Houston M.D.s, P.A.

Scurlock Tower
6560 Fannin, Suite 1836
Houston, TX 77030

Telephone: (713) 790 – 1775 or (832) 336 – 1530 **Fax: (713) 790 – 1605**

Dear Sir or Madam:

At your first visit, you will undergo a complete evaluation and your medical history will be reviewed. Any necessary diagnostic testing or further medical evaluation will then be discussed with you and orders provided.

The remaining pages comprise our new patient paperwork and we need you to print these forms and complete them prior to your visit. Please bring the following items with you to your first visit:

- The completed new patient forms.
- ALL insurance cards.
- Your driver's license or other picture identification.
- A list of your current medications (we will require this EACH visit).
- Any diagnostic reports, physician office notes, or hospital records regarding the current condition for which you are being seen.
- If you have an HMO or POS plan you will need to get a referral from your primary care physician. Without this referral - you will be required to pay in full for the visit. A current authorization is necessary for EACH visit and is the responsibility of the patient.
- Payment is expected at the time of service. Any co-pay, co-insurance or unmet deductible will be collected at the time of your visit. We accept all major credit cards.

Due to the congested traffic patterns in the medical center and limited parking, we suggest that you allow **PLENTY** of time to arrive in the office at least 30 minutes prior to your scheduled appointment time. This 30 minute pre-visit period is necessary to prepare your chart, review HIPAA protected healthcare information, and give us time to get you ready for your consultation with the doctor.

Since we must schedule patient appointments efficiently, and we wish to give each patient the care and attention that they deserve, it may be necessary to reschedule your appointment to another date if you arrive late.

Please give us at least 48-hours notice if you must cancel or reschedule your appointment; this allows us the opportunity to offer your appointment time to another patient.

Please call our office if you have any questions.

Sincerely,

Rosa Alvarez
Office Coordinator

Houston M.D.s, P.A.

REGISTRATION INFORMATION

(PLEASE PRINT)

Date_____ Cellular or Home Phone_____

Patient_____
Last Name First Name Middle Initial

Street Address_____

City_____ State _____ Zip _____

Sex: M ☐ F ☐ Age_____Birthdate_____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Patient's School Name _____

Patient Employed By:_____

Business Address_____

Occupation _____ Business Phone _____

Spouse's (or responsible party) Name _____ Birthdate _____

Spouse Employed By:_____

Business Address_____

Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Patients Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? Yes ☐ No ☐ If yes:

Primary Insurance Company_____ Insured's Name _____

ID or Policy # _____ Group # _____ Contract # _____

Secondary Insurance Company (if any)_____ Insured's Name _____

ID or Policy # _____ Group # _____ Contract # _____

Are you covered under any of these programs? ☐ Medicare ☐ Medicaid ☐ CHAMPUS ☐ CHAMPVA

☐ Workers Compensation ☐ FECA Black

Is your condition related to employment (current or previous)? ☐ No ☐ Yes

Is your condition related to an auto accident? ☐ No ☐ Yes In which state? _____

Other Accident? ☐ No ☐ Yes Please describe:_____

_____

In case of an emergency, who should be notified?

Name _____ Relationship to patient:_____ Phone _____

Name _____ Relationship to patient:_____ Phone _____

Please list other doctors you have seen in the past 5 years:

Doctor:_____ City/State _____ Condition_____

Doctor:_____ City/State _____ Condition_____

Doctor:_____ City/State _____ Condition_____

How did you learn of our practice? _____

Who may we thank for referring you? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____

Name of Insurance Company

and assign directly to Houston M.D.s, P.A. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made *either to me or* on my behalf to Houston M.D.s, P.A. for any services furnished *to* me by these physicians. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature *requests* that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier *agrees* to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

HISTORY OF PRESENT ILLNESS

INTRODUCTION

Patient Name _____ Today's Date _____

Age _____Date of Birth _____ Race _____ Sex_____

With which hand do you write? Right ☐ Left ☐

Present Occupation _____ Past Occupation _____

If not presently working, please state the reason why:_____

_____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

PRESENT ILLNESS

Who referred you to our office_____

What is the reason for your consultation with the doctor? _____

_____

_____

How and when did this problem start? _____

_____

_____

Please check all the following that apply to you <u>with regard to this visit only</u>.

___ Problem with sense of smell
___ Problem with vision such as: blindness, blurred vision, or colored vision
___ Problem with double vision
___ Problem with facial numbness or with chewing
___ Problem with facial droopiness, salivation, tasting, loud noises, or tearing of the eyes
___ Problem with deafness, dizziness, vertigo, imbalance, or ringing in the ear
___ Problem with swallowing food (state if it is worse with solid foods or with liquids)
___ Problem with turning you head side to side
___ Problem with control of your tongue movements

Or,

___ Shortness of breath
___ Waking at night to urinate
___ Sleeping with your head propped up
___ Ankle or leg swelling
___ Palpitation or heart racing
___ Unexplained loss of consciousness
___ Leg discomfort while walking or exercising
___ Problem controlling urine or stool

Please check if you have, or have ever had, any of the following:

___Headache or facial pain
___Neck pain
___Spine pain (low back pain)
___Stroke
___Seizure
___Loss of consciousness (passing out, fainting)
___Memory loss or forgetfulness
___Learning disability
___Problem in sleeping
___Thinking problems (confusion, disorientation, feeling strange)
___Emotional problems (psychological, psychiatric)
___Problems at home, at work or school

Patient's Name _____ Today's Date _____

MEDICATIONS

Are you allergic to any medications or drugs? ☐ Yes ☐ no

If you are allergic to any medications or drugs please list them, with the type of reaction:

	Medication	Reaction
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____

List any medication you are taking at this time:

	Medication	Strength Per Pill (mg)	Number of Pills taken at one time	How many times per day
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____
6)	_____	_____	_____	_____
7)	_____	_____	_____	_____
8)	_____	_____	_____	_____
9)	_____	_____	_____	_____

PAST MEDICAL HISTORY

Please check if you have ever had any problems with the following systems:

___Heart ___Kidneys
___Lung ___Glands
___Skin ___Digestive
___Blood ___Bone or Muscle

Women – When was your last menstrual period? _____

Men – Do you have problems with erection? _____

Please check if you have ever had any of the following:

____Cervical or Lumbar Disk Herniation
____Spine or Head Injury
____Stroke or TIA
____Heart Attack or Angina
____High Blood Pressure
____Cancer, Leukemia, or Lymphoma
____Epilepsy or Seizure
____Heart rhythm disturbance
____ALS, Ataxia, Muscular Distrophy, Polymyositis
____Diabetes, Anemia, or B-12 Deficiency
____Bell's Palsy or Shingles
____Syringomyelia
____Hydrocephalus
____Tuberculosis
____History of bleeding
____Heart valve disease
____Headaches such as Tension, Migraine or Cluster

Other_____

SURGICAL HISTORY

Please list any previous operations you have had:

PREVIOUS OPERATIONS

	Type of Operation	Year	Surgeon/Location
1)			
2)			
3)			
4)			
5)			
6)			

Any previous spine or head injury? ☐ Yes ☐ No

When _____ How many times? _____

How did it happen? _____

_____

Treatment? _____

_____

Pacemaker/ICD or electronic stimulator ☐ Yes ☐ No

Please provide your card for documentation of the maker and serial number(s).

Date of last interrogation _____

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of Siblings? _____ Number Living? _____ Number Deceased? _____

Number of Children? _____ Number Living? _____ Number Deceased? _____

Do you know of any blood relative that has had any of the following (Please circle and give relationship):

Cancer _____ Heart Disease _____ Rheumatic Fever _____ Tuberculosis _____

Leukemia _____ High Blood Pressure _____ Stroke _____ Diabetes _____

Epilepsy _____ Bleeding Tendency _____ Asthma _____ Multiple Sclerosis _____

ALS _____ Alcoholism _____ Depression _____ Alzheimer's Disease _____

Parkinson's Disease _____ Other_____

SOCIAL HISTORY

HABITS

	Quantity	How Often	Have You Quit	When Did You Quit
Alcohol				
Tobacco				
Caffeine				
Drugs				

PLEASE LIST ALL THE TESTS YOU HAVE HAD IN THE PAST RELEVANT TO THE PROBLEM FOR WHICH YOU ARE SEEING US

_____

_____

_____

_____

_____

_____

PLEASE LIST ANYTHING SPECIFIC YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR

_____

_____

_____

_____

_____

_____

_____

_____

Contact me by mail at the following address: _____

_____

Email: _____

Contact me at the following telephone numbers: ☐ Daytime:_____
*Preferred contact telephone – please check box

☐ Evening/Weekends:_____

☐ Cell:_____

AUTHORIZATION TO DISCUSS PRIVATE HEALTH INFORMATION WITH THE FOLLOWING FAMILY MEMBER OR OTHER DESIGNATED PERSON

Pinky S. Tiwari, M.D. OR James M. Wilson, M.D. may discuss my health information, if necessary, with the following persons without my written permission at each occurrence.

_____	_____	_____
NAME	RELATIONSHIP	PHONE
_____	_____	_____
NAME	RELATIONSHIP	PHONE

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Pinky S. Tiwari, M.D. or James M. Wilson, M.D. may obtain/furnish from/to any consulting physician or insurance company, and its representative any information or copies of all hospital, medical records, consultations, and prescriptions relating to illness or injury. A copy of this authorization shall be effective and valid. INITIAL:_____

AUTHORIZATION TO LEAVE MESSAGES

Pinky S. Tiwari, M.D., James M. Wilson, M.D. or their representatives may leave necessary messages at my home, place of employment, or cell phone recorder or voice mail or with a person answering the phone numbers indicated above. INITIAL:_____

AUTHORIZATION FOR BILLING

Houston M.D.s, P.A. may obtain direct payment from insurance benefits otherwise payable to me for services received. A copy of this authorization shall be effective and valid. I understand that I am responsible for any remaining balance that my insurance does not pay. I acknowledge that my office visit co-pay, any co-insurance or unpaid deductible will be due at the time of service.
INITIAL:_____

GENERAL CONSENT FOR TREATMENT
I voluntarily present myself to Pinky S. Tiwari, M.D. or James M. Wilson for examination and evaluation. I consent to any necessary procedures, medical care, and other services under their general and specific instructions. I have the right to accept or decline any healthcare service requested by either physician. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination.
INITIAL:_____

I have read, understand and had the opportunity to ask questions regarding the Health Information Privacy Practices of Pinky S. Tiwari, M.D. and James M. Wilson, M.D.

PATIENT SIGNATURE _____ DATE_____

PLEASE PRINT YOUR NAME:_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.