REGISTRATION FORM

(Please Print)

Today's date:	Email Address:		
Referring Provider:		PCP:	

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss	Last Name:	First:	Middle:
Birth Date:	Age:	Sex:	

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Address City State Zip:	Cell Phone:	Office phone :
Home Phone:	Occupation:	Employer:
Pharmacy:	Phone:	City:
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other pacific island ☐ Not Provided ☐ White	Ethnicity: ☐ Hispanic or latino ☐ Not Hispanic or latino ☐ Not provided	Language:

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No	Other Coverage:

Person Responsible for bill:		Address:	Phone:
Occupation:	Employer:	Employer address:	Employer phone:

	Please provide copy of ins. card and driver's license		

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone:	Work phone :

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required for processing my claims.

I also give my permission for Huntsville Family Medicine, LLP to download any electronic prescriptions and medication history that may help in my medical treatment. I also confirm that I have been advised that this practice prescribes medications, via e-prescribing, according to state regulations.

_____ _____

Patient/Guardian signature *Date*

It is the policy of this clinic that once you establish with a physician, we do not allow transfer of care to another physician within the practice without authorization from both physicians involved. _____ (initial)

NO-SHOW appt policy:

We require 24 hour notice for appt cancelation or a $25 fee may be assessed

Patient Name:_____

DOB_____ **Date of visit:**_____

Medical history: list all chronic illnesses None ☐

_____
_____
_____
_____
_____

Surgical history: list all past surgeries/procedures

Surgery/Procedure **None** ☐ **Date**

_____/_____
_____/_____
_____/_____
_____/_____
_____/_____
_____/_____

Family history: list any significant family illnesses & relation

Relation **Problem/disease**

_____/_____
_____/_____
_____/_____
_____/_____
_____/_____

Social history: circle one

Tobacco: Current smoker/past smoker/never

Amount _____

Alcohol: Currently drinks/past drinker/never

Amount _____

Medication history: list all current medications

Name of drug **(none)** **dosage** **1 a day/2 a day/3 a day, etc**

_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

Drug allergies: None ☐

Name of drug **Reaction**

_____/_____
_____/_____
_____/_____
_____/_____

Food & Environmental allergies: None ☐

Name of allergen **None** ☐ **Reaction**

_____/_____
_____/_____
_____/_____
_____/_____

Immunization history: list immunizations and date given if available

Immunization **Date given**

_____/_____
_____/_____
_____/_____
_____/_____
_____/_____
_____/_____

List additional immunizations on back ⇨

(If the following information has already been given please skip)

I give consent to retrieve medication list from any approved entity:_____ **(initial here)**

Preferred Pharmacy_____

Huntsville Family Medicine, LLP is now using electronic medical records (EMR). When using EMR the government requires that we attempt to collect the following data. You may choose not to respond by circling *REFUSE TO REPORT* or you may respond by circling/checking the appropriate response.

Race: ☐ *American Indian* ☐ *Alaskan* ☐ *Asian*

☐ *Black* ☐ *African* ☐ *Caucasian* ☐ *Hispanic*

☐ *Native Hawaiian* ☐ *White* ☐ *Other*

Ethnicity: ☐ *Hispanic or Latino*

☐ *Non-Hispanic or Latino*

Huntsville Family Medicine, LLP

Patient Name:_____ **Date:** _____

Reason for today's visit: (check appropriate box(s) below)

☐ **Recent illness (list all symptoms associated with recent illness)**

_____

☐ **Routine follow up**

☐ **week follow up**

☐ **month follow up**

☐ **Medication refills (list medications)**

_____

_____

_____

☐ **Yearly Physical**

☐ **Yearly Medicare Wellness Exam**

Preferred Pharmacy_____

Huntsville Family Medicine, LLP is now using electronic medical records (EMR). When using EMR the government requires that we attempt to collect the following data. You may choose not to respond by circling *REFUSE TO REPORT* or you may respond by circling the appropriate response.

Race: ☐ ***American Indian/ Alaskan*** ☐ ***Asian*** ☐ ***Black/African American***

☐ ***Caucasian*** ☐ ***Hispanic*** ☐ ***Native Hawaiian*** ☐ ***White*** ☐ ***Other***

Ethnicity: ☐ ***Hispanic or Latino*** ☐ ***Non-Hispanic or Latino***

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.

_____
Signature of Patient of Personal Representative

_____
Date

_____
(Please Print) Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

I hereby give permission to discuss my medical conditions with the follow person(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____
Signature of Patient of Personal Representative

This authorization will be in effect until otherwise noted or indicated.

Please let us know how you heard about us. Circle all that apply.

1. Radio
2. Local Printed Advertising
3. Social Media
4. Friends/Family
5. Professional Referral
6. Other

NO-SHOW Policy

Huntsville Family Medicine, LLP

123 Medical Park Lane, Ste A

Huntsville, TX 77340

A patient who does not arrive for a scheduled appointment and did not cancel the appointment with at least 24 hours' advance notice is considered a "no-show". Patients may be assessed a $25 No Show fee if they do not show up for appointments or contact the practice 24 hours in advance.

Exceptions may be made for emergency situations on a case-by-case basis to be decided by management. If approved, the missed appointment status will be changed to "same day cancellation" and no fee will apply.

Patients who repeatedly fail to keep appointments or fail to cancel with at least a 24 hours' advance notice may be dismissed from the practice.

(Patient response)

My signature below indicates that I have received and understand the above policy.

_____ _____

Signature of patient/parent or guardian Date

Electronic Communications Consent Form

Patient-Healthcare Provider Electronic Communication Agreement

The patient agrees that, all electronic communications will be sent either through the patient portal or secure email. This is to provide an opportunity to communicate with your healthcare provider relative to issues that are **non-emergent, non-urgent or non-critical.** Electronic Communications are not a replacement for the interpersonal contact that is the very basis of the doctor-patient relationship.

General Considerations

Your Healthcare Provider will treat Electronic Communications with the same degree of privacy and confidentiality as written medical records. Your Healthcare Provider has taken reasonable steps with internal information technology systems to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1992, as amended (HIPAA.)

Standard email services (including, but not limited to Yahoomail, Outlook.com, and Gmail) are not secure. This means that the email messages are not encrypted and can be intercepted and read by unauthorized individuals.

Transmitting email that contains protected health information through an email system that is not encrypted do not meet and electronic communication security guidelines as required by HIPAA. Any electronic communications sent from this office will be sent via the patient portal or secure email. I understand that an email will not be sent via non secure email, and any such correspondence will be reported to Huntsville Family Medicine, LLP.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with Huntsville Family Medicine, LLP.

I understand that I can withdraw this consent authorizing Healthcare Provider to communicate with me via Electronic Communications at any time by written notification to Huntsville Family Medicine, LLP.

I release and hold harmless Healthcare Provider, its physicians and their staff, employees, affiliates, agents, officers, directors and shareholders from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses, of any kind that I may have resulting from Electronic Communications between Healthcare Provider and me based on this authorization given to Healthcare Provider to communicate with me via Electronic Communications.

Having been informed of the risks associated with Electronic Communications, I still desire to communicate with Healthcare Provider via electronic communications. I hereby authorize Healthcare Provider to engage in Electronic Communication with me.

Patient Signature _____

Date: _____

Provider Signature _____

Date: _____

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This practice also utilizes **electronic health records**. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed below.

Brenda Waters – Privacy Officer

Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care. OR

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer. The form will contain medical information, such as a description of the medical service provided to you that your insurer needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. 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.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:
- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and your are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by the Texas workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military

command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment or test results. ***It is also in our practice to leave messages on answering machines or voice mail. Please advise the Privacy Officer if you do not agree to this specific type of release.***

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Brenda Waters
123 Medical Park Lane Ste A, Huntsville, Texas 77340
phone: 936-291-2116
fax: 936-435-7824

This notice is effective on the following date: November 20, 2012.

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.