

Attention All Patients!

We have some changes to our admission packet in compliance with Centers for Medicare and Medicaid. We are now collecting information on race, ethnicity, and preferred language.

Note: The full description of race and ethnicity is available at the US Bureau of Census

We are also doing medical photography.

Note: This consent does not authorize the use of the images for other purposes, such as teaching or publicity. A separate consent for photography form should be used for such purposes.

Thank you for your cooperation!

SOUTH HOUSTON INTERNAL MEDICINE, LLC

PATIENT HEALTH QUESTIONNAIRE

PATIENT'S NAME: _____ **DOB:** _____

ALLERGIES Medications and Reactions i.e. rash, nausea, shock, etc. _____

MEDICATIONS: _____

MEDICAL HISTORY **FAMILY HISTORY** *Please indicate relative*

- Diabetes _____
- Hypertension _____
- High Cholesterol _____
- Others _____

- Colon Cancer _____
- Prostate Cancer _____
- Breast Cancer _____
- Heart Disease _____
- High Cholesterol _____
- Diabetes _____
- Depression _____
- Others _____

SOCIAL HISTORY

Smoking: ___ Never ___ Quit Smoking ___ Current Smoker ___ No. of packs per day
_____ No. of years smoked

Alcohol: ___ Never ___ Occasionally: What kind and how much _____

Illicit Drugs: ___ Never ___ Past Use ___ Present Use

PAST SURGERIES/OPERATIONS *Please indicate dates*

HEALTH MAINTENANCE *Please indicate the last time that the following were performed or received*

Pap Smear _____	Prostate Exam _____
Mammogram _____	Colonoscopy _____
Bone Density Test _____	Flu Vaccine _____
Tetanus Vaccine _____	Pneumonia Vaccine _____

How did you find out about our practice? _____

Previous Physician or Medical Provider _____

Pharmacies _____

SOUTH HOUSTON INTERNAL MEDICINE, LLC

AUTHORIZATION

*****PLEASE PRESENT INSURANCE CARDS AND PICTURE ID TO THE RECEPTIONIST*****

I hereby authorize and request the medical treatment necessary to care for the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow the fax transmittal of my medical records if necessary.
I acknowledge full financial responsibility for services rendered by SOUTH HOUSTON INTERNAL MEDICINE, LLC. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductible and co-insurance fees.
I understand that insurance companies have agreements with certain laboratories for lab work and that it is responsibility to know which laboratory my insurance authorizes and to inform the staff of SOUTH HOUSTON INTERNAL MEDICINE, LLC as to which my insurance covers.
I further authorize and request that insurance payments be made directly to SOUTH HOUSTON INTERNAL MEDICINE, LLC for services rendered,

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

Patient / Parent / Guardian (Please print name)

Signature of Patient / Parent / Guardian

Date

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to protect that privacy. We strive to always take reasonable precautions to protect your privacy, when it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing, under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections with this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our Privacy notice, or request restrictions and revoke consent in writing after you have reviewed our privacy notice.

SOUTH HOUSTON INTERNAL MEDICINE, LLC

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Male/Female _____ SS#: _____

Race: <i>(Per US Census Bureau categorization)</i>	Ethnicity:	Preferred Language:
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> English
<input type="checkbox"/> Asian	<input type="checkbox"/> Non-Hispanic or Latino	<input type="checkbox"/> Spanish
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Sign Language
<input type="checkbox"/> Black Hispanic or Latino		<input type="checkbox"/> Other _____
<input type="checkbox"/> Native Hawaiian or Pacific Islander		
<input type="checkbox"/> White		
<input type="checkbox"/> White Hispanic or Latino		
<input type="checkbox"/> Some other race or 2 races		

Address: _____ Home Phone: _____

City/State/Zip _____ Work Phone: _____

Single Married Widowed Divorced Cell Phone: _____

Spouse Name: _____ Email Address: _____

Employer Name: _____ Emergency Contact Person: _____

Primary Insurance: _____ Relationship to Patient: _____

Secondary Insurance: _____ Contact Number: _____

SPOUSE INFORMATION

Name: _____ Work Phone: _____

SS#: _____ Employer: _____

Date of Birth: _____ Work Address: _____

MUST COMPLETE IF UNDER 18

Father/Guardian

Mother/Guardian

Name: _____ Name: _____

Address: _____ Address: _____

SS#: _____ SS#: _____

Date of Birth: _____ Date of Birth: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

SOUTH HOUSTON INTERNAL MEDICINE, LLC

NOTICE OF PRIVACY PRACTICE

- This office is authorized to release my health information to the following member of my family without further permission from me. I will notify this office if this individual changes
 Full name: _____ Date of Birth: _____ Relationship: _____
 Full name: _____ Date of Birth: _____ Relationship: _____
 Full name: _____ Date of Birth: _____ Relationship: _____
- The following person is authorized to sign or act on my behalf should I become unable to sign or act for Myself.
 Full name: _____ Date of Birth: _____ Relationship: _____
 Full name: _____ Date of Birth: _____ Relationship: _____
 Full name: _____ Date of Birth: _____ Relationship: _____
- I have the right to review the Notice of Privacy Practice and I understand the Notice of Privacy Practice is available for further review upon request
- I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that South Houston Internal Medicine, LLC will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in South Houston Internal Medicine, LLC's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.
- We may make your medical information available electronically through state, regional, or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants.

Note: This consent does not authorize the use of the images for other purposes, such as teaching or publicity. A separate consent for photography from should be used for such purposes.

Print Name: _____ **Signature:** _____ **Date:** _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being our Valued Patients!