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Patient Demographics/Patient History Form

Today's Date _____/_____/_____ Date of Last Physical Exam _____/_____/_____

Patient Demographics

First Name _____ Middle Initial ____ Last Name _____
Address _____ Apt # _____ City _____ State _____ Zip _____
Telephone (_____) _____-_____ Mobile # (_____) _____-_____ E-Mail _____
Date of Birth _____/_____/_____ Age _____ Height _____ Weight _____ SS# _____-_____-_____
Emergency Contact_____ Telephone (_____) _____-_____
Patient's Employer _____ Employer's Telephone (_____) _____ - _____
Spouse's Name _____ Spouse's Mobile # (_____) _____-_____
If patient is a minor, Mother's name _____ Father's Name _____

Insurance Information

Walk-In's/Appointments: Present your Primary Insurance card and Secondary Insurance card (if applicable) to the Receptionist.

For Patients Printing Forms from the Website and Faxing to the Clinic: Copy and fax your Insurance cards for the clinic to verify your insurance prior to your arrival which will expedite your visit.

Medical History

Have you had any of the following:

- □ Anemia
- □ Arthritis
- □ Asthma
- □ Blood Disease
- □ Cancer
- □ Chickenpox
- □ Circulation Problems
- □ Convulsions/Epilepsy
- □ Diabetes
- □ Gallbladder Problems
- □ Heart Problems
- □ Hemorrhoids
- □ Hepatitis
- □ Hernia
- □ Herpes
- □ High/Low Blood Pressure
- □ Malaria
- □ Measles
- □ Mumps
- □ Nervous/Emotional Breakdown
- □ Pleurisy
- □ Pneumonia
- □ Scarlet Fever
- □ Stomach
- □ Ulcers
- □ Thyroid (Goiter)
- □ Tonsillitis
- □ Tuberculosis
- □ Typhoid
- □ Varicose Veins
- □ Venereal Disease
- □ Whooping Cough
- □ Liver Problems
- □ Other _____

Do you have a disability? □ Yes □ No If yes, describe: _____

Female: Age of First Menstrual Period _____ Date of Last Menstrual Period _____/_____/_____
# of Days Between Periods _____ Menstrual Cramps □ Yes □ No
Date of Last Pap Smear___/___/___
Date of Last Mammogram ____/____/____ Type of Contraception_____ Postmenopausal □ Yes □ No

Male: Penal Discharge □ Yes □ No

Adult Immunizations: Flu ___/___/___Pneumonia ___/___/___ Tetanus ___/___/___ Other ___/___/___

Child Immunizations: (Please submit your Immunization Records with this form)
Are they Current? □ Yes □ No DPT _____/____/____ Polio _____/_____/_____
MMR ____/____/____ TB Test ____/____/____ Chickenpox ____/____/____ HIB ____/____/____

Hepatitis: □ Yes □ No If yes, Hepatitis A ____/____/____ or Hepatitis B ____/____/____
If Hepatitis B, have you had the 3 shot series? □ Yes □ No

Medical History (continued)

Illnesses/Injuries/Surgeries	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

List Allergies (medication, food, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

Social History

Have you ever smoked □ Yes □ No If yes, how much_____ How long _____ When did you quit_____

Do you drink alcoholic beverages □Yes □No I f yes, how often and much _____

Do you exercise □Yes □ No If yes, how often? _____ How long? _____

Advanced Directive □ Yes □ No Tattoo's □ Yes □ No

Family History

List which of your family is living or deceased and their medical condition(s):

Relative	Living/Deceased	Sex	Age	Cause of Death	Medical Conditions
Father	_____	____	____	_____	_____
Mother	_____	____	____	_____	_____
Sibling	_____	____	____	_____	_____
Sibling	_____	____	____	_____	_____
Sibling	_____	____	____	_____	_____

Have any of your family members had any of the following medical conditions?

□ AIDS
□ Allergies
□ Anemia/ Bleeding
□ Arthritis
□ Cancer
□ Chronic
□ Diabetes
□ Convulsions/ Epilepsy
□ Heart Disease
□ Hepatitis
□ Herpes
□ High Blood Pressure
□ Cough
□ Kidney Disease
□ Migraine
□ Nervous/Emotional Breakdown
□ Obesity
□ Paralysis/Stroke
□ Rheumatism
□ Rheumatic Fever
□ Tuberculosis
□ Venereal Disease
□ Other _____
_____
_____

THIS IS A CONFIDENTIAL RECORDS AND WILL BE KEPT AT **HealthCareClinics** IN YOUR FILE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

Patient Signature _____ Date ____/____/____

Medical Assistant Signature _____ Date ____/____/____

Physician/FNP/PA-C _____ Date ____/____/____

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Notice of Patient Privacy/Patient Consent Form

I understand that as part of my healthcare, the physicians of HealthCareClinics originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

HealthCareClinics *Notice of Privacy Practices* provides specific information and complete description of how my personal information may be used and disclosed. I understand that a copy of the *Notice of Privacy Practices* is available at the front desk and understand that I have the right to review the notice prior to signing this consent. I understand that HealthCareClinics reserves the right to change the *Notice of Privacy Practices.* Prior to implementation of the revised *Notice of Privacy Practices* , the revised *Notice* will be mailed to me if I provide my address below. I understand I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that HealthCareClinics is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that HealthCareClinics has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

NOTE: HealthCareClinics must obtain your written authorization to use your Private Health Information for any purpose other than treatment or billing. If you want HealthCareClinics to have access to disclose your Private Health Information to your spouse or any other person during your treatment, please sign below.

I agree to allow HealthCareClinics to disclose my Private Health Information (including date/time of appointments) to:

___ Spouse _____ Tel (____) _____ - _____
(print name)

___ Family Member(s) _____ Tel (____) _____ - _____
(print name)

___ Other (i.e. friend, physician etc.) _____ Tel (____) _____ - _____
(print name)

___ Myself only, no other family member

This does not serve as an Authorization to Release Medical Records

I further understand that any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I understand that I have access to or have reviewed HealthCareClinics *Notice of Privacy Practices* for the following medical practice:

HealthCareClinics
5315 Ross Avenue
Dallas, Texas 75206
Tel: (214) 826-2151
Privacy Official: Laura Miller – Office Manager

A copy of this agreement may be used with the same effectiveness as an original.

Print Name of Patient/Legal Representative _____ Date ___/___/___

Signature of Patient/Legal Representative _____ Patient Date of Birth ___/___/___

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Authorization for Treatment

I hereby voluntarily agree to diagnostic procedures, medical and/or surgical treatment, which may be administered to or performed on me under the general and special instructions of the attending provider's care and service or the provider's designee(s).

I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment at **HealthCareClinics**. I further understand that **HealthCareClinics** encourages me to ask questions and voice concerns about medical care and/or services and that asking questions and voicing concerns will not compromise my care. (I understand any invasive procedure(s) will be explained and I will be asked to sign an authorization for that treatment).

By signing below I certify that I have read this agreement and/or that it has been explained to me. I certify I understand its contents and that I am the patient or a person duly authorized to execute this agreement and accept its terms.

NOTE: A copy of this agreement may be used with the same effectiveness as an original.

Patient/Parent (if minor) Signature _____ **Date** _____/_____/_____

Relationship (if not patient's signature) _____ **Date** _____/_____/_____

Autorización para Recibir Tratamiento Médico

Yo, de manera voluntaria, por intermedio del presente documento estoy de acuerdo en someterme a los procedimientos diagnosticos, tratamientos médicos y/o quirúrgicos que mi médico o persona designada consideren necesarios y bajo atención e instrucciónes de mi médico o de la persona designada.

Además, comprendo que la práctica de la medicina y de la cirugía no es una ciencia exacta y que el diagnostico y tratamiento pueda llevar riesgos. No se me ha otorgado ninguna garantía acerca de los resultados que puedo obtener con el tratamiento recibido en HealthCareClinics. También entiendo que HealthCareClinics me alienta a que haga preguntas y manifieste cualquier preocupación que yo tenga con respecto al cuidado médico o servicios con los cuales me provean. Expresar mi opinión, hacer preguntas o manifestar motivos de preocupación no ponen en peligro mi tratamiento médico. Tengo entendido que cualquier procedimiento(s) que requiera invadir mi cuerpo me será explicado y se requerirá que firme una autorización previa a dicho tratamiento.

Con esta firma doy fe y legalidad que he leido este acuerdo y/o de que me ha sido explicado en su totalidad. Doy fe y legalidad que entiendo el contenido y que yo soy el/la paciente o en su defecto , la persona debidamente autorizada a ejercer y aceptar los terminus de este acuerdo.

NOTA: Copia de este acuerdo puede ser utilizada con la misma validez que con el original.

Firma del Paciente/Padre (si es menor de edad) _____ **Fecha** ___/___/___

Relación al Paciente (si es que esta no es la firma del propio paciente) _____ **Fecha** ___/___/___

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FINANCIAL POLICY

Thank-you for choosing HealthCareClinics for your medical care needs. We are committed to providing you with the very best care possible. The following is a statement of our financial policy that outlines patient and practice financial responsibilities. Please feel free to contact us at (214)826-2151 if you have any questions.

MEDICARE
HealthCareClinics accepts assignment for Medicare. We will file any secondary insurance claims. You may be asked to sign a waiver for tests/procedures that Medicare does not cover. You have the right to refuse these tests/procedures. You will be asked to sign a waiver stating that you have refused these tests/procedures.

ALL INSURANCE CARRIERS
Claims will be filed with your insurance company. You will be responsible at the time of service for all co-pays, co-insurance, deductibles and services not covered by your plan. Financial responsibility for services rendered rest with the patient regardless of any insurance coverage. Although we will do everything possible to facilitate reimbursement from your insurance company, we cannot guarantee payment of your claim. We file insurance as a courtesy. Insurance follow-up is the responsibility of the patient. If the claim becomes the patient's responsibility, the claim must be paid within 30 days.

HMO'S
The patient is responsible for obtaining and maintaining valid referrals for any and all covered services. The insurance department will assist in obtaining referrals for treatments. If the patient chooses to undergo any service without a valid referral, the patient is financially responsible for the full charges. Any and all co-pays are due at the time of service.

SELF PAY PATIENTS
Full payment is due at the time of service. We accept cash, checks, Visa, MasterCard and American Express.

CHANGE OF INSURANCE
IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH ANY INSURANCE CHANGES. Claims denied due to "untimely billing" will be the patient's responsibility, if we were not initially provided with the correct billing information, which resulted in late submission.

MEDICALLY NECESSARY SERVICES
The insurance company may deny some services as not medically necessary. The patient is responsible for all billable services.

STATEMENTS
Regardless of any claim pending, if there is an open balance a statement may be sent to you once a month. Any patient balances remaining after insurance payment must be fully paid within 30 days.

COLLECTIONS AND NSF CHECKS
Delinquent accounts will be forwarded to our collection agency. A collection fee of $25 will be added to the unpaid balance to recover our costs for collection. In the event litigation is necessary, you will be liable for court costs and attorney fees as well. A $30.00 fee will be charged for any NSF checks. Returned checks will be turned over to the Dallas County District Attorney's office.

CANCELLATION POLICY
Any appointment cancelled within 24 hours of the scheduled appointment time may be subject to a cancellation fee. If you need to cancel an appointment, please make sure that you have given us at least 24-48 hours notice.

MEDICAL RECORDS
Your medical records will be held in the strictest confidence. If you request a copy of your records to be sent to another physician or to yourself, a written authorization will be required. Our medical records department will notify you with the processing fees and any additional costs that may incur. Only the records requested will be forwarded. Should you bring in another physician's records to us, you may want to consider keeping a copy for yourself.

I hereby give my consent for HealthCareClinics to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. With this consent HealthCareClinics may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory and/or other pertinent results. HealthCareClinics may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. By signing below, I acknowledge that I have read and understand the information presented above and wish to receive diagnostic and treatment services from HealthCareClinics. I agree to be fully responsible for any and all charges for services rendered and not covered by my insurance plan.
A copy of this agreement may be used with the same effectiveness as an original.
PRINT NAME_____ SIGNATURE _____ DATE _____