FULSHEAR MEDICAL ASSOCIATES

PATIENT INFO **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**_____ **Employer**_____

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** _____

SOCIAL HISTORY

Tobacco: YES NO **How many packs a day?**_____

Alcohol Consumption: YES NO **How many glasses?**_____

Recreational Drugs: YES NO **What Kind?**_____

Salt Intake _____ **Caffeine** _____

FULSHEAR MEDICAL ASSOCIATES

Name _____ **PAST MEDICAL HISTORY**

	You		Family		Relationship		You		Family		Relationship
	Y	N	Y	N			Y	N	Y	N	
Alcoholism						Glaucoma					
Allergies						Gout					
Anemia						Hemophilia					
Angina (chest pain)						Hemorrhoids					
Anxiety						Hepatitis					
Arthritis						High Blood Pressure					
Asthma						High Cholesterol					
Atrial fibrillation						Human Papillomavirus (HPV)					
Auto-Immune Disorder						Irritable bowel disease					
Bipolar Disorder						Kidney Disease					
Blood clots						Liver Disease					
BPH (enlarged prostate)						Lupus					
CAD (heart disease)						Lymphedema					
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						Osteoarthritis					
CVA (stroke)						Parkinson's Disease					
Cystic Fibrosis						Peptic ulcer disease					
Depression						Polio					
Diabetes						Polycystic Kidney					
Gallbladder disease						Polycystic Ovarian Syndrome					
GERD (reflux)						Seizure Disorder					
GI Disorder						Shingles					

Pharmacy Name _____ Pharmacy Phone Number _____

Have you received any of the following screenings and/or vaccines? If yes, please provide with dates and medical records if available.

		Date			Date
	Mammogram			Flu shot	
	Pap smear			Pneumococcal	
	Colonoscopy			Shingles	
	Diabetic eye exam			Tdap	

FULSHEAR MEDICAL ASSOCIATES

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

FULSHEAR MEDICAL
ASSOCIATES

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

FULSHEAR MEDICAL ASSOCIATES

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

FULSHEAR MEDICAL ASSOCIATES

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

FULSHEAR MEDICAL ASSOCIATES

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.

Physician Assistant (P.A.) Consent Form

This office has on staff P.A. to assist in the delivery of medical care. A Physician Assistant is not a doctor.

A Physician Assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, a Physician Assistant can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, rather the overseeing of activities of and accepting responsibility for the medical services provided. A Physical Assistant may provide such medical services that are within his/her education, training, and experience.

These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I, _____ have read the above, and hereby consent to the services of a P.A. for my health care needs.

_____ _____

Patient Signature Date

FULSHEAR MEDICAL ASSOCIATES

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ Date of Birth:_____

Phone Number:_____ Social Security #:_____

Please Note: Copy Fee May Be Charged For Medical Records

The patient listed above request and authorizes the following healthcare facility to make record disclosure.

Facility Name: _____ Facility Phone:_____

Facility Address:_____ Facility Fax:_____

City, State, Zip: _____

Dates and Type of information to disclose:

- ☐ 2 Years prior from last date seen
- ☐ From: _____ to _____
- ☐ Specific Information requested:

_____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuity of care
- ☐ Referral
- ☐ Other:_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse.

This healthcare information may be disclosed and used by the following individual or facility:

Release To: Syed A. Abrar Facility Phone: 346-251-5901

Address: 19255 Park Row Dr. Ste 105 Facility Fax: 832-321-3516 City, State, Zip: Houston, TX 77084

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an authorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the authorized individual or facility making disclosure.

I have read the above foregoing authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ Date:_____

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

_____

Printed Name of Authorization Representative

_____ Relationship/ Capacity to Patient