATIENT HISTORY Today’s Date**

**Name**   **SSN**  **Date of Birth**

**Address**   **City** **State**  **Zip**

**Phone** **Cellular** **Work** **Email**

**Race**: Caucasian African American Asian Pacific Islander  **Ethnicity** **Language**

**Gender** : Male Female **Marital Status**: Single Partnered Married Divorced Widowed

**Primary Insured Name** **Date of Birth of Primary Insured**

**Insured Member Number** **Group Number**

**Emergency Contact** **Phone** **Relation**

**DRUG ALLERGIES** **REACTION**

**CURRENT MEDICATIONS & DOSAGE**

**HOSPITALIZATION or SURGERY**

Reason Date Reason Date

Reason Date Reason Date

Reason Date Reason Date

**Name** **PAST MEDICAL HISTORY**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **You** | | **Family** | | **Relationship** |  | **You** | | **Family** | | **Relationship** |
|  | **Y** | **N** | **Y** | **N** |  |  | **Y** | **N** | **Y** | **N** |  |
| Alcoholism |  |  |  |  |  | Gilbert’s Syndrome |  |  |  |  |  |
| Allergies |  |  |  |  |  | Hemophilia |  |  |  |  |  |
| Anemia |  |  |  |  |  | Hemorrhoids |  |  |  |  |  |
| Angina (chest pain) |  |  |  |  |  | Hepatitis |  |  |  |  |  |
| Anxiety |  |  |  |  |  | High Blood Pressure |  |  |  |  |  |
| Arthritis |  |  |  |  |  | High Cholesterol |  |  |  |  |  |
| Asthma |  |  |  |  |  | Human Papillomavirus |  |  |  |  |  |
| Atrial fibrillation |  |  |  |  |  | Irritable bowel disease |  |  |  |  |  |
| Auto-Immune Disorder |  |  |  |  |  | Kidney Disease |  |  |  |  |  |
| Bipolar Disorder |  |  |  |  |  | Lesch-Nyhan Syndrome |  |  |  |  |  |
| Blood clots |  |  |  |  |  | Liver Disease |  |  |  |  |  |
| BPH (enlarged prostate) |  |  |  |  |  | Lupus |  |  |  |  |  |
| CAD (heart disease) |  |  |  |  |  | Lymphedema |  |  |  |  |  |
| Canavan disease |  |  |  |  |  | Marfan Syndrome |  |  |  |  |  |
| Cancer, type |  |  |  |  |  | Meningitis |  |  |  |  |  |
| Charcot-Marie-Tooth-Disease |  |  |  |  |  | MI(heart attack) |  |  |  |  |  |
| Chronic Ulcer |  |  |  |  |  | Migraine headache |  |  |  |  |  |
| Color Blindness |  |  |  |  |  | Mitral Valve Prolapse |  |  |  |  |  |
| COPD |  |  |  |  |  | Multiple sclerosis |  |  |  |  |  |
| Crohn’s disease |  |  |  |  |  | Muscular Dystrophy |  |  |  |  |  |
| CVA (stroke) |  |  |  |  |  | Neurofibromatosis |  |  |  |  |  |
| Cystic Fibrosis |  |  |  |  |  | Noonan Syndrome |  |  |  |  |  |
| Depression |  |  |  |  |  | Osteoarthritis |  |  |  |  |  |
| Diabetes |  |  |  |  |  | Parkinson’s Disease |  |  |  |  |  |
| DVT |  |  |  |  |  | Peptic ulcer disease |  |  |  |  |  |
| Gallbladder disease |  |  |  |  |  | Polio |  |  |  |  |  |
| GERD (reflux) |  |  |  |  |  | Polycystic Kidney |  |  |  |  |  |
| GI Disorder |  |  |  |  |  | Polycystic Ovarian  Syndrome |  |  |  |  |  |
| Glaucoma |  |  |  |  |  | Seizure Disorder |  |  |  |  |  |
| Gout |  |  |  |  |  | Shingles |  |  |  |  |  |

**HABITS/LIFESTYLE**

Tobacco: YES NO How many packs a day?

Alcohol Consumption: YES NO How many glasses?

Recreational Drugs: YES NO What Kind?

Salt Intake Caffeine

Pharmacy Name Pharmacy Phone Number

**Release of Information**

I, , hereby give consent to Fulshear Medical Associates and his staff to access any and all medical records necessary for continuum of care. I understand that I may refuse, in writing, the release of any and all records per my right under HIPPA. I have been given the HIPPA information sheet and I understand when, where, and how the clinic may, in turn, release my information unless I specify otherwise.

Patient signature Date

I, , hereby give consent to the following persons to discuss my records, and/or results, with doctor and his staff if needed.

1. Relationship: Phone:
2. Relationship: Phone:
3. Relationship: Phone:
4. Relationship: Phone:

I understand that this authorization can be revoked, in writing, at any time and may apply to one or more of the persons.

Patient’s Signature Date

**Assignment of Insurance Benefits (All Insurance)**

I hereby authorize direct payment of surgical/medical benefits to Fulshear Medical Associates for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**Patients with Medicare-Medicaid**

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

*A photocopy of these assignments shall be valid as the original.*

Print Name

Patients Signature

Parent/Guardian

Date

**Consent for Treatment**

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Fulshear Medical Associates unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Fulshear Medical Associates infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Fulshear Medical Associates. If any of these situations occur during your treatment period.

Patient Printed Name Date of Birth

Patients/Guardian Signature Date

Relationship Date

**Controlled Substances**

Please be advised that effective October 1, 2014 only limited quantities of pain medications for acute pain will be prescribed. All patients being prescribed said medications will be asked to sign a pain management agreement. Failure to agree and comply with said terms on agreement will result in denial of such medications. Patients that require additional and/or long-term management of their pain symptoms will be referred to pain management for additional evaluation and treatment.

This notice shall also apply to patients seeking medications used to treat anxiety and ADHD, such as Adderall.

By signing this document I fully acknowledge that I have read and understand the above.

Patient Printed Name Date of Birth

Patients/Guardian Signature Date

Relationship Date

**HIPPA Notice of Privacy Practices**

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians' practice, and any other use required by law.

**Treatment:**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For Example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:**

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physicians ‘practice. These activities include, but are not limited to, quality assessment activities, Employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you byname in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization.

These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physicians' practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Following is a statement of your rights with respect to your protected health information:**

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Printed Name Date of Birth

Patients/Guardian Signature Date

Relationship Date

**Patient Rights and Responsibilities**

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

***You have the right to:***

* A personal clinician who will see you on an on-going, regular basis.
* Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
* A second medical opinion from the clinician of your choice, at your expense.
* A complete, easily understandable explanation of your condition, treatment and chances for recovery.
* The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
* Confidential management of communication and records pertaining to your medical care.
* Information about the medical consequences of exercising your right to refuse treatment.
* The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
* Be free from mental, physical and sexual abuse.
* Humane treatment in the least restrictive manner appropriate for treatment needs.
* An individualized treatment plan.
* Have your pain evaluated and managed.
* Refuse to participate as a subject in research.
* An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
* The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
* The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

***You are responsible for:***

* Knowing your health care clinician’s name and title.
* Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
* Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
* Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
* Signing a “Release of Information” form when asked so your clinician can get medical records from other clinicians involved in your care.
* Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
* Telling your clinician about any changes in your condition or reactions to medications or treatment.
* Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
* Following your clinician’s advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
* Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
* Paying copayments at the time of the visit or other bills upon receipt.
* Following the office’s rules about patient conduct; for example, there is no smoking in our office.
* Respecting the rights and property of our staff and other persons in the office.