Seton Family of Doctors at Hays

PATIENT INFORMATION

First Name:______________________________ M.I.__________Last Name:______________________________

Address:________________________________City:______________________State:________Zip Code:___________

Phones: (H)_____________________________(W)_______________________ (C)____________________________

DOB:_______________ Sex: M F SSN:_________________________Marital Status:________________________

Ethnicity: _______________________________Race:_____________________Language:____________________

Emergency Contact/Phone:____

Preferred Pharmacy:_________________________________ Phone:_________________________________

RESPONSIBLE PARTY

First Name:______________________________ M.I.__________Last Name:______________________________

Address:________________________________City:______________________State:________Zip Code:___________

Phones: (H)_____________________________(W)_______________________ (C)____________________________

DOB:_______________ Sex: M F SSN:_________________________Relationship:__________________________

Email Address:____

PHARMACY INFORMATION

Pharmacy Name:_______________________________ Pharmacy Phone #:________________________________

PRIMARY INSURANCE INFORMATION

Insurance Company:____________________________Policy Holder Name:_____________________________

Policy Holder Phone #:_________________________________Relationship to Patient:____________DOB:________

SECONDARY INSURANCE INFORMATION

Insurance Company:____________________________Policy Holder Name:_____________________________

Policy Holder Phone #:_________________________________Relationship to Patient:____________DOB:________

APPOINTMENT REMINDERS

Preferred Time:________________________________Preferred Phone:________________________________

REFERRAL SOURCE (Please Circle)

Newspaper TV Radio Direct Mail Magazine Website/Internet Billboard Event Friend/Family Other:_______________

Do you have an advanced directive? (Please Circle) Yes No

MEDICAL INFORMATION: I authorize the physicians of this office to release any information they have acquired in the course of my or my child's treatment to my insurance company or companies or any third party payor so that they may obtain payment for medical services rendered.
INSURANCE AUTHORIZATION: I hereby authorize the physicians or staff of this office to furnish information to my insurance carries concerning myself or my child's illness and treatments.
ASSIGNMENT OF BENEFITS: I authorize the insurance company or any third party payor to pay any benefits due directly to this office should they accept assignment on my claim. **I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

Signature:____Date:_______________

Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee. I understand that Seton Family of Doctors at Hays includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

I understand that this Consent to Treat will be valid for each visit I make to the Seton Family of Doctors at Hays until revoked by me in writing.

2. Consent to Release Information

I acknowledge that Seton Family of Doctors at Hays may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Seton's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Seton Family of Doctors at Hays.

I acknowledge and consent to allow Seton Family of Doctors at Hays to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Seton Family of Doctors at Hays all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Seton Family of Doctors at Hays are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

The HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I certify that I understand the privacy risks of mail, telephone and email. I hereby authorize a representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, laboratory results and referral arrangements. I understand that I have the right to rescind this authorization at any time by notifying us in writing.

Name of Patient: _________________________________ Effective Date: __________________ DOB: _______

If we need to reach you during business hours regarding test results, how may we reach you? (check all that apply):

☐ **Home Phone:** ________________________

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Work Phone:** ______________________________

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Cell Phone:** __________________________

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Written Communication:**

- ☐ Mail to home address
- ☐ Mail to alternate address (see below)

Alternate Address: ____

City/Town, State: ___________________________________ Zip Code: ______________________

I give permission to send test results via secure encrypted email: Yes ____ No ____

E-mail address ____

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following:

__________________________________ Relationship ____________________________________

__________________________________ Relationship ____________________________________

__________________________________ Relationship _____________________________________

Patient Signature ____ Date ________

Parent/Legal Guardian ____ Date _________

Created: May 23, 2013

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Seton Family of Doctors at Hays on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Seton Family of Doctors at Hays or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payor for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Seton Healthcare Family will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

8. Notice of Privacy Practice

I acknowledge receipt of the "Notice of Privacy Practices" from Seton Family of Doctors at Hays.

____________________________________ __________________
Patient Printed Name Patient Date of Birth

____________________________________ __________________
Patient/Responsible Party Signature Date

____________________________________ __________________
Witness Date

Seton Family of Doctors

ADULT HEALTH HISTORY

Name: ____ DOB: ____/____/______ Sex: M F

Check all items that apply to you and fill in the blanks as needed:

PAST MEDICAL HISTORY:

O Allergies (other than drugs) _____________
O Anemia or Blood problems
O Arthritis
O Asthma
O Birth Defects
O Blood transfusion, what year? ___________
O Cancer/Tumor, explain _________________
O Chicken pox
O Colon disease
O COPD, Emphysema, lung disease
O Diabetes, type: ______ how long: _______
O Drug or Alcohol abuse
O Epilepsy (seizures)
O Glaucoma or Cataracts
O Headaches, type: _____________________
O Hearing loss
O Heart disease or heart attack
O Hepatitis, A B C or Jaundice
O HIV or AIDS
O Hypertension (High Blood Pressure)
O Hypothyroid or Hyperthyroid
O Inherited disease
O Kidney disease or stone
O Mental illness or Depression
O Pap Smear, abnormal
O Peptic ulcer disease
O Sexually transmitted disease (STD)
O Sickle cell anemia or trait
O Skin disease, eczema, psoriasis
O Stroke
O Tuberculosis (TB)
O Other _____________________________

Past Surgical & Hospitalization History:

O Angioplasty
O Appendectomy
O Back, procedure: _____________________
O Breast , R or L, procedure: ______________
O Cervical freezing or LEEP
O Fracture, _____________________________
O Gall bladder
O Hernia, R or L, type: ___________________
O Hysterectomy (uterus) O Ovaries removed
O Knee, R or L, procedure: ________________
O Psychiatric treatment, In or Out patient
O Tonsillectomy
O Tubal ligation (tubes tied)
O Vasectomy
O Other: ________________________________
O Other: ________________________________

Females Only:

Age at first period: ______________ years old Birth control method: _____________________

Number of… Pregnancies ______ Live births ______ Miscarriages ______ Abortions ______

Date of last… Period ________________ Pap Smear ________________ Mammogram ________________

Males Only:

Date of last … Physical exam _____________ Prostate exam _______________ PSA ________________

Allergies:

O No known drug allergies

Name of Drug	Reaction

Current Medications: **(Prescription, Over-the-Counter, Herbs, Vitamins)**

Drug/Medication	Strength/Dosage	Frequency	Drug/Medication	Strength/Dosage	Frequency

Immunizations: **(Check those that apply and dates received)**

O Tetanus booster ___________ O Flu vaccine _____________ O Other _____________
O Pneumovax _______________ O Hepatitis B _____________ O TB skin test ________

Social History:

Marital Status: O Married O Divorced O Single O Separated O Widowed
Occupation: _____________________________ Highest level of education: __________________________
Tobacco : O Cigarettes O Smokeless; how much/day _______; how long _______ quit, when ______
Alcohol: Number of drinks or bottles of beer per week: ____
Caffeine: Number of cups of coffee _______/day, glasses of tea _______/day, sodas _______/day
Do you exercise regularly? O No O Yes, routine: ____
Sexually active: O Yes O No New partner in last year? O Yes O No
Victim of abuse: O Physical O Sexual O Mental O Verbal ; Who is/was abuser? _________________
Seat belt use: O Yes O No Firearms in home: O Yes O No; are they locked up? O Yes O No
Exposure to hazardous materials? _________________ Military service? ___________________________
Special diet or vegetarian? ________________________ Travel to foreign countries? _________________

Family History:

	Living	Deceased	Age	Medical issues and/or cause of death
Mother				
Father				
Father's father				
Father's mother				
Mother's father				
Mother's mother				
Siblings:				
Children:				

Patient Signature: _____________________________________ **Date:** _______/______/______________