Dr. Van Tran
Family Practice

1919 North Loop West • Suite 218 • Houston, Texas 77008
Office: 713-862-5797• Fax: 713-862-0166• Web: www.Drvantran.com

Welcome to Dr. Van Tran Family Practice. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

We will do our best to provide you with same-day office visits and usually accommodate same day office visits for all sick patients. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually, so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription and over-the-counter medications with you at each visit.

Our office policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment will not be rescheduled;
- Two (2) no-show appointments will result in dismissal from the practice.
- Please call 24 hours prior to your appointment if you need to cancel or reschedule. If 24 hour notice is not given, we do charge a $25 fee that is not covered by insurance plans.

We understand that appointments sometime need to be changed, so we ask that you call our office at 713-862-5797 or send us a message via Patient Portal in advance if you cannot keep your scheduled appointment.

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. ***Dr. Van Tran Family Practice does not offer chronic pain management and will not dispense chronic pain medication*** (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.
2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.
    a. When you are down to a 30 day supply of medication, we ask that you call and schedule your follow-up office visit in order to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.
3. For the safety and well-being of our patients,
    a. Requests for new medications (including antibiotics) and medication refills will not be taken over the phone or over the Internet during office hours without an appointment and evaluation by the physician.
    b. No new medications (including antibiotics) will be called in over the phone after office hours by the on-call physician.
    c. We understand that unexpected situations arise, thus a small refill of a chronic medication will be granted for one or two days after office hours on an as-needed basis determined by the on-call physician. This allows patients to be seen and evaluated by the physician during office hours for all their medication refills.

If you need to reach the physician after hours, you can reach our answering service at 713-862-5797. Our office hours for patient care are Monday through Thursday, 7am-5pm and Fridays 7am-4pm.

Dr. Van Tran Family Practice is affiliated with Memorial Hermann Hospital System. I am on the medical staff at Memorial Hermann- Greater Heights and work with the many specialty physicians there. I will be directing our patients to use Memorial Hermann's laboratory services and imaging resources. Our electronic medical record allows us to receive patient results quickly and efficiently through our direct link with Memorial Hermann services. This is an important resource in meeting our goal of providing high quality care in a timely manner.

Welcome to our practice and thank you for choosing Dr. Van Tran Family Practice for all your health care needs.

Sincerely,

Van Tran

Van Tran
Medical Director

Dr. Van Tran
Family Practice

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Today's Date: _____

PATIENT INFORMATION

Last Name:	First:	Middle:
Marital status:	Primary Language:	
Ethnicity:	Race:	
Birth date:	Age:	Sex:
Address:		
Email Address:		
Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:		
Employer:	Employer phone no.:	
Referred By:		
Other family members seen here:		

INSURANCE INFORMATION

(Please give your insurance card and Photo ID to the receptionist.)

Please indicate primary insurance:

Policy Number.:	Group Number.:
Subscriber's Name:	Subscriber DOB:
Co-payment:	
Patient's relationship to subscriber:	

Name of secondary insurance (if applicable):

Policy Number.:	Group Number.:
Subscriber's Name:	Subscriber DOB:
Co-payment:	
Patient's relationship to subscriber:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship to patient:	Phone no.:

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Notice of Privacy Practices

This notice describes how protected medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

1. Dr. Van Tran Family Practice is permitted to make uses and disclosures of protected health information for treatment, payment, and healthcare operations, as described in the following examples:
    a. For treatment- consultation, lab work, etc.
    b. For payment- claim filing, collection of payments due, etc.
    c. For health care operations- chart maintenance, regulatory requirements, accounting, HIPAA compliance activities, etc.
2. Dr. Van Tran Family Practice is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Other uses and disclosures will be made only with the authorization, and the individual may revoke such authorization.
3. Dr. Van Tran Family Practice may engage in the following activities:
    a. Dr. Van Tran Family Practice may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
    b. Dr. Van Tran Family Practice may contact adult immediate family members to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
4. The individual has the following rights regarding protected health information:
    a. The right to request restrictions on certain uses and disclosures of protected health information. However, Dr. Van Tran Family Practice is not required to agree to a requested restriction.
    b. The right to receive confidential communications of protected health information, as applicable.
    c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
    d. The right to amend protected health information, as provided in the Privacy Regulation.
    e. The right to receive an accounting of disclosures of protected health information.
    f. The right to obtain a paper copy of the notice from the covered entity upon request. The right extends to an individual who has agreed to receive the notice electronically.
5. Dr. Van Tran Family Practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
6. Dr. Van Tran Family Practice is required to abide by the terms of the notice currently in effect.
7. Dr. Van Tran Family Practice reserves the right to change the terms of this notice. The new notice will be effective for all protected health information that it maintains.
8. Dr. Van Tran Family Practice will provide individuals or patients with revised notice as requested
9. Individuals may complain to Dr. Van Tran Family Practice and the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. Complaints may be submitted in writing to 1919 North Loop West, Suite 218, Houston, TX 77008.
10. Dr. Van Tran Family Practice contact person for matters relating to complaints is Sandy Alvarez at 713-862-5797
11. This notice is in effect on April 30, 2004.
12. Dr. Van Tran Family Practice elects to limit the uses or disclosures that it is permitted to make by law.

I, _____ , hereby acknowledge that I have received a copy of Dr. Van Tran Family Practice's Notice of Privacy Practices.

_____ _____

Individual's Signature Date

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Consent for Treatment/ Assignment of Benefits

I, _____, hereby request and authorize Dr. Van Tran Family Practice to examine and treat me. I understand that I will be required to sign a separate release for medical records transfer to any other source. I authorize payment(s) of medical benefits to Dr. Van Tran Family Practice. If services are denied and considered non-covered by my insurance carrier, I will be responsible for the balance due.

Consent for Release of Protected Health Information

I, _____, consent to the release of protected health information that is required to carry out treatment, payment and healthcare operations of my behalf.

I have read the Notice of Privacy Practices and I am aware of the following:

1. I have the right to place restrictions on the way my protected health information is used or disclosed.
2. I understand that Dr. Van Tran Family Practice is not required to agree with my restrictions. I also understand that once Dr. Van Tran Family Practice agrees to my restrictions, it must comply with those restrictions.
3. I have the right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
4. I understand that Dr. Van Tran Family Practice must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
5. Dr. Van Tran Family Practice has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practice, we will modify the Notice accordingly; and we will inform you via posted notice.

I give permission to the following individuals to receive health information on my behalf. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification.

_____ _____

Name of Person Authorized to Receive Health Information | Relationship to Patient (Ex: Spouse, Son, etc.)

_____

Patient Printed Name

_____

Patient Signature

_____

Date

Office Use Only

Witness:

Printed Name

Signature

Date

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Authorization For Release of Protected Health Information

I authorize **Dr. Van Tran Family Practice** to:

(Check One) ____ **release** medical records to or ____**receive** medical records from:

Person or Organization | Address

Phone Number | Fax Number

Information/ copies from the medical records on:

Patient Name | Date of Birth | Social Security Number

Date(s) of Service

Information to be released:

___ History & Physical ___ Medication list(s) ___ Billing Records

___ Consultation Notes ___ Diagnostic Procedure Report

___ Progress Notes ___ EKG Reports (Most Recent)

Other: _____

This information is being released for the following purpose:

___Continued Care ___Attorney/ Litigation ___ Insurance ___ Disability Services

___ Billing Purposes ___ Other:_____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire ____days from the date of my signature.

If no time period is specified, it shall expire in 180 days from the date of signature.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

To the party receiving this information: this information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulation (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

For patient records applicable under federal law 42 CFR part 2

Patient Signature | Date

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Narcotic Agreement

This agreement is between the patient and Dr. Van Tran Family Practice. It is agreed that **Dr. Van Tran** will give narcotic medication to patient **only** if the following terms are met:

1. By signing a contract for narcotic administration, the patient indicated that he/she has understood the discussion about the use of narcotic medications, including side effects, and is agreeable to start this treatment under the terms set by Dr. Van Tran.
2. The patient has the chance to ask questions regarding alternatives to the use of narcotic medications.
3. Dr. Van Tran Family Practice should be the **one and only source** of narcotic medications unless written permission is given by physician for the patient to get narcotic prescriptions from another physician.
4. **Only one pharmacy** will be used for filling narcotic prescriptions.

   Pharmacy Name: _____

   Pharmacy Phone Number: _____
5. If it is found that the patient received prescriptions for narcotic medications from a source other than physician, without written permission physician, may void this agreement and discontinue any prescriptions of narcotic medications to the patient.
6. **The patient agrees to have urine tests for medications done randomly at the physician's request.**
7. The patient must agree to allow the physician to communicate with the referring physician and any pharmacists regarding the patient's use of controlled substances.
8. The patient must supply documentation of treatment by other physician for co-existing, or related condition, including psychiatric conditions.
9. **The patient understands that Dr. Van Tran Family Practice will not replace any lost or inaccessible narcotic prescriptions or narcotic medications, for ANY REASON WITHOUT A POLICE REPORT.**
10. The patient must take the narcotic medications **exactly as instructed** by the Physician.
11. Any unauthorized increase in the dose of narcotic medication may be viewed as a cause for discontinuation of the treatment with narcotic medications.
12. If the patient demonstrates unacceptable behavior patterns, the physician may discontinue prescribing the narcotic medications for the patient.
13. The patient must **keep all regular follow up appointments** as recommended by the Physicians. Failure to comply may cause discontinuation of narcotic prescriptions.
14. The patient must comply with **all** aspects of the treatment plan, including, but not limited to, Physical Therapy, Behavioral Management, and Pain Management programs.
15. All prescriptions must be picked up by the patient himself/herself. If the patient is too debilitated or sick, an exception may be allowed.
16. **No narcotic prescriptions will be refilled on weekends or afterhours.**
17. **Narcotic prescriptions WILL NOT be refilled early.**

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18. The patient understands that the benefit of the narcotic medications will be evaluated periodically using the following criteria of pain relief, increase in general functions, increase in exercise, completion of rehabilitation program, return to work, maintenance of job, etc.
19. The patient understands the narcotic medications can be discontinued immediately, at the treating physician's discretion, if the patient does not fulfill the terms of this agreement. Medication can also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or if significant side effects develop.
20. The patient certifies or agrees to the following:
    a) That he/she is **not currently abusing illicit** or prescription drugs.
    b) That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substance (narcotics, sleeping pills, nerve pills, or pain killers).
    c) That she is not pregnant and that she will use appropriate contraception during her course of treatment.
    d) **Sharing your narcotics is strictly prohibited**. Any sharing will result in immediate cancellation of your prescription refills.
21. Evidence of medication hoarding, increasing the amount of medication without communication to your physician, refilling your prescription too frequently, getting the medication from multiple physicians, increasing the amount of medication despite significant side effects, altering prescription, medication sales, unapproved use of other drugs (alcohol, sedatives, or using non-prescription, medications inconsistent with drug labeling) during narcotic analgesic treatment or other unacceptable behavior will result in tapering and discontinuing of narcotic therapy.
22. **If the patient is non-compliant or un-cooperative with the Physician or Office Staff we reserve the right to discharge you at any time.**

I, _____, fully understand the explanations regarding the benefits and the risks of this method of treatment. I agree to the use of narcotic medication in treatment of my pain problem.

This form has been fully explained to me, I have read it or have had it read to me, and I understand it. I have had the opportunity to ask questions, and have received acceptable answers. I agree to the terms of this contract.

Today's Date: _____

Patient Signature: _____

Patient Printed Name: _____