Integrative Primary

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Patient Information Sheet **Date**_____/_____/_____

NAME: LAST: _____ FIRST: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

DATE OF BIRTH _____/_____/_____ SEX □ F □ M AGE: _____ **SSN:**_____-_____-_____

HOME PHONE (_____) _____ - _____ CELL PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____

PREFERRED CONTACT NUMBER: □ HOME PHONE □ CELL PHONE □ WORK PHONE

REFERRING PHYSICIAN _____ REFERRAL SOURCE: How did you find out about our practice? _____

MARITAL STATUS: □ SINGLE □ DIVORCED □ LEGALLY SEPARATED □ PARTNER
□ MARRIED (SPOUSE NAME _____) □ WIDOWED □ UNKNOWN

EMERGENCY CONTACT:

NAME: LAST_____ FIRST_____ RELATIONSHIP_____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____

I AUTHORIZE THE FOLLOWING PERSON/PERSONS TO RECEIVE INFORMATION ABOUT MY HEALTH:

_____ _____
SIGNATURE RELATIONSHIP

I WILL NOTIFY THE PRACTICE IN WRITING IF I CHOOSE TO MAKE CHANGES TO THE ABOVE NAMED PERSON/PERSONS.

PHARMACY:

NAME _____ ADDRESS: _____ PHONE (_____) _____ - _____

E-MAIL ADDRESS FOR PATIENT: _____

I authorize and consent to examination and treatment including procedures by Integrative Primary Care. I understand that I am financially responsible for charges not covered by my insurance company. I hereby authorize photocopies of this form to be as valid as the original. I have received a copy of Integrative Primary Care, Notice of Privacy Practices. I hereby grant permission to Integrative Primary Care to view my prescription history from external sources.

_____ _____
PATIENT, PLEASE SIGN FOR PERMISSION TO TREAT **IF PATIENT IS A MINOR, PARENTS SIGN HERE FOR PERMISSION TO TREAT IN YOUIR ABSENCE**

ALLERGIES

Have you ever had any allergic reaction (bad effect) to a medicine or shot?

☐ No ☐ Yes Please write the name of the medicine or shot and the effect you had below:

Medicine I am allergic to	What happens when I take that medicine
EXAMPLE: Atenolol	I get a rash

Medicines

Are you taking any **prescription medicines?**

☐ **No**, I do not take any prescription medicines.

☐ **Yes**, List your medicines below **OR** ☐ I brought my pill bottles or a list

Medicine Name	**Strength or Amount**	**How many pill or doses do you take at a time?**			
EXAMPLE: Furosemide	20 mg	2 Morning	1 Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
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		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed

SPECIALTY SERVICES

Are you currently seeing any other doctors?

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Family History

Please place an X in the box that applies:

	Father	Mother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Children	Siblings
Diabetes								
Alzheimer's								
Heart Disease								
Colon Cancer								
Breast Cancer								
Prostate Cancer								
Ovarian Cancer								
Other Cancers								
Obesity/ Overweight								
Hypertension/ High Blood Pressure								

Please list other Diseases that Run in your family:

_____

_____

Screening Tests if applicable:

When was your last Colonoscopy? _____

When was your last Bone Density? _____

PAST MEDICAL HISTORY:

Please check all that apply:

☐ Anxiety Disorder	☐ Diverticulosis/ Diverticulitis	☐ Kidney Stones
☐ Arthritis	☐ Fibromyalgia	☐ Leg-Foot Ulcers
☐ Appendicitis	☐ Gallstone	☐ Liver Disease
☐ Asthma	☐ Gout	☐ Osteoporosis
☐ Bleeding Disorder	☐ Heart Attack	☐ Pacemaker
☐ Blood Clots (or DVT)	☐ Heart Murmur	☐ Peptic Ulcer Disease
☐ Coronary Artery Disease	☐ Hiatal Hernia	☐ Pulmonary Embolism
☐ Cancer:	☐ HIV or AIDS	☐ Stroke
Type: _____	☐ High Cholesterol	☐ Thyroid Disorder
☐ Diabetes	☐ High Blood Pressure	☐ Tuberculosis
☐ Dialysis	☐ Kidney Disease	☐ Other: _____

PAST SURGICAL HISTORY:

Surgery:	Year:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY:

Last PAP Smear Date: _____ ☐ Abnormal

Last Mammogram Date: _____ ☐ Abnormal

Age of first menstrual period: _____

- Bleeding Between Periods
- Heavy Periods
- Extreme menstrual pain
- Hot Flashes
- Breast Lump
- Birth Control Method:

  _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤

I, _____, DOB _____ hereby give consent to Integrative Primary Care and his staff to access any and all medical records necessary for continuum of care. I understand that I may refuse, in writing, the release of any and all records per my right under HIPPA. I have been given the HIPPA information sheet and I understand when, where, and how the clinic may, in turn, release my information, unless I specify otherwise.

_____ _____

Patient's Signature Date

I, _____ hereby give consent to the following persons to discuss my records, and/or results, with the doctor and his staff if needed.

1. _____ Relationship:_____ Phone:_____
2. _____ Relationship:_____ Phone:_____
3. _____ Relationship:_____ Phone:_____
4. _____ Relationship:_____ Phone:_____

I understand that this authorization can be revoked, in writing, at any time and may apply to one or more of the persons.

_____ _____

Patient's Signature Date

Thank you for choosing Integrative Primary Care as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

Patients must read and sign this form prior to receiving services.

It is your responsibility to provide us with your most current insurance information. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. If you have medical coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered. We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company. Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by our contract with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's obituary determination of usual and customary rates. Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determination by our insurance company once they have paid your claim- regardless of our estimation. It is your responsibility to provide us with your most current billing information. You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have questions or dispute the validity of this balance, it is your responsibility to contact us with updated information. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or disputes of the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (832) 500-7585. Payment is full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue rate are deemed past due. Past due accounts may be referred to a professional collections agency. You will be responsible to pay all collection cost incurred, including attorney's fees and court costs if applicable. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $30.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law. We may charge you a "no show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date. Failure to keep your account balance current may require us to cancel or reschedule your appointment. Full payment is due at the time of service. We accept cash, checks, and credit cards. I have read and understand this Financial Policy.

Signature of responsible party _____ date _____

Patient name _____ DOB _____

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Integrative Primary Care for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Medicare- Medicaid

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

_____

Print Name

_____

Patients Signature

_____

Parent/ Guardian

_____

Date

HIPPA Notice of Privacy Practices

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care options (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as a necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also all you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contract you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization.

These situations include: as required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your right with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.