

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 home: _____ 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:

- | | |
|---|---|
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> ADD OR ADHD | <input type="checkbox"/> Heart valve disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Arrhythmia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart attack (MI) |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Atrial Fib | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hyperlipidemia |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Birth defects or inherited disease | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> CAD | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> COPD | <input type="checkbox"/> 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
	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):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical test <input type="checkbox"/> Medication sheets		<input type="checkbox"/> Operative information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm strips <input type="checkbox"/> Nursing information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER information		<input type="checkbox"/> Labor/delivery summary <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-04: <input type="checkbox"/> Other: <input type="checkbox"/> 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:

