**\*\*New Phone Number 281-446-1520\*\* Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Humble Family Practice**

**Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MI:\_**\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please circle below)**

**Marital Status:** Married / Divorced / Widowed / Single / Other  **Gender:** Male/Female

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City:**\_\_\_\_\_\_\_\_\_\_\_\_ **State:**\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Employer& Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact in case of an emergency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy of Choice:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

**Insurance Co Name & Phone#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** Male / Female (please circle) **Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidential Communication**

**I give Humble Family Practice permission to give/discuss any of my medical information to the following people:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We may leave confidential messages on my: (Please Circle)** Home Phone Cell Phone Work Phone Email Address

**Financial Responsibility**

All professional services rendered are charged to the patient and are due at the time of service. Based on insurance coverage co-pays and deductibles may apply. A $25.00 No Show charge will be applied if appointment is not cancelled 24 hours in advance.

**Assignment of Benefits**

I hereby assign all medical, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Humble Family Practice for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices Acknowledgement**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can, and will be used to:

* Conduct, plan and direct my treatment and follow-up among the employees of Humble Family Practice PLLC.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations as quality assessment and physical certifications.

I have been given the opportunity to read and understand the Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my health information. I understand that Humble Family Practice PLLC has the right to change the Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of this notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operation. I also understand this office is not required to agree to my restriction, but if they do agree then they are bound to abide by such.

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Privacy and Release of Information Authorization**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Humble Family Practice PLLC and its

affiliates, its employees and agents, to use and disclose protected health information (e.g., information

relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided

to me and which identifies my name, address, social security number, Member ID number) for the

purpose of helping me to resolve claims and health benefit coverage issues. I understand that any

personal health information or other information released to the person or organization identified above

may be subject to re-disclosure by such person/organization and may no longer be protected by

applicable federal and state privacy laws. I understand that I have a right to revoke this authorization

by providing written notice to. However, this authorization may not be revoked if, it’s employees or

agents have taken action on this authorization prior to receiving my written notice. I also understand

that I have a right to have a copy of this authorization. I understand that information used or disclosed

pursuant to this authorization may be disclosed by the recipient and may no longer be protected by

federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign

this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment

for or coverage of services. I have been advised of this practice’s Privacy Practices, Release of Billing

Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. If

applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal

representative of the Member identified above and will provide written proof (e.g., Power of Attorney,

living will, guardianship papers, etc.) that I am legally authorized to act on the Member’s behalf with

respect to this authorization form.

**Patient Printed Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signed Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Roles & Responsibilities**

Please initial each of the following office procedures

\_\_\_\_\_\_\_ I understand and agree to inform the front office staff of any changes to my personal data and insurance information at all times. If information is incorrect at any time, I could be subject to a service fee of $20.00.

\_\_\_\_\_\_ I understand and agree that payment is always due at the scheduled check in date and time. We will not bill you for your financial portion.

\_\_\_\_\_\_ I understand and agree that this practice bills my insurance, but I am financially responsible for all/any balances and/or payments due as stated by my insurance benefit plans as verified.

\_\_\_\_\_\_ I understand and agree all prescriptions, including refills, require an office visit with the doctor’s office. Please do not call or fax. NO EXCEPTIONS.

\_\_\_\_\_\_ I understand and agree to help facilitate waiting time, ALL physicals will be scheduled separate from office sick visits.

\_\_\_\_\_ I understand and agree to call the doctor’s office to cancel or reschedule my scheduled appointment with at least a 24 hour notice. Failure to do so will result in a $25.00 fee.

\_\_\_\_\_ I understand and agree that I will be responsible for an additional $25.00 service fee for insufficient fund returned checks.

**Printed name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient contract for using controlled substances**

This is an agreement between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the patient) and Humble Family Practice concerning the use of controlled substances.

I give permission for the doctor to verify that I am not seeing other providers for controlled substances or going to other pharmacies. Any violations of this contract will result in the discontinuation of treatment and I will no longer be able to receive controlled substances from this clinic.

1. **Risk**: I have been advised and understand that controlled substances are strong medications with significant risks, such as physical dependency, and side effects.
2. **Dosing and refills**: I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Needing early refills, changing doses without permission, or losing prescriptions may be considered signs of misuse of the medication and violation of this contract and may justify discontinuation of the prescription. Any and all refills will require a scheduled office visit.
3. **Replacing medication**: I agree to keep my medication in a safe and secure place.

**Under no circumstances will lost or stolen medications be replaced.**

1. **Personal use**: I agree to not sell, lend, or give my medications to any other person.
2. **Alcohol and drugs**: I agree not to drink alcohol or take other mood-altering drugs while I am taking any controlled substances. I agree to submit to a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.
3. **Quantity**: I understand that the quantity of medication given is intended for one month of use. Refills will not be given prior to the one month follow-up. The quantity will not exceed sixty (60) tablets or capsules for any one month period.
4. **Physical therapy or psychiatric referral**: A referral for physical therapy or a psychiatric evaluation may be required in an effort to treat the underlying problem.

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Medical History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies - List allergies to food / medicaitons \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications – Please list any prescription medication, dosage, and how often you take them ; Include over the counter medications.

|  |  |  |
| --- | --- | --- |
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|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

 Name Dosage How Often

Past medical history – Please write the year the diagnosis was made next to it

\_\_ High Blood Pressure \_\_ Peptic Ulcer Disease \_\_ Arthritis \_\_ IBS

\_\_ High Cholesterol \_\_ Enlarged Prostate \_\_ Osteoporosis \_\_ Gout

\_\_ Heart Attack (Date\_\_\_\_\_) \_\_ Renal Failure \_\_ Diabetes \_\_ Anemia

\_\_Asthma \_\_ Kidney Stones \_\_ Hyperthyroid \_\_ Anxiety

\_\_ Chronic Bronchitis \_\_ Urinary Incontinence \_\_ Hypothyroid \_\_ Migraines

\_\_ COPD \_\_ Fibromyalgia \_\_ Stroke \_\_ Allergies

\_\_ Pneumonia \_\_ Sleep Apnea \_\_ Parkinson’s Disease \_\_ Cirrhosis

\_\_ Tuberculosis \_\_ Reflux Disease \_\_Pancreatitis \_\_ Hepatitis

\_\_ Colon Polyps \_\_ Depression \_\_ Mental Illness \_\_ Diseases(\_\_\_\_\_\_

Surgeries – Have you had any surgeries? \_\_\_\_No \_\_\_\_Yes ; List all & dates

|  |  |
| --- | --- |
|  |  |
|  |  |

Do you use tobacco products? \_\_\_\_No \_\_\_\_Yes ; How often? \_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_

Do you drink alcohol? \_\_\_No \_\_\_Yes ; How often? \_\_\_\_\_\_\_\_ Caffine intake?\_\_\_No\_\_\_Yes How often?\_\_\_\_\_\_\_\_\_\_

Do you exercise? \_\_\_No\_\_\_Yes How often?\_\_\_\_\_ Do you take recreational drugs? \_\_\_No \_\_\_\_Yes How often?\_\_\_

Colonoscopy?\_\_\_No\_\_\_Yes\_\_\_Yr Chest X-ray?\_\_\_No\_\_\_Yes\_\_\_Yr Stress Test?\_\_\_No\_\_\_Yes\_\_\_Yr

Echo or Doppler?\_\_\_No\_\_\_Yes\_\_\_Yr Hospitalizations?\_\_\_No\_\_\_Yes ; Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccinations – If you have had any of these, list the dates received

\_\_ Tetanus \_\_ HPV \_\_ Flu \_\_ Pneumonia

\_\_ Hepatitis A \_\_ Hepatitis B \_\_ Meningitis \_\_ Other

|  |
| --- |
| Women:Last Pap Smear \_\_\_\_\_\_\_ History of abnormal pap smears?\_\_\_\_\_ Last Mammogram \_\_\_\_\_\_\_\_\_\_Bone density test? \_\_\_\_\_\_\_ Number of pregnancies \_\_\_\_\_\_\_\_ Number of deliveries \_\_\_\_\_\_\_\_ |

Family History Grandparent Mother/Father Sibling Children

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| High Blood Pressure |  |  |  |  |
| High Cholesterol |  |  |  |  |
| Heart Attack |  |  |  |  |
| Stroke |  |  |  |  |
| Heart Disease |  |  |  |  |
| Diabetes |  |  |  |  |
| Osteoarthritis |  |  |  |  |
| Hypo/Hyperthyroid |  |  |  |  |

Cancer – Who / Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Illness – Who / Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other family history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Humble Family Practice to leave messages on these phone numbers

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Humble Family Practice to leave messages with these persons regarding medical information

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity and race is a major factor affecting the health of individuals and communities. New health guidelines are requiring us to document your ethnicity, language, and race. Please choose an ethnicity, language, and race from the list below.

**Language**

* Arabic
* Chinese
* English
* French
* German
* Japanese
* Spanish
* Russian
* Vietnamese
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race**

* American Indian or Alaska Native
* Asian
* Black or African American
* Native Hawaiian or other Pacific Island
* White
* Other
* Declined

**Ethnicity**

* Hispanic or Latino
* Not Hispanic or Latino
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Declined

**Advanced Directives:**

Do you have an executed advanced directive? Yes/ No

Do you have a living will? Yes/ No

Would you like information regarding advanced directives or a living will? Yes /No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Patient Name** (Printed) **Date of birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Patient Name** (Signed) **Date**