Lone Star Medical Group
PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

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

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____- _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM _____/DD _____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work hone: _____ Ext. _____

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 recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), 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.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

Lone Star Medical Group

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, Lone Star Medical Group may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Lone Star Medical Group may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Lone Star Medical Group any insurance or other third-party benefits available for health care services provided to me. I understand Lone Star Medical Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Lone Star Medical Group, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Lone Star Medical Group by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Lone Star Medical Group, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Lone Star Medical Group or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Lone Star Medical Group or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient.

Circle or mark relationship(s) from list below:

Spouse Guarantor

Parent Healthcare Power of Attorney

Legal Guardian Other (please specify) _____

New Patient History (Adult) To be completed by the Patient or Guardian

Patient Name:_____ **DOB:**_____ **Date:**_____

Describe your main problems:

_____

_____

List any allergies or adverse reactions:

Drug/Allergen:	Reaction:	Onset Date:

□ NKDA (no known allergies)

List all medications you are currently taking, the dosage and the reason:

Name:	Dosage:	Reason:

List all other providers you currently see:

Name:	Specialty:

Past medical history:

- □ Other: _____
- □ ADD OR ADHD
- □ Allergies
- □ Anemia
- □ Anxiety disorder
- □ Aortic aneurysm
- □ Arrhythmia
- □ Arthritis
- □ Asthma
- □ Atrial Fib
- □ Back pain
- □ Bedwetting
- □ Birth defects or inherited disease
- □ Bleeding disorder
- □ Blood clots
- □ Breast cancer
- □ CAD
- □ COPD
- □ Heart problems
- □ Heart valve disorder
- □ Heart Arrhythmia
- □ Heart attack (MI)
- □ Heart murmur
- □ Hemophilia
- □ Hepatitis
- □ Hernia
- □ Hiatal Hernia
- □ Hypercholesterolemia
- □ Hyperlipidemia
- □ Hypertension
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Joint pain
- □ Kidney disease
- □ Kidney stones
- □ Leg or foot ulcers

Past medical history cont'd:

- □ CVA
- □ Cancer
- □ Chest pain
- □ Chicken Pox
- □ Claustrophobic
- □ Congenital Heart Disease
- □ Congestive Heart Failure
- □ Constipation
- □ Depression
- □ Developmental or behavioral disorders
- □ Diabetes
- □ Dialysis
- □ Diverticulitis
- □ Ear or hearing problems
- □ Eczema, hives, or other skin conditions
- □ Endometriosis
- □ Epilepsy
- □ Eye problems
- □ Fibromyalgia
- □ GERD
- □ Gastrointestinal disease
- □ Genitourinary Disease
- □ Gout
- □ HIV or AIDS
- □ Head Trauma
- □ Headaches or Migraines
- □ Heart disease
- □ Liver disease
- □ Migraines
- □ Muscle, joint or bone problems
- □ Obesity
- □ Organ transplant
- □ Osteoarthritis
- □ Osteopenia
- □ Osteoporosis
- □ Otitis media
- □ Pacemaker
- □ Previous fracture
- □ Psychiatric illness
- □ Pulmonary embolism
- □ Rheumatoid arthritis
- □ Seizures
- □ Serious illness or injuries
- □ Shortness of breath
- □ Skin problems
- □ Sleep apnea
- □ Sleep disorder
- □ Stroke / CVA
- □ Thyroid problem
- □ Tuberculosis
- □ Ulcers
- □ Urinary tract infection
- □ Urologic disorder
- □ Alcohol or drug abuse

Family History:

	Diseases	Onset age	Died of age, if app'l
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
Other:	_____	_____	_____
	_____	_____	_____

Surgical History:

Procedure:	Surgery Date:
_____	_____
_____	_____
_____	_____

Patient Social History:

Smoking Status (select one):	Never	Current every day smoker
	Former Smoker	Current occasional smoker
Smoking-How Much:	_____ pack per day	
Tobacco-years of use:	_____	
Occupation:	_____	

Education (select last completed):	Less than 8th grade	High school graduate
	9th grade	2 year college
	10th grade	4 year college
	11th grade	Post graduate

Marital status:	Unknown	Separated
	Married	Widowed
	Single	Domestic partner
	Divorced	

Sexual orientation:	Heterosexual	Homosexual	Bisexual

Exercise level:	None	Occasional
	Moderate	Heavy

Diet:	Regular	Specific
	Vegetarian	Carbohydrate
	Vegan	Cardiac diabetic
	Gluten free	

General stress level:	Low	Medium	High

Alcohol intake:	None	Occasional
	Moderate	Heavy
Alcohol-years of use:	_____	

Caffeine intake:	None		Occasional	
	Moderate		Heavy	
Chewing tobacco:	None	1/day	2-4/day	5+/day

Illicit drugs:	_____	
Sunscreen used routinely:	Yes	No
Smoke alarm in home:	Yes	No
Advance directive:	Yes	No
Sporting Activities:	_____	
Sexually active:	Yes	No
Passive smoke exposure:	Yes	No

Family history of heart disease	Yes	No
Family history of heart disease before late 50's?	Yes	No
Sexually Transmitted Disease	Yes	No
At risk for Hip B?	Yes	No
At risk for TB?	Yes	No

For female patients ONLY:

Last menstrual period:	________	Unknown	Approximate	Definite
Frequency of cycle (days):	________			
Menses monthly	Yes	No		
Age of menarche:	________			
Prior hysterectomy?	Yes	No		

Current birth control method: ______________________

If post menopausal, age at menopause: _______

Date of last pap:	________	
# of child births:	________	
# of pregnancies:	________	
Sexually active:	Yes	No

Past pregnancies:

Date: _________ # of Fetuses: _____ GA wks: _____ Labor Length (hrs): ___ Sex: M / F
Delivery Type: _______ Anesthesia: ______ Delivery Place: ____________
Preterm Labor: Y / N

Date: _________ # of Fetuses: _____ GA wks: _____ Labor Length (hrs): ___ Sex: M / F
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Date: _________ # of Fetuses: _____ GA wks: _____ Labor Length (hrs): ___ Sex: M / F
Delivery Type: _______ Anesthesia: ______ Delivery Place: ____________
Preterm Labor: Y / N

Date: _________ # of Fetuses: _____ GA wks: _____ Labor Length (hrs): ___ Sex: M / F
Delivery Type: _______ Anesthesia: ______ Delivery Place: ____________
Preterm Labor: Y / N

Date: _________ # of Fetuses: _____ GA wks: _____ Labor Length (hrs): ___ Sex: M / F
Delivery Type: _______ Anesthesia: ______ Delivery Place: ____________
Preterm Labor: Y / N

MEDICATION PRESCRIPTION POLICY AND AGREEMENT

The following is an outline of our medication prescription refill policy here at Lone Star Medical Group.

1. If you need a refill on your medication, we ask that you call **your pharmacy** and tell them which medication you need refilled. They, in turn, will fax or call us with all the information we need to refill the medication. **If you call us, we will ask you to call your pharmacy.**

2. **We do not refill medications after business hours or on weekends.** Our providers do not have access to your medical records after business hours. Please make sure you contact your pharmacy **at least 3 days before you run out of the medication** to allow time for the refill to be processed. Any calls for medication received after 3:30 PM will not be addressed until the following business day.

AFTER BUSINESS HOURS , WEEKENDS AND HOLIDAYS

Our normal business hours are 8 AM to 12 PM and 1:30 PM to 5 PM, Monday through Friday. We are closed on major holidays. This can vary by provider, so be sure to ask your provider the clinic hours. In case of an emergency, a life-threatening situation, or concerning symptoms, call 911 or go to the nearest emergency room.

Our providers do not have access to your medical records after business hours, weekends, or major holidays. If you would like to schedule a routine appointment, please call during business hours.

LATEX ALLERGY NOTIFICATION (check one)

- ☐ I am not allergic to latex.

- ☐ I am allergic to latex.

I have read and understood the above policies and agree to adhere to the policies.

Patient Signature:_____ Date:_____

Printed Name:_____

Parent/Legal Guardian Signature:_____ Date:_____

Printed Parent/Legal Guardian name:_____

Witness Signature:_____

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional)**
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:**		
	Address 2:	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD, eDelivery)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical test ☐ Medication sheets		☐ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm strips ☐ Nursing information ☐ Transfer forms ☐ ER information		☐ Labor/delivery summary ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-04: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

ROI