Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present **INSURANCE ID** cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Policyholder: _____ Date of Birth: _____ Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Policyholder: _____ Date of Birth: _____ Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____

PATIENT'S EMPLOYER INFORMATION

Employer: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Occupation: _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Lilette Daumas MD PA, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Lilette Daumas, MD
FAMILY MEDICINE

Name: _____ _____ _____ Sex: M F Date of Birth: _____ Age: _____
Last First Middle

Pharmacy Name: _____ Pharmacy Telephone Number: _____

CURRENT MEDICATIONS

* Please include vitamins, over the counter meds, birth control pills, and herbal medications. Example: Lipitor 20 mg 1 tablet daily at night, etc.

NAME	DOSAGE -mg/units/puffs/drops	FREQUENCY - How many times per day? Morning and/or night? After meals?

Other Current Medications_____

ALLERGIES TO MEDICATIONS/FOODS _____ None _____

Name of Medication/Food	Allergic Reaction	Other Adverse reaction

Name of Medication/Food	Allergic Reaction	Other Adverse reaction

PAST MEDICAL HISTORY _____ None _____

*Please write a check (√) if you have or you had any of the following.

	Anemia		Cancer – specify/ type _____		Heart Valve Problem		Prostate Problem
	Aneurysm		Depression- major/bipolar on meds?		Hepatitis		Seizures
	AIDS/HIV Positive		Diabetes Mellitus Pills/ insulin?		High Blood Pressure		Sexually Transmitted Disease/ Herpes/other
	Anxiety- on meds		Emphysema/ Chronic Bronchitis		High Cholesterol		Sleep Apnea
	Asthma		GERD/ reflux		Kidney Problem		Stroke/ TIA
	Atrial Fibrillation		Glaucoma – Right/Left?		Migraine Headache		Thyroid Problem
	Arthritis		Heart Attack		Osteoporosis		Other _____
	Blood Clot-lung/leg		Heart Failure		Pancreatitis		

Other Chronic Illness(es): _____

Patient Name:_____ Date: _____

SURGICAL HISTORY/PROCEDURES *Please write a check (√) if applicable. _____ **None _____**

TYPE	√	Month/Year
Abdominal Surgery		
Amputation (finger/toe/leg)		
Arthroscopy – Knee/ shoulder		
Appendix removal		
Back Surgery		
Biopsy (site)s		
Bladder Suspension		
Cataract Removal		
Colon Surgery- Removal		
Fracture/Bone Repair		
Heart Bypass/Valve Surgery		

TYPE	√	Month/Year
Hernia Repair		
Hysterectomy		
Joint Replacement		
Kidney Surgery		
Mastectomy		
Neck Surgery		
Thyroid Surgery		
Tonsillectomy		

PROCEDURE	√	Month/Year
Echocardiogram		
EGD Stomach Endoscopy		
Heart Cauterization With or without stent?		
Normal/Abnormal		
Stress Test		
Colonoscopy		
Normal		
Abnormal		
Polyps		
Diverticulitis		
Cosmetic Procedure		

FAMILY HISTORY *Please write a check (√) if applicable. _____ **None _____**

	Father	Mother	Brother	Sister	Other
Alcoholism					
Alzheimer's/Dementia					
Aneurysm					
Arthritis					
Asthma					
Circulation Problem					
Coronary Artery Disease					
Heart Attack/Sudden Death					
Heart Failure					
Cancer:					
Bladder					
Breast					
Cervical					
Colon					
Kidney					
Esophagus					
Liver					
Lung					
Lymphoma					

	Father	Mother	Brother	Sister	Other
Cancer (continued):					
Ovarian					
Pancreas					
Prostate					
Stomach					
COPD/Lung Disease					
Depression/Nervous/ Emotional Disorder					
Diabetes					
Glaucoma					
High Blood Pressure					
High cholesterol					
Kidney Disease					
Migraine					
Osteoporosis					
Seizure					
Stroke					
Suicide					
Thyroid Problem					

SOCIAL HISTORY/LIFESTYLE *Please write a check (√) and complete the following if applicable.

MARITAL STATUS	Married_____ Single_____ Divorced_____ Widow_____ Legally Separated_____ No. of biological children_____
TOBACCO	Non-Smoker _____Smoker _____ Type: _____(cigars/ cigarettes/ other)
	How much per day? _____ For how long? _____ Date/Year Quit _____ ____
	Uses Smokeless Tobacco? _____Yes _____ No
ALCOHOL	Non-Drinker _____ Yes_____ Please estimate your alcohol intake per week (1 unit = 12 oz beer or 1 glass of wine or 1 measures spirit). Number of units per week_____ Quit Drinking? _____ if yes, when?_____

IMMUNIZATION HISTORY *Please write a check (√) if you had any of the following immunizations and the most recent date/year it was administered.

	Yes	No	Date/ Year
Tetanus Diphtheria Booster *For everyone			
Influenza Vaccine (Yearly Flu Shot) *For everyone			
Pneumococcal Vaccine *For age >=65			
Other:			

Patient Name:_____ Date: _____

Patient Portal Informed Consent

Lilette Daumas, MD
FAMILY MEDICINE

Patient Information

Name: _____

DOB: _____

Email address: _____

Preferred Pharmacy: _____
(Specify address and/or phone number to identify the correct location)

Purpose of this Form

Lilette Daumas MD PA offers secure viewing of parts of your medical record and communication with our staff as a service to our patients. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. This service is optional and not necessary to interact and communicate with our clinic.

How the secure patient portal works

A secure Web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site.

How to participate in our patient portal

You can compose, pickup, and reply to secure messages or view information sent to you through a website. Once this form is agreed to and signed, we will send you an e-mail notification that tells you how to register for the first time. This notification will give you the URL (internet address) of the website where you can log in using the username and password provided. Next you will be able to look in your message box and see any new or old messages or view other parts of your electronic medical record. You can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

You can view more clinic specific information or access the Patient Portal through www.drdaumas.com using the portal link on our clinic web page.

Protecting your private health information and risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors:

- The secure message must reach the correct e-mail address.
- Only the correct individual, or someone authorized by that individual, must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct e-mail address and are informed if it ever changes. You also need to keep track of who has access to your e-mail account; so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up the secure messages from a website, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Portal Informed Consent

Lilette Daumas, MD
FAMILY MEDICINE

We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible and will never sell or give away any private information, including e-mail addresses, without your written consent.

Conditions of participating in the patient portal

Access to the secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate the service we will notify you as promptly as we reasonably can. You agree to not hold Lilette Daumas MD PA or any of its staff liable for network infractions beyond their control.

Before you were given this form, we provided you with our policies and procedures for using this web portal. We need you to understand and comply with these, and by signing the form below you acknowledge that they were explained to you and that you agree to comply with them. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this form. If you have any questions, we will gladly provide more information.

It is the responsibility of the patient to keep Dr. Daumas' office informed of any changes of the linked email address as well as the preferred pharmacy.

Patient Acknowledgement

Signature: _____

Date: _____

LILETTE DAUMAS, MD, PA
12755 Woodforest Blvd.
Houston TX 77015
P: (713) 455-1306 F: (713) 455-9560

FINANCIAL POLICIES

Lilette Daumas, MD
FAMILY MEDICINE

Commercial Insurance Plans

As a courtesy to you, we will call your insurance to verify coverage and get a summary of benefits. Remember, verification of coverage and benefits given over the phone by an insurance representative to you or to one of our office staff is NEVER a guarantee of payment.

Our office staff will be happy to discuss our fees with you prior to seeing the doctor. We want our patients to understand our fees and feel confident that they are getting the best medical care available. Payment in full for patient due items (deductibles, co-pays, etc.) will be requested for each visit before you leave. We will not invoice these amounts.
Should you have an outstanding balance and are unable to pay it in full at the time of your visit; we request that you speak to our office staff before your visit.

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Lilette Daumas MD PA, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

_____
Patient Name (please print)

Signature:_____DATE:_____
(Patient's signature)

Medicare

If you are a Medicare participant you are required to furnish us with your Medicare card upon arrival for your first visit. If this is unavailable you will be required to pay for your visit in full at checkout. As a Participating Provider we accept assignment on your Medicare claims and allow 45 days to remit payment in full to this office. Any charges that are not covered by Medicare will be your responsibility and we expect payment in full within 10 days from billing. If you have secondary insurance, this must be registered with Medicare as a secondary insurance so that Medicare can electronically forward any claims to your secondary carrier. If your secondary insurance does not pay within 30 days the balance is your full responsibility and due at this time.
We also collect the yearly Medicare deductible at the time of your first visit. Should you have an outstanding balance and are unable to pay it in full at the time of your visit; we request that you speak to our office staff before your visit.

_____
Patient Name (please print)

Signature:_____DATE:_____
(Patient's signature)

Revised 02-25-2010

LILETTE DAUMAS, MD, PA
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Lilette Daumas, MD
FAMILY MEDICINE

CLINIC POLICY INFORMATION

Welcome to the practice of Lilette Daumas, MD. In order to ensure that all of our patients understand our policies, please read the following policy information carefully. Afterwards, please **sign where indicated**. You will receive a copy to keep for future reference. Thank you!

NO SHOW/LATE CANCELLATION
In case you can't show up for your appointment we ask you to cancel it 24 hours prior to the appointment time. Excessive no shows/late cancellations will be reviewed by the physician and you may be charged a missed appointment fee or dismissed from the practice.

REFILL POLICY
For any refills, first call your pharmacy; they will contact us. Routine refills will be called back to your pharmacy within one business day. Allow 48 hours to the next business day before you check with your pharmacy or us to see if the medicine was called in. Remember that we are not here on weekends or after 5:00 pm. This may seem like a long time, but it is necessary to provide you with the best medical care. Part of that care is ensuring that you have the appropriate lab work and follow-ups required for your condition. In order for this to occur, our staff must review your medical record before refilling medication. Make sure you allow plenty of time **BEFORE** you run out of medication to get your refill.

NURSE CALL BACKS
Each nurse at the clinic has a voice mail. Usually you will be asked to leave any message on that voice mail. The voice mail is listened to throughout the day and calls are returned no later than by the next business day. If your concern is urgent and cannot wait until then, you may speak with the receptionist. If a nurse is not available, a message will be taken and hand delivered to the nurse's station. Our nurses are sometimes not available to speak directly to patients when they call because they are taking care of patients in the office. They do, however, set aside time daily to return calls.

NURSE VISITS/LAB WORK
Nurse visits and lab work are by appointment only Monday thru Friday. Make sure you find out if you need to be fasting for any labs ordered. These times for labs, blood pressure checks or injections are ordered by OUR providers. We DO NOT draw labs for other doctors.

MEDICAL RECORDS
This office holds your medical records in strict confidence. They will not be released to anyone without your explicit written permission. All requests for the release of records must be in writing. A reasonable fee based on the guidelines by the Texas Medical Board will be charged for the compilation of medical records.

I have read and understand the clinic guidelines of Lilette Daumas MD PA.

_____
Patient Name (please print)

_____ _____
Signature Date

Revised 8-22-2012

LILETTE DAUMAS, MD, PA
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Lilette Daumas, MD
FAMILY MEDICINE

GENERAL GUIDELINES FOR PATIENTS

Dear patient:

In order to improve safety, efficiency and prevent errors, we all need to do our part, the patient as well as the doctor and staff.

We implement the followings guidelines effective immediately:

- Bring all **medications** or updated list to **every** visit, including over-the-counter medicines. You must know your medicines by name and not just size, color or shape as all those can change when it comes to generics. You also need to know the condition/problem for which you are taking them and understand why. If you don't understand, ask.
- Update **contact information.** If your phone number or address changes, you must notify us ASAP. We cannot report results or remind you of follow-ups if we cannot get a hold of you.
- Let us know if you cannot **read.** While this might embarrass you, we must know this as much important information is in writing.
- **Prioritize:** Too many unrelated complaints causes confusion for me. If we are asked to deal with too many complaints at once, some things wi11 be forgotten. Make a list of your problems and we will decide what we can discuss at the visit and what needs another visit. This is a situation when mistakes can happen or rushed decisions are made because our attention is not focused. Please understand we have limitations.
- Have **someone with you during your office visit** if you have trouble remembering instructions.
- If you get a **lab/test result** that you did not understand or that frightened you, call or make an appointment to discuss ASAP. On the other hand, if you do not hear about your results within 3-7 days, call the office. "No news" does not necessarily mean "Good news".
- Point out if we have **forgotten something.** We appreciate being reminded and will not take offense.
- Cancel **appointments** in a timely fashion. This is so others can be worked in same day if needed as you might need to someday.
- **When you call for an appointment,** make it clear what you need to be seen for and whether it is urgent but be reasonable in your demands. Sometimes we cannot work in everybody that wants to be seen on a same day appointment and we have to prioritize based on urgency.
- Notify me if you have **seen any other doctor.** This is to prevent duplication of meds, dangerous interactions, unnecessary/costly repeat testing and gives us a chance to obtain medical records to be available at the next visit.

LILETTE DAUMAS, MD, PA
12755 Woodforest Blvd.
Houston, Texas 77015
713-455-1306

NOTICE OF PRIVACY PRACTICES

Lilette Daumas, MD
FAMILY MEDICINE

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.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well *as* for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example - we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example - we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. For example - we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

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

As ***Required by Law.*** We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries *or* illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

*A **Paper Copy of This Notice.*** *You* have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

***Inspect and** Copy.* *You* have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment. *You* have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. *You* have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example - you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting** of **Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. *You* have the right to request how we communicate with you to preserve your privacy. For example you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our practice manager.

(Effective date: April 14, 2003)

LILETTE E. DAUMAS, M.D., P.A.
12755 Woodforest Blvd.
Houston, Texas 77015
713-455-1306

Lilette Daumas, MD
FAMILY MEDICINE

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____ , have received a copy of this office's Notice of Privacy Practices.

Please print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)_____

_____