☐ New Patient ☐ Updated Information

Patient Demographics

Patient Name:_____ Birth Date:_____/_____/_____
LAST FIRST MI

Social Security No: _____-_____-_____ Gender: ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #: ____-____-____ Cell #: ____-____-____ Work #: ____-____-____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language: _____

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

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: ____-____-____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company:_____ Insured's Name:_____

Policy #:_____ Group #:_____ Insured's Date of Birth: _____

Secondary Insurance

Secondary Company:_____ Insured's Name:_____

Policy #:_____Group #:_____ Insured's Date of Birth: _____

Self-Pay Agreement

I agree to pay for medical services rendered from IMPACT PHYSICIANS OF TEXAS, P.A. and/or affiliated providers. I understand that payment arrangements must be made prior to establishing as a new patient.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize IMPACT PHYSICIANS OF TEXAS PA and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with IMPACT PHYSICIANS OF TEXAS PA and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of IMPACT PHYSICIANS OF TEXAS PA. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the IMPACT PHYSICIANS OF TEXAS PA and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical / surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered, unless payment arrangements have been made.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

IMPACT PHYSICIANS OF TEXAS PA and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that IMPACT PHYSICIANS OF TEXAS PA and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

_____ _____ _____

Patient Name (Please Print) Date Patient Signature

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of IMPACT PHYSICIANS OF TEXAS PA and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of IMPACT PHYSICIANS OF TEXAS PA and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of IMPACT PHYSICIANS OF TEXAS PA and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of IMPACT PHYSICIANS OF TEXAS PA and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of IMPACT PHYSICIANS OF TEXAS PA and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of IMPACT PHYSICIANS OF TEXAS PA and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of IMPACT PHYSICIANS OF TEXAS PA and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of IMPACT PHYSICIANS OF TEXAS PA and affiliated providers may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Date

NEW PATIENT HEATH HISTORY QUESTIONNAIRE

IMPACT PHYSICIANS OF TEXAS

PATIENT NAME:_____ **DOS:**_____/_____/_____ **DOB:** _____/_____/_____

Do you have any of the following symptoms (Please circle if applicable)

Weakness	Ringing in ears	Night Sweats	Incontinence
Loss of appetite	Blood from nose	Swallowing problems	Excessive Thirst
Fever	Hoarseness	Indigestion	Blood in urine
Chills	Cough	Stomach pains	Snoring
Weight Loss	Coughing up blood	Vomiting blood	Anxiety
Weight Gain	Wheezing	Black tarry stools	Cold or heat intolerance
Changes in hair or skin	Shortness of breath	Blood in stools	Enlarged Lymph nodes
Headaches	Chest pains	Jaundice	Weakness or numbness
Head injury	Palpitations	Diarrhea	of arms hands feet legs
Blurred Vision	Waking up short of breath	Change in bowel habits	Back or neck pain
Double Vision	Passing out	Burning w/ Urination	Unsteady Gait (walking)
Eye Pain	Swelling of hands or feet	Frequent Urination	Recent Falls
Dizziness	Joint pain	Bladder Problems	

Do you have or have you ever had…..? (Please check if applicable)

☐ Deafness / Decreased Hearing	☐ Epilepsy / Seizures	☐ Diabetes Mellitus
☐ Heart Problems	☐ Mental Illness	☐ Hemorrhoids
☐ Heart Attack	☐ Blood Clots	☐ Stomach / Bowel Problems
☐ High Blood Pressure	☐ Tuberculosis	☐ Ulcers/bleeding
☐ Blood Transfusion	☐ Cancer	☐ Migraines/HA
☐ Anemia	☐ Stroke/TIA	☐ Arthritis
☐ Bleeding Disorder	☐ Blindness / Decreased Vision	☐ Hepatitis
☐ High Cholesterol	☐ Glaucoma/Cataract	☐ Liver Problems
☐ Lung Problems	☐ Sinus Infection	☐ Gout
☐ Asthma / Hay Fever	☐ Urine Infection	☐ Broken Bones
☐ Pneumonia	☐ Kidney Disease	☐ Joint Dislocation
☐ Rheumatic Fever	☐ Kidney Stone	☐ Other:_____
☐ COPD	☐ Thyroid Problems	_____

PAST OBSTETRICAL AND GYNECOLOGICAL HISTORY (Women Only)

Age at onset of menses_____ Date of last menstrual cycle _____
Flow: Light____ Medium_____ Heavy_____ Pain or cramp_____
Any bleeding or spotting between periods?_____ Menopause____ Age at onset_____
Was menopause natural or surgical (hysterectomy)?_____
Any complications of pregnancy or childbirth?_____

FAMILY HISTORY

Has any close Blood Relative (i.e. Parents and Siblings) ever had…..? If so, who?

Diabetes	_____	Cancer	_____	Blood Clots	_____
High Blood Pressure	_____	Anemia	_____	Other:	_____
Heart Disease	_____	Anesthesia Allergies	_____		_____
Heart Attack	_____	Stroke	_____		_____
Heart Surgery	_____	Bleeding Disorders	_____		
Kidney Disease	_____	Tuberculosis	_____		
Lung Disease	_____				

PATIENT NAME:_____ **DOS:**_____/_____/_____ **DOB:** _____/_____/_____

SOCIAL AND PERSONAL HISTORY

Any recent travel outside of the USA: _____ When: _____
Marital Status Single Married Widowed Divorced Separated No. of Children_____
Number of persons in your household_____
Do you or have you worked before?_____ If so, doing what?_____

PERSONAL HABITS

Tobacco_____ How many packs per day?_____ Smoked for how many years?_____
Have you quit smoking?_____ If so, when did you quit?_____
Do you currently drink alcohol?_____ Beer?_____ Whiskey?_____ Wine?_____
How much do you drink per week/day?_____ Have you quit drinking?__ When?_____
How much coffee do you drink per day?_____
Do you use any recreational drugs?_____ What?_____

PAST SURGICAL HISTORY

Please list surgeries you have ever had that required treatment or hospitalization:

☐ Appendectomy Year: _____ ☐ Bypass Year: _____

☐ Gallbladder Surgery Year: _____ ☐ Hysterectomy Year: _____

☐ Spine Surgery Year: _____ ☐ Other: _____

☐ Joint Surgery:Type/year _____ _____

_____ _____

Specialist Physicians you currently see:

Name	Type of Physician	Phone

Past Medical Examinations / Tests:

Exam / Test	Date	Exam / Test	Date
Stress Test		Chest X-Ray	
Cardiac Catheterization		EKG	
Nuclear Scan Test		Blood Work	
Echocardiogram		Other:	

PATIENT NAME:______________________________________ DOS:_____/_____/_____ DOB: _____/_____/_____

Allergies/Sensitivity to Medications: ____

Preferred Pharmacy: _______________________________________Phone# _________________________________

Current Medications:

List ALL medication that you are currently taking including Non-Prescriptions Medication & Herbal remedies.

Medications	Dose	How Often	Approximately Start Date (Month/Year)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 14, 2003* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Chris Mathis. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: IMPACT PHYSICIANS OF TEXAS, P.A.

Privacy Officer: CHRIS MATHIS

Telephone:210.690.0202 Fax:210.690.0206

Address: 21 SPURS LANE SAN ANTONIO, TEXAS 78240