

Patient Information

PATIENT NAME(FIRST, MIDDLE INITIAL, LAST)	PRIMARY PHONE	SECONDARY PHONE	EMERGENCY CONTACT
ADDRESS	D.O.B.	SOCIAL SECURITY NUMBER	CONTACT RELATION TO PT
CITY,STATE,ZIP	SEX [] MALE [] FEMALE	MARITAL STATUS [] MARRIED [] SINGLE [] OTHER	CONTACT TELEPHONE 1
EMPLOYER NAME AND ADDRESS	OCCUPATION	EMAIL ADDRESS	CONTACT TELEPHONE 2

Guarantor/Responsible Party Information

GUARANTOR NAME(FIRST, MIDDLE INITIAL, LAST)	PRIMARY PHONE	SECONDARY PHONE
ADDRESS (IF DIFFERENT THAN PATIENT)	D.O.B.	SOCIAL SECURITY NUMBER
CITY,STATE,ZIP	SEX [] MALE [] FEMALE	GUARANTOR RELATION TO PT
EMPLOYER NAME AND ADDRESS	OCCUPATION	

Primary Insurance

INSURED NAME(FIRST, MIDDLE INITIAL, LAST)	PRIMARY PHONE	SECONDARY PHONE
ADDRESS (IF DIFFERENT THAN PATIENT)	D.O.B.	SOCIAL SECURITY NUMBER
CITY,STATE,ZIP	SEX [] MALE [] FEMALE	INSURED'S RELATION TO PT
INSURED NAME AND ADDRESS	POLICY/ID NUMBER	
CITY, STATE, ZIP	GROUP NUMBER	COPAY AMOUNT

Secondary Insurance

INSURED NAME(FIRST, MIDDLE INITIAL, LAST)	PRIMARY PHONE	SECONDARY PHONE
ADDRESS (IF DIFFERENT THAN PATIENT)	D.O.B.	SOCIAL SECURITY NUMBER
CITY,STATE,ZIP	SEX [] MALE [] FEMALE	INSURED'S RELATION TO PT
INSURED NAME AND ADDRESS	POLICY/ID NUMBER	
CITY, STATE, ZIP	GROUP NUMBER	COPAY AMOUNT

Authorization and Acknowledgement

I/we hereby state that the above information is true and correct to the best of my/our knowledge. I/we authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient/Parent Guardian

Printed Name

Date

I/we authorize direct payment to be made to the above named practice for any and all medical and surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred.

Signature of Patient/Parent Guardian

Printed Name

Date

Patient Questionnaire

Name _____ D.O.B. _____ Sex: [] Male [] Female
 Marital Status _____ Referred by _____ Occupation _____
 Main Reason for today's visit _____

ILLNESSES, INJURIES, AND OPERATIONS

Type	Date		Type	Date

Indicate with an "X" immediate blood relatives that have:

(X)	Illness	Relation
	Cancer	
	Cerebral Aneurysm	
	Diabetes	
	Heart Disease	
	Stroke	
	Other: _____	

Health Habits, please indicate yes or no by marking "X"

	Yes	no
Alcohol		
Caffeine		
Recreational Drugs		
Tobacco		

Is this related to an on the job injury? [] yes [] no
 Date of Injury ___/___/___

Is this related to a motor vehicle accident? [] yes [] no
 Date of Accident ___/___/___

List symptoms related to your visit today:

Signature

Date

PRIVACY PRACTICES ACKNOWLEDGMENT

ACKNOWLEDGEMENT FORM

I have received the Notice Of Privacy Practices for Edward C. Murphy, M.D. and I have been provided an opportunity to review it.

Name (Please print) _____ D.O.B. _____

Signature _____

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!

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

For Treatment. We are permitted to use and disclose your PHI to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you at Edward C. Murphy, M.D., PA or provide you with medical treatment or services. We also may disclose your PHI to health care providers outside Edward C. Murphy, M.D., PA who may be involved in your medical care, such as physicians who will provide follow-up care, physical therapy organizations, medical equipment suppliers, and skilled nursing facilities.

For Payment. We are permitted to use and disclose your PHI so that the treatment and services you receive at Edward C. Murphy, M.D., PA may be billed to (and payment may be collected from) your insurance company or a third party. For example, we may need to give your health plan information about the surgery you received at Edward C. Murphy, M.D., PA so your health plan will pay us or reimburse you for the surgery. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We are permitted to use and disclose your PHI for our business operations. These uses and disclosures are necessary to run Edward C. Murphy, M.D., PA and to make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you.

To Business Associates for Treatment, Payment and Health Care Operations. We are permitted to disclose your PHI to our business associates in order to carry out treatment, payment or health care operations. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for the health care services we provide.

Individuals Involved in Your Care or Payment for Your Care. We may release your PHI to a family member, other relative or close personal friend who is involved in your medical care if the PHI released is directly relevant to the person's involvement with your care. We also may release information to someone who helps pay for your care.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment with Edward C. Murphy, M.D., PA.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full— we must comply with this request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/hospital;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:
 1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 2. Is not part of the health information kept by or for the office/hospital;
 3. Is not part of the information that you would be permitted to inspect and copy; or,
 4. Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.
- Elect to opt out of receiving further fundraising communications from the office/hospital.
- If you want to exercise any of the above rights, please contact the office, in person or in writing, during regular, business hours. We will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office/hospital is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the office at (713) 795-4300. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to 6550 Fannin, Ste 2323, Houston, Texas 77030. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

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

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of Covered Entities to funeral directors as necessary for them to carry out their duties.

Other Uses

Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."