

PERSONAL HEALTH HISTORY

NOTE: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name _____ Today's Date _____

Age* _____ Birth Date _____ Last Physical Exam Date _____

***Patients under the age of 18 must be accompanied by parent or guardian on the first visit.**

ACTIVE AND INACTIVE PROBLEMS:

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past, Date		Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past, Date
Asthma						Rheumatic Fever				
Abnormal Electrocardiogram						Rectal Trouble				
Angina						Recurrent Boils				
Anemia (Type)						Stroke				
Arthritis						Stomach or Duodenal Ulcer				
Blindness Either Eye						Syphilis				
Broken Bones						Skin Disease				
Cataracts						Serious Depression				
Chronic Bronchitis/Lung Disease						Serious Emotional Problems				
Cirrhosis of Liver						Tuberculosis				
Colon or Bowel Trouble						Thyroid (overactive)				
Deafness						Thyroid (underactive)				
Dysentery						Varicose Veins				
Diabetes						Men				
Ear Infections						Prostate Problems				
Emphysema						Women				
Enlarged Heart						Menstrual Difficulties				
Glaucoma						Cystitis				
Gall Stones						Mastitis				
Gout						Ovarian Cyst				
Goiter						Breast Cancer				
Gonorrhea						Other Breast Disease*				
Hay fever						Other Gynecological Problems*				
Heart Murmur as Adult						Still Menstruating (circle) YES NO				
Heart Attack						Age Period Started				
High Blood Pressure						Age Periods Stopped				
Hepatitis						Why Periods Stopped				
Hemorrhoids						Number of Pregnancies				
Kidney Infection						Number of Children				
Kidney Stones						Number of Miscarriages				
Nervous Breakdown						*Explain				
Poor Blood Clotting										
Polio										
Phlebitis										

SURGERIES:

	Yes	No	Date			Yes	No	Date
Tonsils					Hernia			
Appendix					Breast (women)			
Gall Bladder					Uterus (women)			
Stomach					Ovaries (women)			
Kidney					Prostate (men)			
Colon					Other – Specify			
Thyroid								

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

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FAMILY RECORD:

Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below.	Father	Mother	Brother	Sister	Son	Daughter
Alcoholism						
Allergies						
Anemia						
Arthritis						
Asthma						
Birth Defects						
Bleeding Tendency						
Cancer, Tumor						
Colitis						
Congenital Heart						
Diabetes						
Emphysema						
Epilepsy						
Glaucoma						
Goiter						
Hay Fever						
Heart Attack						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Leukemia						
Liver Disease						
Mental Illness						
Migraine						
Nervous Breakdown						
Obesity						
Rheumatism						
Rheumatic Fever						
Sickle-cell Anemia						
Stomach Ulcer						
Stroke						
Suicide						
Tuberculosis						

Name _____ DOB _____

FAMILY MEMBERS:

Living					Deceased	
	Age	Health			Age at Death	Cause of Death
		Good	Fair	Poor		
Father						
Mother						
Brother(s)						
Sister(s)						

Tobacco Use: ☐ No ☐ Yes ☐ Former Packs/Day _____ How Long _____ yrs Date Quit _____

Alcohol Use: ☐ No ☐ Yes Beers/Day _____ Hard Liquor Drinks/Day _____

Former Alcohol Use: How many years? _____ Date Quit _____

Do you drink coffee? No Yes How many per day? _____

HOSPITALIZATIONS/REASONS: _____ **DATE(S)** _____

Do you wear artificial devices? _____ Yes _____ No _____

Please list _____

IMMUNIZATIONS:

	Yes	No	Date
Pneumonia			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			
Other (specify)			

X-RAYS:

	Yes	No	Date
When was your last mammogram?			
Back			
Chest			
Colon			
Extremities			
Gall Bladder			
Kidney			
Stomach			
Treatments			
Other (specify)			

Name _____ DOB _____

New Patient Information

Patient Name: _____
Last First Middle Initial

Address: _____ E-Mail: _____
Street City State Zip

Telephone (home) _____ (cell) _____

Date of Birth: ____/____/____ * Gender: M F Marital Status: S M D W SS#: _____

Race _____ [may decline] Ethnicity _____ [may decline] Language _____

Emergency Contact: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Work Phone (_____) _____ Employed: Full Time Part Time

Are you a student? YES NO If yes: FULL TIME PART TIME

Primary Insurance Company: _____

Primary Insured's Name: _____ Date of Birth: _____

Member ID: _____ Group #: _____ Relationship to Patient: _____

Secondary Insurance Company: _____

Insured's Name: _____ Date of Birth: _____

Member ID: _____ Group #: _____ Relationship to Patient _____

Whom may we thank for referring you? _____

Preferred Pharmacy: _____
Name Location Phone

NOTE: YOU MUST ALLOW NO LESS THAN 48 HOURS FOR MEDICATION REFILLS. PATIENTS ARE ASSESSED \$100 FOR AN APPOINTMENT NOT CANCELED AT LEAST 24 HOURS IN ADVANCE.

I hereby assign all medical benefits, including major medical to which I am entitled, Medicare, and other government-sponsored programs, private insurance and any other health plan to Primary Care Physicians of Texas, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize assignee to release all information to secure the payment.

Patient, Parent or Guarantor Signature

Date

*Patients under the age of 18 must be accompanied by parent or guardian on the first visit.

COMPLETE THIS FORM ONLY IF YOU ARE ASKING US TO GET YOUR PAST MEDICAL RECORDS FROM ANOTHER DOCTOR.

Authorization for Disclosure of Health Information

Patient's Name _____ DOB _____ SSN _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

Authorizes (Doctor from Whom You Wish Us to Get Your Records):

Name _____ Street Address _____ City _____ State _____ Zip _____ Phone/Fax _____

To Release Protected Health Information To:

**Primary Care Physicians of Texas, PA
1005 Ralph Hall Parkway, Ste 137, Rockwall, Tx 75032**

Information to be Released:

- | | | |
|---|---|---|
| ☐ Entire Medical Record | ☐ Medical History, Examination, Report | ☐ Surgical Reports |
| ☐ Treatment or Tests | ☐ Hospital Records, Including Reports | ☐ Allergy Records |
| ☐ Immunizations | ☐ Prescriptions | ☐ X-ray Reports |
| ☐ Billing & Payment Information | ☐ Consultations | ☐ Laboratory Reports |
| ☐ Other (Specify) _____ | | |
| ☐ Only for the Following Dates _____ | | |

I understand that 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, and treatment for alcohol and drug abuse.

- ☐ Yes, I consent to the release of this information. ☐ No, I do not consent to the release of this information.

Purpose for Need of Disclosure (Check Applicable Categories):

- | | | |
|---|--|---|
| ☐ Further Medical Care | ☐ Personal = At the Request of the Individual | ☐ Insurance Eligibility/Benefits |
| ☐ Changing Physicians | ☐ Legal Investigation or Action | ☐ Other (Specify): |

Date Records Are Needed: _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to 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 individual or organization releasing information. I understand that the revocation will not apply to information already 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 in six months. 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 ensure treatment. I understand that I may inspect or copy 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 unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Office Manager of Primary Care Physicians of Texas, PA

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

AUTHORIZATIONS

Authorization for Disclosure of Health Information (As defined by HIPAA, a separate authorization must be used for psychotherapy notes.)

Patient Name: _____ Date of Birth: _____

I authorize Primary Care Physicians of Texas, PA, to release my records or information relating to my health care to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Information to be Released:

- | | | |
|--|---|---|
| ☐ Entire Medical Record | ☐ Medical History, Examination, Report | ☐ Surgical Reports |
| ☐ Treatment or Tests | ☐ Hospital Records, Including Reports | ☐ Allergy Records |
| ☐ Immunizations | ☐ Prescriptions | ☐ X-ray Reports |
| ☐ Billing & Payment Information | ☐ Consultations | ☐ Laboratory Reports |
| ☐ Other (Specify) _____ | | |
| ☐ For All Dates | ☐ Only for the Following Dates _____ | |

We have no control over the person(s) you have listed as your personal representative(s). Therefore, your PHI disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Primary Care Physicians of Texas, PA.

Disclosure of Protected Health Information Via Alternative Means

I consent to receive calls from Primary Care Physicians of Texas, PA, regarding my protected healthcare and other services at the phone number(s) below, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated notification system.

☐ Home _____ ☐ Cell _____ ☐ Work _____

These authorizations will remain in effect until terminated by the patient, the patient's personal representative, or another individual legally authorized to do so by court order. The patient has the right to revoke or terminate these authorizations by submitting a written request to: **Primary Care Physicians of Texas, PA, 1005 Ralph Hall Parkway, Ste 137, Rockwall, Tx 75032**

Patient Signature _____

Date _____

Witness Signature _____

Date _____

Primary Care Physicians of Texas, PA

Notice of Privacy Practices

We are required by law to maintain the privacy of our patients with respect to protected health information. Our Notice of Privacy Practices is enclosed. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Print Name

Patient/Guardian Signature

Date

Witness Signature

Date

PRIMARY CARE PHYSICIANS OF TEXAS, PA, NOTICE OF PRIVACY PRACTICES

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with Primary Care Physicians of Texas, PA. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Primary Care Physicians of Texas, PA, is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. If you have any questions about this Notice, please contact our Office Manager at 972-463-2001.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff. You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. You have the right to authorize other use and disclosure. This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

You have the right to request a restriction of your protected health information. This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information. This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request disclosure accountability. This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Office Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may 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 that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

We may also call you by name 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 contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For Payment - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care

services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service and compliance with privacy requirements.

Other Permitted and Required Uses and Disclosures - We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required By Law - We may use or disclose your protected health information to the extent that law requires the use or disclosure.

For Public Health - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement - We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

In Cases of Criminal Activity - Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

Primary Care Physicians of Texas, PA
1005 W. Ralph Hall Parkway, Ste. 137, Rockwall, TX 75032
(972) 463-2001 Phone
(972) 463-2003 Fax

OFFICE POLICIES

GENERAL:

- Office hours are 8:00 AM to 5:00 PM, Monday through Friday.
- Patients are seen by appointment only. No Walk-ins
- All appointments not confirmed by 5PM, the day before the appointment will be cancelled.
- If you are over 10 minutes late to your appointment, your appointment will be rescheduled.
- New patient paperwork must be completed and returned in 24 hours BEFORE the scheduled appointment. If the new patient paperwork is NOT completed & returned to our office at least 24 hours in advance, the patient must arrive 1 hour early. Otherwise, we will reschedule the appointment.

MEDICATIONS:

- Medication refills are NOT given to patients who do not keep their follow-up appointments.
- Medications will NOT be prescribed for an illness unless the patient sees the physician first.
- Patients must allow no less than 48 hours for prescription refills.
- After 5pm and on weekends, there is an "on call" physician. The "on call" physician will not refill medications. After-hour calls are restricted to emergencies only.

FEES:

- Patients will be charged a \$ 100 fee for appointments that are not cancelled at least 24 hours in advance.
- Patients will be charged a \$100 fee for any No Shows
- We charge a \$55 fee for preparation of forms for FMLA. The fee is payable in advance. We require no less than 10 days for preparation of the forms.
- Payment is required at the time of service. This includes co-pays, deductibles, and previous balances.
- Payment for services is the responsibility of the patient.
- Any balances not paid after 60 days will be sent to collections.

Patient or Guarantor Signature

Date

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and other health care providers or the designees as deemed necessary to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name of Patient or Personal Representative

Relationship to Patient

Witnessed By

Date

Signature of Patient or Personal Representative

Date