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:**_____

Seton Family of Doctors at Hays

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.

Seton Family of Doctors at Hays

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

NEW PEDIATRIC HEALTH HISTORY

Person completing the form: _____ Relationship to Patient: _____
Patient Name: _____ DOB: ____/____/_____ Sex: M F
Check all items that apply to the child and fill in the blanks as needed.

Pregnancy: Mother's age at pregnancy: _____Hospital:_____

Y N
O O Medications during pregnancy _____
O O Illness during pregnancy _____
O O Tobacco use during pregnancy _____
O O Street drug use during pregnancy _____
O O Alcohol use during pregnancy _____
O O Complications during labor, delivery, postpartum_____

Newborn: O Full term O Premature _____weeks Type of delivery: O Vaginal O C-Section
Birth weight: _____ lbs. _____ ozs. Length: _____ in. Apgar rating: _____
Complications during labor, delivery, or as a newborn? _____
Did infant receive first Hepatitis B series as a newborn? O Yes O No O Unknown
Did infant receive 2 newborn screens in the first month of life? O Yes O No O Unknown

Past Medical History:

Y N
O O Allergies (other than drugs) _____
O O Anemia or Blood problems
O O Arthritis
O O Asthma
O O Birth Defects
O O Blood transfusion, what year? _____
O O Cancer/Tumor, explain _____
O O Chicken pox
O O Depression or suicide attempts
O O Diabetes, type: _____ how long:_____
O O Ear Infections
O O Eating disorder, bulimia, or anorexia
O O Eczema or psoriasis
O O Epilepsy (seizures)
O O Headaches, type: _____
O O Head injury
O O Hearing loss

Y N
O O Heart problems or murmur
O O High blood pressure
O O HIV or AIDS
O O Hypothyroid or Hyperthyroid
O O Inherited disease
O O Kidney disease or stone
O O Learning disability, type_____
O O Lung disease
O O Measles, German measles, or Mumps
O O Pneumonia
O O Rheumatic or Scarlet fever
O O Sexually transmitted disease (STD)
O O Sickle cell anemia or trait
O O Strep throat
O O Tuberculosis (TB)
O O Whooping cough
O O Other _____

Past Surgical & Hospitalization History:

Y N
O O Appendectomy
O O Ear tubes
O O Fracture, type _____
O O Hernia

Y N
O O Psychiatric treatment, in/out patient
O O Tonsillectomy
O O Other _____
O O Other_____

Females Only:

Age at first period: _____ years old Date of last period: _____
Number of… Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____
Date of last Pap Smear _____ Birth Control Method: _____

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: Immunizations up to date? O Yes O No

If not available today, please provide a copy of your child's Immunization record by the next visit.

Social History:

Parent(s): O Married O Single O Separated O Widowed O Divorced, child lives with? _____
How is the child doing in school? O Good O Fair O Poor In special classes? O Yes O No
Tobacco O Cigarettes O Smokeless; daily use___ how long ___ quit, when ___Smokers in Home? O Yes O No
Alcohol: Number of drinks or bottles of beer per week_____
Drug use: O No O Yes If yes, use in O Past O Present ; Type of drugs used:_____
Caffeine: Number of cups of coffee _____/day, glasses of tea _____/day, sodas _____/day
Sexually active: O Yes O No If yes, new partner in last 6 months? O Yes O No
Victim of abuse: O Physical O Sexual O Mental O Verbal ; Is your child safe now? O Yes O No
Infant car seat, toddler seat, or seat belt restraint always used? O Yes O No
Firearms (guns or rifles) in home? O Yes O No; are they locked up? O Yes O No
Exposure to hazardous materials or lead? O Yes O No; if yes, explain _____
Special diet or vegetarian? O Yes O No Travel to foreign countries? O Yes O No
Death in family in last year? O Yes O No; relationship to child: _____
Number of people in the household: _____

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/Guardian Signature: _____ **Date:** ____/ _____ / _____

Provider Signature: _____ **Date:** ____/ __ ___/ _____