Patient Authorization for Release of Protected Health Information

Ph #:

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ SS#: _____-_____-_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated healthcare providers.

Disclosing Physician / Practice: _____ Phone: (_____) _____-_____

FX:

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Chest X-Rays
_____ Echocardiograms
_____ Office Notes
_____ Labs Reports / Tests
_____ Nuclear Stress Test
_____ EKG Test / Results
_____ Holter Monitor Results

Protected Health Information to be disclosed to:

HEALTHCHOICE MEDICAL GROUP PLLC
Attn: MEDICAL RECORDS
136 OLD SAN ANTONIO ROAD, SUITE 406
BOERNE, TX 78006
PHONE: (830) 331-4270 FAX: (830) 331-4218

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to HealthChoice Medical Group, PLLC.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). HealthChoice Medical Group, PLLC will not condition treatment or payment based upon my signing of this Authorization.
4). The information disclosed by this authorization may be subject to re-disclosure by HealthChoice Medical Group, PLLC. and no longer protected by Federal Law.
5). I have reviewed this Authorization and understand its purpose and intent
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature Date Name (if other than Patient)

HEALTHCHOICE
PRIMARY CARE & INTERNAL MEDICINE

To: HEALTHCHOICE MEDICAL GROUP From: _____

Fax: (830) 331-4218 Phone: _____

Thank you for choosing HEALTHCHOICE MEDICAL GROUP. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

1). New Patient Forms

2). Insurance Card(s)

3). Any and all recent X-rays and MRI's

4). Medications

Office Information:

HealthChoice Medical Group
136 Old San Antonio Road, Suite 406
Boerne, Texas 78006
Ph: (830) 331-4270 Fax: (830) 331-4218

Thank you for choosing HealthChoice Medical Group. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

☐ New Patient ☐ Updated Information

HEALTHCHOICE
PRIMARY CARE & INTERNAL MEDICINE

Patient Demographics

Patient Name: _____ Birth Date: ____/____/____
LAST FIRST MI

Social Security No: ___-___-____ Gender: ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #: ___-___-____ Cell #: ___-___-____ Work #: ___-___-____

E-Mail Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language: _____

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

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: ___-___-____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Secondary Insurance

Secondary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Self-Pay Agreement

I agree to pay for medical services rendered from HEALTHCHOICE MEDICAL GROUP PLLC. I understand that payment must be made prior to establishing as a new patient.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize HEALTHCHOICE MEDICAL GROUP PLLC and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with HEALTHCHOICE MEDICAL GROUP PLLC and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of HEALTHCHOICE MEDICAL GROUP PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the HEALTHCHOICE MEDICAL GROUP PLLC and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical and surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

HEALTHCHOICE MEDICAL GROUP PLLC and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that HEALTHCHOICE MEDICAL GROUP PLLC and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

Patient Name (Please Print)	Date	Patient Signature

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of HEALTHCHOICE MEDICAL GROUP, PLLC and affiliated providers may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Date

HealthChoice Medical Group

CONTROLLED SUBSTANCES AGREEMENT

I, _____, a patient of HealthChoice Medical Group, have been informed that individuals who are prescribed certain controlled substances including, but not limited to, narcotic pain medicines, stimulants (e.g., ADD/ADHD medications), benzodiazepine tranquilizers, non- benzodiazepine sleep aids, and barbiturate sedatives, can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat my condition(s).

1. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.

2. I agree that I may be subject to a voluntary evaluation by psychologists and/or psychiatrists, possibly at my own expense, before any controlled substances will be prescribed to me. I agree that the need to be evaluated by psychologists and/or psychiatrists may be revisited every three (3) to six (6) months thereafter while taking the medication.

3. My controlled substances will come from the physician whose signature appears below, or during his or her absence, by the covering physician, unless specific written authorization is obtained from the office for an exception.

4. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform my treating provider.

5. I will inform my treating provider of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

6. I will inform my other health care providers that I am taking the controlled substances listed above, and of the existence of this Agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.

7. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.

8. I will not allow anyone else to have, use sell, or otherwise have access to these medications. The sharing of medications with anyone is absolutely forbidden and is a Federal offense.

HealthChoice Medical Group

CONTROLLED SUBSTANCES AGREEMENT

9. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.

10. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.

11. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

12. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.

13. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by my treating provider.

14. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.

15. I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, amphetamines, cocaine, etc., this may be grounds for termination of the doctor/patient relationship at the sole discretion of my physician. If I decide not to provide a urine sample, I understand that my physician may change my treatment plan, including safe discontinuation of any controlled substances when applicable or complete termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. I accept responsibility for the cost of the urine drug test in the event that my healthcare coverage will not cover the cost of this test. I am also aware that my physician may refer me to the on-staff professional counselor, or that a consult with, or referral to a qualified professional who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy may also be provided if my physician feels it is necessary.

16. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.

17. I understand that medications will not be replaced if they are lost, damaged, or stolen.

18. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.

HealthChoice Medical Group

CONTROLLED SUBSTANCES AGREEMENT

19. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.

20. I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so a minimum of twenty-four (24) hours before it is scheduled.

21. I understand that I may be asked to bring my medications in their original container to all of my appointments while I am on controlled medication(s).

22. Refills will not be given over the phone, after office hours, during the weekends, and on holidays – no exceptions.

23. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my physician believes that the medication usage benefits me. I will comply with all treatments as outlined by my treating provider.

24. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage.

25. I understand that failure to adhere to these policies and/or failure to comply with physician's treatment plan may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment, as well as possible discharge from the practice.

26. I, the undersigned patient, have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.

Patient Signature : _____

Patient Name (printed) : _____

Date _____

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Preferred Pharmacy: _____ **Phone#:** _____

Allergies/Sensitivity to Medications: _____

Chief Complaint for Visit: _____

Current Symptoms you have experienced in the last two weeks: *(Please check all that apply.)*

☐ Change in appetite	☐ Chest Pain	☐ Blood clots in legs
☐ Chills	☐ Dizziness	☐ Cold Extremities
☐ Fatigue	☐ Difficulty breathing while walking	☐ Decreased sensation in extremities
☐ Fever	☐ Irregular Heart Beat	☐ Pain/Cramping in legs after exertion
☐ Weight Gain	☐ Abdominal pain	☐ Discoloration of skin
☐ Weight Loss	☐ Blood in stool	☐ Dry skin
☐ Blurry vision	☐ Change in bowel habits	☐ Hair Changes
☐ Change in vision	☐ Constipation	☐ Skin lumps
☐ Discharge from eye	☐ Diarrhea	☐ Nail changes
☐ Dry Eye	☐ Heartburn	☐ Rash
☐ Itching and redness of eye	☐ Nausea	☐ Skin lesions
☐ Watery eyes	☐ Vomiting	☐ Fainting
☐ Blockage in ear	☐ Bleeding problems	☐ Headache
☐ Decreased hearing	☐ Easy bruising	☐ Paralysis
☐ Difficulty in swallowing	☐ Blood in urine	☐ Seizures
☐ Sinus Pain	☐ Difficulty Urinating	☐ Tingling/Numbness
☐ Sore Throat	☐ Frequent urination	☐ Tremor
☐ Swollen Glands	☐ Painful urination	☐ Feelings of guilt
☐ Cold Intolerance	☐ Back Problems	☐ Decreased energy
☐ Excessive sweating	☐ Leg Cramps	☐ Loss of concentration
☐ Hair loss	☐ Muscle aches	☐ Anxiety
☐ Cough	☐ Painful joints	☐ Depressed Mood
☐ Shortness of breath	☐ Weakness	☐ Difficulty sleeping
☐ Phlegm / Sputum	☐ Swelling in legs	☐ Loss of appetite
☐ Wheezing	☐ Varicose Veins	☐ Suicidal thoughts

Past Medical History: *(Please check all that apply.)*

☐ Deafness/Decreased Hearing	☐ Epilepsy / Seizures	☐ Diabetes Mellitus
☐ Heart Problems	☐ Mental Illness	☐ Hemorrhoids
☐ Heart Attack	☐ Nervous Breakdown	☐ Stomach / Bowel Problems
☐ High Blood Pressure	☐ Mental Retardation	☐ Ulcers
☐ Blood Transfusion	☐ Cancer	☐ Migraines
☐ Anemia	☐ Stroke	☐ Arthritis
☐ Bleeding Disorder	☐ Blindness	☐ Hepatitis
☐ High Cholesterol	☐ Glaucoma	☐ Liver Problems
☐ Lung Problems	☐ Sinus Infection	☐ Gout
☐ Asthma	☐ Urine Infection	☐ Broken Bones
☐ Pneumonia	☐ Kidney Disease	☐ Joint Dislocation
☐ Rheumatic Fever	☐ Kidney Stone	☐ Birth Defects
☐ Scarlet Fever	☐ Thyroid Problems	☐ Amputations
☐ Tuberculosis	☐ Venereal Disease	☐ HIV
☐ Allergies		

Past Surgical History

Operations (Include Biopsy)	Year	Surgeon	Reason for Surgery

Past Hospitalizations ***(non-Surgical)***

Hospital	Year	Reason for Admission

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Family Medical History: *(Please check all that Apply.)*

Conditions	Mother	Father	Siblings	Children	Maternal Grandparent	Paternal Grandparent
Diabetes:	☐	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐	☐
Cancer/Type:	☐	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐	☐
Glaucoma:	☐	☐	☐	☐	☐	☐
Anemia:	☐	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

Immunizations:

Description	Last Known Date
PNEUMONIA	/ /
TETANUS	/ /
FLU	/ /
OTHER:	/ /

Periodic Examinations:
(Please Check Exam and State when.)

☐ *Pap Smear:*	/ /	☐ *Mammogram:*	/ /
☐ *Rectal Exam:*	/ /	☐ *Chest X-Ray:*	/ /
☐ *EKG:*	/ /	☐ *Test for Blood in Stool:*	/ /
☐ *Blood Work:*	/ /	☐ *Colonoscopy Exam:*	/ /

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

FOR WOMEN ONLY:

Last Menstrual Cycle: _____ Method of Birth Control: _____
Number of Pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____
Age of Menopause: _____ Natural or Surgical (Please Circle One)

Social History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employment: ☐ Employed ☐ Unemployed ☐ Retired Occupation: _____.

Living Situation: ☐ Lives alone ☐ Lives with family ☐ Lives with others

Smoking: ☐ Current Smoker, everyday ☐ Current Smoker, some days ☐ Former Smoker
☐ Never Smoker ☐ _____ packs/day ☐ _____ years smoked

Alcohol Use: ☐ YES ☐ NO
☐ Heavy drinker (1-5 drinks/day) ☐ Moderate Drinker (1-5 drinks/week)
☐ Occasional Drinker

Recreational Drug Use:
☐ YES ☐ NO
☐ Heavy User (daily to weekly) ☐ Moderate User (monthly) ☐ Occasional User

List recreational drugs used: _____.

Preventative Screenings:

Patients only over 65 - Fall Risk Assessment:

☐ No Falls in the past year
☐ One fall with injury in the past year
☐ Two or more falls with injury in the past year
☐ One fall without injury in the past year
☐ Two or more falls without injury in the past year

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____

Current Medications:

List ALL medication that you are currently taking including Non-Prescriptions Medication & Herbal remedies.
(Please DO NOT Substitute a List. Please write meds below)

Medications	Dose	How Often	Approximately Start Date (Month/Year)