ALAZAR MEDICALGROUP, PLLC.
INTERNAL MEDICINE
Maurice Alazar, M.D.
Yuly Juarez-Woodworth, F.N.P.
Shellabi Koffi, F.N.P
Keali Mullins, AGNP

ACKNOWLEDGEMENT OF HIPPA PRIVACY PRACTICE

I have reviewed Alazar Medical Group's privacy practice, 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 Responsible Party if Patient is a Minor)

RELEASE OF PATIENT INFORMATION

I consent and authorize the release of any normal and abnormal test result(s) to myself on anyone that might answer at any of the contact numbers I have provided, as well as on any voice mail at any of the numbers I have provided. I consent and authorize this information to be mailed to me at the address I have provided, in case that I am unable to be reached by telephone. In addition, I authorize the release of my medical information to the following person(s):

_____

Printed Name: _____ Today's Date: _____

Signature: _____ Date of Birth: _____

Maurice Alazar M.D
Medicine

Internal

Today's Date _____ **PATIENT INFORMATION** Chart No. _____

Patient's Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security No. _____ Date of Birth _____ Email _____

Age: _____ Marital Status: _____Single _____Married _____Divorced _____ Widowed _____ Other Sex: ____Male ____ Female

Employer's Name _____ Full Time College Student? ____Yes ____ No

Emergency Contact Name **(Someone NOT living in same Household)** _____

Emergency Contact Telephone No. _____

Referred By: _____Physician (if so, Physician's Name) _____
(Please check one)

_____Yellow Pages (which one?)_____ Newspaper (which one) _____

_____ Friend or Relative _____ Other _____ Insurance Plan

RESPONSIBILITY PARTY INFORMATION (IFDIFFERENT FROM PATIENT)

Last Name_____ First Name _____ Middle Initial _____

Relationship to Patient: _____ Spouse _____ Parent _____ Legal Guardian _____ other (if other, explain) _____

Mailing Address_____ City_____ State_____Zip_____
(If different form patient)
Date of Birth_____ Social Security No._____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company_____

Policy Holder's Last Name_____ First Name_____ Middle Initial_____

Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Other Circle One: GroupPolicy or Individual Policy

Policy Holder's Date of Birth_____ Social Security No._____

Policy or ID No_____ Group No._____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company_____

Policy Holder's Last Name_____First Name_____Middle Initial_____

Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Other Circle One: Group Policy or Individual Policy

Policy Holder's Date of Birth_____ Social Security No._____

Policy or ID No_____ Group No._____ Employer_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorized Maurice Alazar M.D. PLLC to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment benefits to Maurice Alazar M.D. PLLC. I understand that I am ultimately responsible for all services whether covered by insurance or not. I authorize my physician, based on his/her discretion, to access my chart for utilization management review.

Date_____ **Signature**_____

(If under 18 years old, parent or guardian)

Alazar Medical Group, PLLC
Internal Medicine
Maurice Alazar, M.D.

FINANCIAL POLICY

To ensure that Alazar Medical Group Internal Medicine has financial stability and can continue to provide medical services to the community and region, the following credit policies shall be enforced:

Payment Responsibility — The patient or his legal representative is ultimately responsible for all charges incurred.

Uninsured Patient — Payment is due at time of service.

Payment Methods — The following payment methods will be accepted: Cash, Visa, Mastercard, Discover and American Express.

Non-covered Service — Payment for all charges which are not covered by insurance is due and payable at the time of service. A pre-treatment deposit may be required.

Assignment of Benefits — Alazar Medical Group Internal Medicine will bill primary insurance plans as a courtesy to its patient provides the required insurance information and signs an assignment of benefits.

Prior Unpaid Accounts — Prior to providing services, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements be approved by the Practice Administrator.

Delinquent Accounts — Patients with unpaid delinquent accounts which have been written off to bad debt may be denied treatment if not medically required.

Third Party Litigation — The practice will not become involved in disputes arising from third party claims (i.e., automobile accidents, liability claims, etc.) with the exception of verified Workers' Compensation claims, or claims involving Medicare and Medical Assistance.

Collection Agency — Accounts which cannot be collected by Alazar Medical Group Internal Medicine after normal in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action. Any fees incurred will be patient's responsibility.

Payment Arrangements — If patient is unable to make full payment of the patient balance when due, periodic, partial payment may be approved in accordance with credit and collection procedures, as authorized by a physician or designee.

Refunds — Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than $5.00 will not be issued unless specifically requested.

No Show — **Failure to call the office 24hrs prior to scheduled appointment will result in a charge of $25.00 as a no-show fee.**

I have read and understand Alazar Medical Group, PLLC's financial office policies.

Print Name: _____ Signature: _____ Date: _____

ALAZAR MEDICAL GROUP, PLLC
INTERNAL MEDICINE

DEEMED CONSENT FOR HIV, HEPATITIS B AND HEPATITIS C VIRUS ANTIBODY TESTING

A law was enacted in Virginia in 1989, which authorized health care providers to perform HIV, Hepatitis B and Hepatitis C virus antibody testing when significant exposure to blood or other bodily fluids occurs in a manner that may transmit the human immunodeficiency virus or hepatitis B or C viruses. The law covers testing of patients and health care workers. Pursuant to this law, in the event of such an exposure, you have deemed to have consented for such testing. Consent is also given to release the result of such testing to the exposed party. You will, however, be notified in the event of such an exposure prior to testing being done and will be given an explanation and an opportunity to have any questions answered.

"I HAVE READ AND UNDERSTAND THE ABOVE DEEMED CONSENT FOR HIV ANTIBODY, HEPATITIS B AND HEPATITIS C VIRUS TESTING."

PRINT PATIENTS NAME: _____ D.O.B: _____

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

Alazar Medical Group, PLLC
Internal Medicine, M.D.
895 N. Nolan River Rd Suite 102
Cleburne TX, 76033
Phone 817-556-9700 Fax 817-556-9702

REQUEST FOR RELEASE OF THE PROTECTED HEALTH INFORMATION (PHI)

(PLEASE PRINT) I, _____ / / _____ - - _____
Patients Name Date of Birth Social Security #

_____
Street Address City State Zip

do hereby authorize the use and/or disclosure of my protected health information (PHI).

AUTHORIZED ENTITY

I request to have information released __from or __to the following entity: (check one)

_____
(Doctor's Name)

_____
Street Address City State Zip

_____
Phone Fax

AUTHORIZED PROTECTED HEALTH INFORMATION

___ Complete Record
__ Record of Care from _____ to _____
__ Records of care regarding condition (s): _____
__ Confer with designated person (s) orally about information in my medical record
__ Other/Specify: _____

I understand that the release of medical records may involve making available to myself or to others information of a personal nature. Issues with regard to personal use of cigarettes, alcohol, and other drugs, as well as possible exposure to infectious disease may be part of the medical record.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. __Yes__No Initials_____

PURPOSE OF DISCLOSURE: __Medical Care __Employer __Attorney
__Insurance __Other: _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the receipt and may no longer be protected by federal HIPPA privacy regulations. I hereby acknowledge that this consent is truly voluntary and valid until revoked, and that I may revoke this consent at any time, in writing, except to the extent that action based on this consent has been taken. I further understand that this authorization will expire in 180 days from the date of signature unless otherwise specified.

Expiration Date_____

_____ _____ **Signature**
of Patient or Legal Guardian **Date** **Signature of Witness** **Date**

ALAZAR MEDICAL GROUP, PLLC
MAURICE ALAZAR. M.D.
INTERNAL MEDICINE

Health History Intake Form

Date: ____/____/____

Name: _____ Birthday: ____/____/____ Age: _____

Local Pharmacy Name: _____

Mail Order Pharmacy Name: _____

Reason for visit today:

_____

_____

_____

Previous Primary Care Physician (if any): _____

Phone: _____ Address: _____

Other Physicians involved in your care: _____

_____

Allergies: (Medications/Food, indicate reaction): _____ None

_____

_____

Current Medication List and Dosage: (Please list name/dose/frequency if known)

_____ _____

_____ _____

_____ _____

_____ _____

Family History: (Please indicate alive or deceased, medical issues and age)

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Review of Systems (mark Yes or No for symptoms in the past 6 months. Circle for symptoms TODAY)

Constitutional/Endocrine
__Yes__No **Fever**
__Yes__No **Chills**
__Yes__No **Weakness/Fatigue**
__Yes__No **Weight Loss**
__Yes__No **Weight Gain**
__Yes__No **Insomnia**
__Yes__No **Snoring**
__Yes__No **Excessive thirst**
__Yes__No **Excessive urination**
__Yes__No **Cold or Heat intolerance**
Other: _____

HEENT
__Yes__No **Sore Throat**
__Yes__No **Stiff neck**
__Yes__No **Change in your voice**
__Yes__No **Sinus Drainage**
__Yes__No **Sinus Head Ache**
__Yes__No **Nose Bleeds**
__Yes__No **Ear ache/drainage**
__Yes__No **Hearing Loss**
__Yes__No **Ringing in your ears**
__Yes__No **Blurred Vision/Loss**
__Yes__No **Wear glasses or contacts**
__Yes__No **Itchy/watery eyes**
__Yes__No **Dental problems**
Other: _____

Gastrointestinal
__Yes__No **Nausea/Vomiting**
__Yes__No **Difficulty swallowing**
__Yes__No **Hemorrhoids**
__Yes__No **Diarrhea**
__Yes__No **Constipation**
__Yes__No **Bloody or Black Stool**
__Yes__No **Abdominal pain**
__Yes__No **Heart burn/indigestion**
__Yes__No **Frequent use of Laxatives**
Other: _____

Urinary
__Yes__No **Pain or Burning with urination**
__Yes__No **Urinary frequency (Night or Day)**
__Yes__No **Blood in urine / Dark urine**
__Yes__No **Incontinence**
__Yes__No **Slow starting or stopping urine**
Other: _____

Genital/Sex Organs
__Yes__No **Penile discharge**
__Yes__No **Testicular lump/pain**
__Yes__No **Breast Pain/discharge/lump**
__Yes__No **Painful intercourse**
__Yes__No **Lack of sexual desire**
__Yes__No **Problems with performance**
Other: _____

FEMALE Reproductive
__Yes__No **Hot Flashes**
__Yes__No **Bleeding after menopause**
__Yes__No **Pap Smear (if yes)**
Date: _____
Age at onset of menstruation_____
1st day of last menstruation_____

Preventive Medicine
__Yes__No **Bone Density Scan/Date_____**
__Yes__No **Mammogram/ Date_____**
__Yes__No **Colonoscopy/Date_____**
__Yes__No **EGD/ Date_____**
__Yes__No **Lipid Profile_____**

Cardiac
__Yes__No **Chest pain**
__Yes__No **Palpitation**
__Yes__No **Irregular heartbeat**
__Yes__No **Exercise intolerance**
__Yes__No **Leg Swelling**
Other: _____

Respiratory
__Yes__No **Persistent Cough**
__Yes__No **Coughing up blood**
__Yes__No **Shortness of breath**
__Yes__No **Wheezing**
__Yes__No **Can't breathe lying flat**
Other: _____

Skin
__Yes__No **Rash/Hives**
__Yes__No **Skin discoloration**
__Yes__No **Lesions/moles/warts**
__Yes__No **Ulcers**
__Yes__No **Itching**
__Yes__No **Nail Problem**
__Yes__No **Unusual Hair loss**
__Yes__No **Easy Bruising**
Other: _____

Psych
__Yes__No **Depressed mood**
__Yes__No **Suicidal thoughts/plans**
__Yes__No **Agitation/irritability**
__Yes__No **Insomnia**
__Yes__No **Anxiety**
__Yes__No **Frequent crying spells**
Other: _____

Musculoskeletal
__Yes__No **Joint pains or stiffness**
__Yes__No **Joint Swelling**
__Yes__No **Muscle weakness**
__Yes__No **Back pain**
__Yes__No **Muscle spasms/ cramps**
__Yes__No **Falling**
Other: _____

Neurologic
__Yes__No **Frequent Headache**
__Yes__No **Seizures**
__Yes__No **Syncope (passing out)**
__Yes__No **Limb weakness**
__Yes__No **Limb numbness**
__Yes__No **Dizziness**
__Yes__No **Swallowing difficulty**
__Yes__No **Loss of Balance**
__Yes__No **Tremors**
__Yes__No **Rigidity**
Other: _____

Past Medical History

Head Aches	_____Yes	_____No	Date: _____
Stroke	_____Yes	_____No	_____
Seizures	_____Yes	_____No	_____
Pneumonia	_____Yes	_____No	_____
Diabetes (type 1 or 2)	_____Yes	_____No	_____
Thyroid Disease (Low or High)	_____Yes	_____No	_____
Glaucoma	_____Yes	_____No	_____
Macular Degeneration	_____Yes	_____No	_____
Hearing Loss	_____Yes	_____No	_____
High Blood Pressure	_____Yes	_____No	_____
Blood Clots	_____Yes	_____No	_____
_____ Pulm. Emboli (lung clots)	_____Yes	_____No	_____
_____ DVT (leg clots)	_____Yes	_____No	_____
Heart Burn, Reflux	_____ Yes	_____No	_____
Stomach Ulcers	_____Yes	_____No	_____
Heart Disease	_____ Yes	_____No	_____
_____ Coronary Disease	_____ Yes	_____No	_____
_____ MI/heart attacks	_____ Yes	_____No	_____
_____ Congestive Heart Failure	_____ Yes	_____No	_____
_____ Atrial Fibrillation	_____ Yes	_____No	_____
_____ Angina	_____ Yes	_____No	_____
_____ Valve Disorder	_____ Yes	_____No	_____
High Cholesterol	_____Yes	_____No	_____
Gastrointestinal Bleeding	_____Yes	_____No	_____
Hepatitis (A, B, C)	_____Yes	_____No	_____
HIV/AIDS	_____Yes	_____No	_____
Chronic Wounds	_____Yes	_____No	_____
Cancer (type)	_____Yes	_____No	_____
Urinary Tract Infections	_____Yes	_____No	_____
Incontinence	_____Yes	_____No	_____
Kidney Stones	_____Yes	_____No	_____
COPD (Emphysema, Bronchitis)	_____Yes	_____No	_____
Asthma	_____Yes	_____No	_____
Depression	_____Yes	_____No	_____
Bipolar Disorder	_____Yes	_____No	_____
Anxiety	_____Yes	_____No	_____
Fibromyalgia	_____Yes	_____No	_____
Chronic Fatigue Syndrome	_____Yes	_____No	_____
Arthritis	_____Yes	_____No	_____
Gout	_____Yes	_____No	_____
Osteoporosis	_____Yes	_____No	_____
Prostate Disease	_____Yes	_____No	_____
Breast Disease	_____Yes	_____No	_____
Erectile Dysfunction	_____Yes	_____No	_____

Other_____

Social History

Habits:

Alcohol: _____None _____Yes: How many drink/day_____ frequency/week_____What kind_____

Tobacco: _____None _____Yes: Chew or Smoke? _____ How many/day_____Since_____

Caffeine: _____None _____Yes: What Kind_____How many/day_____

Other Recreational Drugs: _____None _____Yes: What Kind_____How many/day_____

Do you drive? _____Yes _____No Do you always wear a seatbelt? _____Yes _____No

Do you exercise? _____Yes _____No If yes, how much? _____

Personal Profile:

Work: _____Employed _____Unemployed _____Retired _____Disabled

Current Occupation_____Former Occupation_____

Marital Status: _____Married _____Single _____Divorced _____Domestic Partner

Sexual Preferences: _____Men _____Women _____Both

Children (age): _____

Hobbies: _____

Sports: _____

Pets: _____

Other: _____

Past Surgical History (indicate date if known)

____None
____Cataracts_____
____LASIK_____
____Tonsillectomy_____
____Thyroidectomy_____
____Adenoidectomy_____
____Coronary Bypass_____
____Cardiac Stents_____
____Pacemaker_____
____Heart Valve_____
____Gall Bladder_____
____Appendectomy_____
____Bowel/Stomach Resection_____
____Hemorrhoidectomy_____

___Bariatric surgery_____
___Hysterectomy_____
___Endoscopy_____
___Colonoscopy_____
___Hernia_____
___Spinal Surgery_____
___Tubal Ligation_____
___Bladder surgery_____
___Prostate surgery/resection_____
___C-Section_____
___Orthopedic/joints_____
_____
___Other_____

_____
_____

Patient Signature: _____ Date:_____

Physician Signature: _____ Date:_____