NEW PATIENT INFORMATION

*** All sections MUST be completed. If not applicable, please indicate as "NA"****

PATIENT INFORMATION

Last Name ____________________ First Name ____________________ M.I. ________

Sex ______ Birth date ____/____/____ Age ______ SSN ______________ Marital Status S M W D

Mailing Address ____________________ -Apt______ City ______________ State ______ Zip ________

Billing Address ____________________ -Apt______ City ______________ State ______ Zip ________

Home Phone (_____) ____________ Work Phone (_____) ____________ Cell Phone (_____) ____________

Preferred contact (please circle one) Home Work Cell Driver's License /State ______________ / ______

Student: Yes No Employer/School Name ____________________ Phone (_____) ____________

EMERGENCY CONTACT

1st Name ____________________ Phone (_____) ____________ Relationship ______________

2nd Name ____________________ Phone (_____) ____________ Relationship ______________

REFERRED BY We appreciate our patients and ask that you be as specific as possible with identifying your referral source. Please circle all that apply.

TV Radio Internet Print Advertising School Sports Program Trainer/Coach

Hospital/Clinic HMO/PPO Directory Referral Service Yellow Pages Patient Friend Coworker/Employer

Other ____

Referring Person: Last name ______________ First name ______________ Phone(_____) ____________

INSURANCE

Subscriber/Employee's Name ____________________ Employer ______________

Sex ______ Birth date ____/____/____ SSN ______________ Patient's Relationship to Insured ______________

Insurance Co Name ____________________ Phone (_____) ____________

ID # ____________________ Group # ______________

Do you have Secondary Insurance? ☐ NO, Initial ______________ **Date** ______________

☐ Yes, Subscriber/Employee's Name ____________________ Employer ______________

Sex ______ Birth date ____/____/____ SSN ______________ Patient's Relationship to Insured ______________

Insurance Co Name ____________________ Phone (_____) ____________

ID # ____________________ Group # ______________

GUARANTOR/RESPONSIBLE PARTY ☐ Same as above

Last Name ______________ First Name ______________ M.I. ______ Birth date ____/____/____

SSN ______________ Driver's License #/State ______________ / ______ Relationship to patient ______________

Address ____________________ City ______________ State ______ Zip ________

Home Phone (_____) ____________ Work Phone (_____) ____________ Cell Phone (_____) ____________

➔ **CONSENT FOR TREATMENT:** I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment

Date ______________ Signature(patient/parent/guardian)____________________ Relationship ______________

Texas Sports & Family Medicine
Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Texas Sports & Family Medicine** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Texas Sports & Family Medicine to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Texas Sports & Family Medicine** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

______________________________ ____________________

Patient/Responsible Party Signature Date

______________________________ ____________________

Witness Date

Texas Sports & Family Medicine
Patient Financial Policy

Texas Sports & Family Medicine is dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. To reduce confusion and misunderstanding with our patients, Texas Sports & Family Medicine has adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our billing coordinator.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. There is a 15% discount for full payment at the time of service. For your convenience we accept VISA, MasterCard, and personal checks. There is a $25 fee for returned checks.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans with which we have an agreement and will only require you to pay the amount you are responsible for under the terms of your insurance agreement (i.e. co-payment, co-insurance, deductible).

- If you have insurance coverage with a plan with which we do not have a prior agreement, the charges for your care and treatment are due at the time of service. The 15% discount for payment at the time of service will apply. We will provide you with a statement describing the services rendered which you may use to file a claim for reimbursement with your insurer.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patient

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of Texas Sports & Family Medicine, and I agree to be bound by its terms. I also understand and agree that Texas Sports & Family Medicine may amend such terms from time to time.

____
Printed Name of the Patient

________________________________ ____________________
Signature of Patient or Responsible Party Date

Texas Sports & Family Medicine
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 (or Personal Representative)

____

Name of Patient (or Personal Representative)

____

Date

____

Description of Personal Representative's Authority

Today's Date:____________

HEALTH HISTORY

Last Name: __________________ ***First Name:*** ________________ ***Name you prefer:*** _______________

Date of Birth: ____________ Preferred phone number: ______________(home/work/cell—circle one)

Marital Status: ___Single __ Partnered __ Married ___ Separated ___Divorced ___Widowed

Who lives with you?: ___spouse/partner/children ____roommate _____parent(s)/sibling(s) ___live alone

Have you or a family member ever had any of the following?:

	Me	Parent(s)	Sibling(s)	Grandparent(s)
Allergies/hay fever:	☐	☐	☐	☐
Asthma/emphysema:	☐	☐	☐	☐
Diabetes/high blood sugar:	☐	☐	☐	☐
Thyroid disease:	☐	☐	☐	☐
Migraines:	☐	☐	☐	☐
Epilepsy/seizures:	☐	☐	☐	☐
High blood pressure/hypertension:	☐	☐	☐	☐
High cholesterol:	☐	☐	☐	☐
Heart problems:	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐
Liver/digestive problems:	☐	☐	☐	☐
Kidney disease:	☐	☐	☐	☐
Severe Infections:	☐	☐	☐	☐
Anxiety/Depression:	☐	☐	☐	☐
Bipolar illness:	☐	☐	☐	☐
Alcoholism/substance abuse:	☐	☐	☐	☐

Details if known: ____

____

Are you taking ANY prescription medications (including oral contraceptives), over-the-counter medicines, herbs, vitamins, or supplements? ☐Yes ☐No
Please list names, dosages, and how often you take them: ____

____

____

Are you allergic to/intolerant of any medications, foods, or stinging insects? ☐Yes ☐No
Please describe any reactions or side effects: ____

____

Have you ever had surgery or been hospitalized overnight? ☐Yes ☐No
Date(s): ___/___/___ Reason: ___________________________Doctor: _____________City: ____________
Date(s): ___/___/___ Reason: ___________________________Doctor: _____________City: ____________
Date(s): ___/___/___ Reason: ___________________________Doctor: _____________City: ____________

IMMUNIZATIONS AND DATES:
Last tetanus:____________ MMR (measles, mumps, rubella): ____________
Pneumonia: ____________ Influenza/flu: ____________
Hepatitis B: ____________ Chickenpox: ____________

OVER→

Reproductive History (for primary care patients only):

Sexual preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Method of contraception: ______________________________

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDs, has become a major public health problem. Risk factors for HIV include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your physician about your risk of this illness? __ Yes __ No

Females only:

Age of first menstrual period: ________ Age of menopause: ______________

Number of pregnancies: ____ Number of live births: ____ Number of miscarriages/terminations: ______

Do you perform breast self-exams? ☐Yes ☐No Date of last mammogram: ______/______/______

Date of last pap smear: ___/_____/_____ Any history of abnormal pap smears? ☐Yes ☐No

Males only:

Do you perform testicular self-exams? ☐Yes ☐No

Last prostate exam/PSA test? ________ Any history of abnormal PSA? ☐Yes ☐No

---

Review of Systems:

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:

Fever/chills	☐	____________	Lungs	☐	____________
Wt loss/gain	☐	____________	Chest/heart	☐	____________
Excessive fatigue	☐	____________	Back	☐	____________
Head/neck	☐	____________	Intestinal	☐	____________
Ears	☐	____________	Bladder/kidney	☐	____________
Nose	☐	____________	Joint/muscle pain	☐	____________
Throat	☐	____________	Skin	☐	____________
Eye/Visual problems	☐	____________	Sleep	☐	____________

Lifestyle/Health Habits: All answers are optional and are kept strictly confidential.

Exercise: ____ Sedentary (no exercise) ____ Mild exercise (e.g. climb stairs, walk 3 blocks, golf)
____ Occasional vigorous exercise (work or recreation, <4x/wk for 30 min)
____ Regular vigorous exercise (work or recreation, 4+x/wk for 30 min)

Alcohol: Ever felt the need to cut down on alcohol use? __Yes ___No
Ever been angry when criticized about your alcohol use? ___ Yes ____No
Ever felt guilty about something that happened while you were drinking? ___Yes ___No
Ever needed an "eye opener" in the morning? ___Yes ___ No
Do you tend to binge drink? ___ Yes ___ No

Tobacco: Do you use tobacco in any form? ☐Yes ☐No # years______ or year quit_______
Cigarettes: _____packs/day Chew: _____# times/day Cigar/pipe :_____#/day

Caffeine: ___None ___Coffee ___Tea ___Soda/cola # cups/cans per day: _______

Drugs: Do you currently use recreational or street drugs? ____Yes ___No
Have you ever given yourself street drugs with a needle? ____Yes ____No

Safety: Seatbelts: _____Yes _____No Helmets: _______Yes ________No
Physical and/or mental abuse have become major public health concerns in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your physician? ___yes ___no

Mental Health:
During the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐Yes ☐No
During the past month, have you often been bothered by little interest or pleasure in doing things? ☐Yes ☐No
During the past month, have you had difficulty sleeping? ☐Yes ☐No
During the past month have you been sleeping more than is typical for you? ☐Yes ☐No
During the past month, have you been feeling tired or felt a loss of energy? ☐Yes ☐No

Diet: How would you describe your diet? ______________ # meals/day________ # eat out/take-out/wk__________

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 notice describes our privacy practices. 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. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. 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 that physician, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO 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. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted 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 that rely 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.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations 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:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may 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 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 person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

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

C. Your Rights Under Federal Law

The U. S. 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 patients who exercise 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 health care 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.

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

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 at the end of this document.

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 at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

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

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information 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 arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you 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.

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 at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- 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 now have the incorrect information.

Accounting of Certain Disclosures
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 at the end of this document. 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.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits
We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. 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 U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government. 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

F. 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.

G. 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

Mark Hutchens, MD
Texas Sports & Family Medicine
3200 Red River, Suite 201
Austin, Tx. 78705
(512) 473-0201
Fax: (512) 473-0202

This notice is effective April 14, 2003.