287 FAMILY MEDICINE
PATIENT REGISTRATION

5790 W Hwy 287, Midlothian, TX 76065
Office #972-346-8115 Fax #888-583-2028

Name (first, middle initial, last) ____

Date of Birth ______________ Age _____ Gender ________ Marital Status S M W D

Address ____

City ____________________________ State ______ Zip Code ____________________

Phone Number _________________________ Social Security # ___________________

Drivers License Number ___________________________

Email Address ______________________________

I would like to be added to the patient portal Yes_____ No ______

Employer ___________________________________Phone Number ________________

Employer Address ____

City ____________________________ State ______ Zip Code ____________________

If student, school name _________________________________ Full/Part Time _______

RESPONSIBLE PARTY

Name ________________________________Relationship to Patient ________________

Address ____

City ____________________________ State ______ Zip Code ____________________

Phone Number _________________________ Social Security # ___________________

Employer ___________________________________Phone Number ________________

Employer Address ____

City ____________________________ State ______ Zip Code ____________________

INSURANCE & SUBSCRIBER INFORMATION

Primary Insurance Company ____

Claims Mailing Address ____

City __________________________ State ______________ Zip Code _____________

Policy ID Number __________________________ Group ID Number ________________

Subscriber Name (policy holder) ____

Date of Birth ____________________ Social Security # ___________________________

Relationship to Patient _________________________

Subscriber Employer ________________________________ Work Phone # ___________

Subscriber Employer Address ____

City __________________________ State ______________ Zip Code _____________

Secondary Insurance Company ____

Claims Mailing Address ____

City __________________________ State ______________ Zip Code _____________

Policy ID Number __________________________ Group ID Number ________________

Subscriber Name (policy holder) ____

Date of Birth ____________________ Social Security # ___________________________

Relationship to Patient _________________________

Subscriber Employer ________________________________ Work Phone # ___________

Subscriber Employer Address ____

City __________________________ State ______________ Zip Code _____________

Race, Ethnicity & Language
Acct # __________

We are implementing a systematic method of collecting date on race, ethnicity, and communication needs directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Which category best describes your race?

___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ White or Caucasian
___ Some Other Race
___ Unknown
___ Patient Declined

Which category best describes your ethnicity?

___ Not Hispanic or Latino
___ Hispanic or Latino
___ Unknown
___ Patient Declined

What language do you feel most comfortable speaking with your doctor or nurse?

___ English
___ Spanish
___ Vietnamese
___ Chinese
___ Dutch
___ Hindi
___ Other ______________________

____ ________________________

Patient Name (please print) **Date**

Name: ____________________________________ **Date:** ____________________

DOB: _______________________ **Prior Physician:** _______________________

Phone Number: _______________________

MRSA – Staph Infection ? Y/N If Yes, Where? ____________________________

PAST MEDICAL HISTORY – (Check all applicable)

____ Tuberculosis Exposure? Y/N
____ Depression
____ Anxiety
____ Asthma
____ Emphysema
____ Sleep Apnea
____ High Cholesterol
____ High Blood Pressure
____ Stroke
____ Diabetes Type I or Type II
____ Thyroid Problems
____ Heart Disease (Chest pain, heart attack, stress test, EKG, etc.)

____ Enlarged Prostate
____ Kidney Stones
____ Diverticulitis
____ Gastritis
____ GERD-Reflux-Heartburn
____ Blood Clots
____ Bleeding Disorder – Type? _____________
____ Mental Illness
____ Other _________________________________
____ ADHD

CANCER Y/N Type _______________ Treatment ____

PREVIOUS SURGICAL HISTORY – (Mark all applicable)

Endoscopy Y/N DATE: __________
Colonoscopy Y/N DATE: __________ Polyps Y/N Hemorrhoids Y/N
Gallbladder Surgery Y/N DATE: __________
Hernia Surgery Y/N DATE: __________
Hysterectomy Y/N DATE: __________
Appendix Surgery Y/N DATE: __________
Thyroid Biopsy/Surgery Y/N DATE: __________
Breast Procedures Y/N Explain: ____
____
Bariatric Surgery Y/N Year: __________ Type ____

PATIENT NAME: ________________________________ DOB: __________________

OTHER SURGERIES:

TYPE OF SURGERY YEAR DOCTOR WHERE

____
____
____

DAILY MEDICATION

Names/Doses/Directions: (Include over the counter) Aspirin Y/N Blood Thinners Y/ N

____
____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y/ N
PLEASE LIST MEDICATION & REACTIONS?

____
____

ARE YOU ALLERGIC TO LATEX? Y/N

FAMILY HISTORY

Does any family member have any medical conditions? (Mother, Father, Brother, Sister, Grandparents, Great Grandparents) If so please list:

Heart Disease ____

Diabetes ____

Stroke ____

Thyroid Disease ____

Cancer(Who? What Kind?) _____________________________________
Other ____

Mother: Living/Deceased Father: Living/Deceased

PERSONAL HISTORY (CIRCLE ONE)

Minor Married Single Divorced Widowed Separated Children #____

(MARK ALL APPLICABLE)

Tobacco Products # pack(s) per day_____________
Have you ever smoked? Y/N Started Stopped
Snuff/Chew Y/N ____
Alcohol Y/N If Y, what kind/how much ____________________
Street Drugs Y/N If Y, what type ____________________________

PATIENT'S CONSENT TO TREATMENT

I _________________________________ give my consent for **287 Family Medicine**, to provide my medical treatment. I understand **Dr. Wilfred Miller** will explain my condition, foreseeable risks, and methods of treatment for my condition before treatment is provided. I also authorize **287 Family Medicine** to perform any additional or different treatment that is considered necessary in an emergency situation or in the event a condition is discovered that was not previously known.

I have carefully read and fully understand this **PATIENT CONSENT TO TREATMENT** form and have had the opportunity to discuss my condition and any procedures with a care provider. All my questions have been adequately answered.

Patient's Name _______________________________________ DOB _____________

Patient's Signature ____

Provider's Signature ____

Date __________________________

CONSENT TO TREAT MINOR

I consent for _________________________ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Parent/Guardian Signature ____

Date __________________________

COMMUNICATION PREFERENCE

My preferred method of communication regarding my medical conditions is indicated below:

___ Cell Phone __ Mailed Letter __ Guardian __ My Care 360 (Patient Portal)

If the above method of communication is by phone, please check the appropriate box below:

__ Leave a message with detailed information.

__ Leave a message with a call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications. For example, charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result of if you do not want to be called at all.

APPROVED HIPPA CONTACTS

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient or legal guarding.

If you would like to add additional contacts (other than the patient or legal guardian) that 287 Family Medicine is allowed to disclose this type of information to, please complete the fields below and select the appropriate fields based on your approval for each person you list. In addition, please choose the person you would like 287 Family Medicine to list as your Emergency Contact in the event an emergency situation was to take place at our office.

1. ______________________________Contact Name ____________ Relationship to Patient

   ______________________________ Phone Number

2. ______________________________Contact Name ____________ Relationship to Patient

   ______________________________ Phone Number

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Patient Name (please print____ DATE ___________

Signature of Patient, Parent, or Legal Guardian ____

Appointment/CanceIlation/No Show Policy

Appointments

Office visits are by appointment only please call (972-346-8115). The receptionist may ask about the reason for your visit. This helps us schedule the doctors time more efficently. Please arrive 10 minutes early for your appointment. **Patients who are late for any appointment more than 15 minutes will be rescheduled.** Remember to bring all of your prescriptions, over the-counter medicines, vitamins and supplements to each office visit. This will enable your doctor to review the medications at each visit.

Cancellations

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best medical care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving a time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. **If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. If this is not possible, call as soon as you can so that another patient can be given your appointment time.**

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reaaons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" Is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge for a missed or a non-cancelled appointment. Insurance will not cover charges for no show/late or late cancellation fees. The $35 charge is in addition to any other charges you may have incurred. No refunds will be given. Repeated missed appointments may result in your physician sending a letter discharging you from the practice. We will offer 30 days of emergent care only and transfer your medical records when you find a new physician.

Please sign below agreeing to these terms.

Signature:________________________________ Date:________________________________

Printed Name:______________________________ Date:____________________________

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to 287 Family Medicine and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to 287 Family Medicine. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of 287 Family Medicine, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Patient Name (please print) ____

Signature of Patient, Parent, or Legal Guardian ____________________________________

Date _______________________

ACKNOWLEDGEMENT OF THE RECEIPT OF 287 Family Medicine NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of our privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

We are furnishing you with the attached notice which provides information about how the physician may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of the Notice of Health Information Practices.**

Patient Name (please print) _____________________________________

Signature of Patient, Parent, or Legal Guardian ____

Date _________________________

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.

Understanding Your Health Record/ Information

This notice describes the practices of 287 Family Medicine and that of its physician with respect to your protected health information created while you are a patient at 287 Family Medicine. 287 Family Medicine, physician and personnel authorized to have access to your medical chart are subject to this notice. In addition, 287 Family Medicine and its medical staff may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at 287 Family Medicine. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at 287 Family Medicine.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of 287 Family Medicine, the information belongs to you. You have the right to.

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction, unless the request relates to a restriction on disclosures to your health insurer regarding health care items or services for which you have paid out-of pocket and in-full.
- Obtain a paper copy of this notice of information practices.
- Inspect and request a copy of your health record as provided by law.
- Request that we amend your health record as provided by law. We Will notify you if we are unable to grant your request to amend your health record,
- Obtain an accounting of disclosures of your health information as provided by law.
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Compliance Officer at 287 Family Medicine, 5790 W Hwy 287, Midlothian, TX 76065

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health Information.
- Subject to certain exceptions under the law, provide notice of any unauthorized acquisition, access, use or disclosure of your protected health information to the extent it was not otherwise secured.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures; and
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available upon your request at 287 Family Medicine. The revised notice will also be posted at 287 Family Medicine.

Uses and Disclosures of Medical Information That Do Not Require Your Authorization.

The following categories describe different ways that we may use and disclose medical Information without your authorization, For each category of uses or disclosures we will explain what we mean, but not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information without your authorization should fall within one of the categories,

We will use your health information for treatment..

For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at 287 Family Medicine. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it.This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use and disclose your health information as otherwise allowed by law. Examples of those uses and disclosures follow.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include x-ray services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: Unless you object, we may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care about your location and general condition.

Individuals involved in your care: Unless you object, we may disclose to a family member, other relative, a close personal friend or other person you identify the health information that is directly relevant to that person's involvement in your health care or payment for your health care. If you are not able to agree or object to such disclosure, we may disclose the information as necessary if we determine it is in your best interest in our professional judgment.

Disaster Relief: We may use or disclose your health information to public or private disaster relief organizations to coordinate your care or to notify your family or friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to these disclosures when practical.

Communications regarding treatment alternatives and appointment reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA) We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplernents, product and product defects, or post marketing surveillance Information to enable product recalls, repairs. or replacement.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable laws we may disclose health information about you tor judicial, administrative and law enforcement purposes.

Health oversight activities: We may disclose health information to a health oversight agency for activities authorized by law, such as audits. investigations, inspections and licensure.

Threats to health or safety: We may use or disclose health information as allowed by law if we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or for law enforcement authorities to identity or apprehend an Individual involved in a crime.

Special government functions: We may disclose health information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law, or for protective services to the President of the United States or certain other government officials. If you are a member of the military, we may disclose health information to military authorities under some circumstances. If you are an inmate of a jail. prison or other correctional facility or in the custody of law enforcement personnel, we may disclose health information necessary for your health and the health and safety of others.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

Electronic Health Information Exchange. 287 Family Medicine uses a third party to maintain a Health Information Exchange (HIE). 287 Family Medicine stores electronic health information about you in the HIE. Electronic health information about you from other health care providers or entities that are not part of 287 Family Medicine who have treated you or who are treating you is also stored in the HIE, and 287 Family Medicine and these other providers can use the HIE to see your electronic health information for the purposes described in this Notice, to coordinate your care and as allowed by law 287 Family Medicine monitors who can view your information, but the individuals and entities who use the HIE may disclose your information to other providers..

You may opt out of the HIE by providing a written request to the Compliance Officer at 287 Family Medicine, 5790 W Hwy 287, Midlothian, TX 76065. If you opt out, your information will still be stored in the HIE by 287 Family Medicine, but your information will not be viewable

through the HIE. You may opt back in to the HIE at any time. You do not have to participate in the HIE to receive care.

When We Need Your Written Authorization

We will not use or disclose your health information without your written authorization, except as described in this notice. Uses or disclosures that require your written authorization include the following:

- Most uses and disclosures of psychotherapy notes.
- Uses and disclosures for marketing purposes, unless we speak with you face-to-face or provide a nominal promotional gift.
- Disclosures that constitute a sale of your health information under applicable law.

You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization, send written notice to your 287 Family Medicine physician's office.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Secretary of Health and Human Services

If you believe your privacy rights have been violated, you can file a complaint With the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: 10/03/2016