Phone#: 325-643-3300

Heart of Texas Internal Medicine

Fax#: 325-646-7146

Current Physician: _____ Preferred Provider: _____

PATIENT REGISTRATION INFORMATION

PLEASE FILL IN ALL QUESTIONS AND PRINT CLEARLY:

Email: _____

Patient's Social Security: _____ Date of Birth: _____ Today's Date: _____

Patient's Name: Last: _____ First: _____ Middle Initial: _____

Address: _____

CITY STATE ZIP CODE

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

If Minor - Parent/Guardian: _____ Contact Phone: ( ) _____

Relation to Patient: _____

Other Address (Mailing) If Different Than Above:

Address: _____

CITY STATE ZIP CODE

Guarantor: _____ Contact Phone: ( ) _____

Relation to Patient: _____

Other Address (Mailing) If Different Than Above:

Address: _____

CITY STATE ZIP CODE

Sex: ___ FEMALE ___ MALE SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( )

How you heard of our practice: Friend ( ) Advertising ( ) Internet ( ) Insurance Co ( ) Other ( ) _____

Patient's Employer: _____ Department: _____

Employer's Address: _____ Employer's Phone: ( ) _____ Ext: _____

Spouse's Name: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Department: _____

Employer's Address: _____ Employer's Phone: ( ) _____ Ext: _____

Person To Contact In Case Of Emergency: _____

Address: _____

Relation: _____ Phone: ( ) _____

INSURANCE INFORMATION

PRIMARY COVERAGE

Insured:

___ Self ___ Spouse ___ Other/Relation:_____ **Insured**

Name of Insured: _____ **Date of Birth:** _____ SS#: _____

Insurance Name: _____ Policy No.: _____

Group Name/Number: _____ Relation to Insured: ___ Self ___ Spouse ___ Child

Employer: _____ ___Other/Specify: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Eligibility Phone Number: _____

SECONDARY COVERAGE

Insured:

___ Self ___ Spouse ___ Other/Relation:_____ **Insured**

Name of Insured: _____ **Date of Birth:** _____ SS#: _____

Insurance Name: _____ Policy No.: _____

Group Name/Number: _____ Relation to Insured: ___ Self ___ Spouse ___ Child

Employer: _____ ___Other/Specify: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Eligibility Phone Number: _____

WE ASK YOUR PERMISSION TO MAKE A COPY OF YOUR INSURANCE CARD(S) AND DRIVERS LICENSE FOR OUR FILES

Clinic Witness: _____

Heart of Texas Internal Medicine
109 South Park Drive
Phone #: 325-643-3300 Brownwood, Texas 76801 Fax #: 325-646-7146

David G. Morales, M.D. · Stephen P. Oines, M.D. • Amy Tindol, M.D.
Tanja Morgan, FNP-C • Michael Kingston, P.A.-C • Charles Cooper, P.A.-C

Name: _____ Date of Birth: _____

1. WHY DID YOU COME TO SEE THE DOCTOR TODAY?

2. WHAT OTHER PROBLEMS ARE YOU EXPERIENCING?

3. LIST ALL SURGERIES ALONG WITH DOCTOR AND DATE. (Continue on back if necessary)

4. LIST ALL SERIOUS ILLNESSES AND INJURIES.

5. LIST ANY CHILDHOOD DISEASES AND IMMUNIZATIONS.

6. LIST ALL KNOWN ALLERGIES

FAMILY HISTORY:

	AGE	STATE OF HEALTH	AGE AT DEATH (IF DECEASED)	CAUSE
FATHER	____	_____	_____	_____
MOTHER	____	_____	_____	_____
BROTHERS	____	_____	_____	_____
SISTERS	____	_____	_____	_____
SONS	____	_____	_____	_____
DAUGHTERS	____	_____	_____	_____
SPOUSE	____	_____	_____	_____

PERSONAL HISTORY:

DO YOU DRINK COFFEE?	**YES / NO**	**CUPS DAILY?**	_____
DO YOU DRINK ALCOHOL?	**YES / NO**	**AMOUNT DAILY?**	_____
DO YOU SMOKE OR USE TOBACCO?	**YES / NO**	**HOW MANY YEARS?**	_____
DO YOU EXERCISE?	**YES / NO**	**DAYS PER WEEK?**	_____
DO YOU WEAR A SEATBELT?	**YES / NO**	**WHAT % OF TIME?**	_____

LIST ALL MEDICATIONS:

Heart of Texas Internal Medicine

109 South Park Drive
Brownwood, Texas 76801

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GENERAL CONSENT FOR TEST, TREATMENT AND SERVICES

I hereby voluntarily consent for treatment to the Facility. I permit the Facility and its employees, physician and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for the treatment of tests. I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physicians and their associates and assistants, or rendered by the Facility personnel under the instructions, orders or direction of such physician(s).

In addition, I understand and agree that Radiologists, Pathologists, other Facilities, etc. who render professional services as a result of a procedure performed in this office will bill and collect independently. I understand that their bills will be separate and apart from this office's billing and collection, but are subject to the authorizations granted me in accordance with this agreement.

_____ _____

Signature of Patient/Legal Guardian Date

Heart of Texas Internal Medicine

109 South Park Drive
Brownwood, Texas 76801

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Physician Assistant (PA-C) and Family Nurse Practitioner (FNP) Mid–Level Consent for Treatment

This facility utilizes Mid-Level Providers (Nurse Practitioners & Physician Assistants) to assist our physicians in the delivery of medical care.

A Mid-Level provider is not a doctor. A Mid-Level Provider is a graduate of a certified training program and is licensed by the Texas State Board of Medical Examiners and the Texas Medical Board. Under the supervision of a physician, a Mid-Level Provider can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Mid-Level Provider may provide such medical services that are within his/her education, training and experience. These services may include, but are not limited to:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a mid level provider for my health care needs.

I understand that at any time I can refuse to see the mid-level provider and request to see a physician.

_____	_____
Patient Name	Date
_____	_____
Patient/Legal Guardian Signature	Witness Signature

PHI Designated Contact List

Under the Health Insurance Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI (protected health information) to family members, friends and/or other persons identified as involved in the patient's care or payment for the patient's health care. To comply with the regulations, as outlined in the CHS HIPAA Privacy Policy, documentation of the patient's wishes must be present in the medical record.

Unless you object, PHI can be verbally disclosed to those individuals listed below for medical purposes. Your signature also authorizes our staff to update this list per your discretion.

_____	_____	_____
Signature	Relationship, if not the patient	Date

Please list all individuals that you authorize for verbal disclosure of medical information:

Spouse	_____	Phone: _____
Significant Other	_____	Phone: _____
Child	_____	Phone: _____
Child	_____	Phone: _____
Step-Child	_____	Phone: _____
Step-Child	_____	Phone: _____
Mother	_____	Phone: _____
Father	_____	Phone: _____
Step-Mother	_____	Phone: _____
Step-Father	_____	Phone: _____
Sibling	_____	Phone: _____
Sibling	_____	Phone: _____
Grandparent	_____	Phone: _____
In-Law	_____	Phone: _____
Other	_____	Phone: _____
Other	_____	Phone: _____
Other	_____	Phone: _____
Other	_____	Phone: _____

Heart of Texas Internal Medicine
109 Southpark Dr
Phone #: 325-643-3300 **Brownwood, TX 76801** **Fax #: 325-646-7146**

PATIENT INFORMATION FORM

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

FINANCIAL AGREEMENT

1) **Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.**

   A) **You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.**
   B) **For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.**

2) **It is your responsibility to notify our front desk staff of any insurance or address changes.**

3) **You will be responsible for any charges that occur if we are not notified.**

PATIENT AUTHORIZATION

I authorize **REAP - Victoria** to submit insurance claims using my signature on file below.

I authorize the release of any medical information necessary in order to process this assignment on the claim.

I authorize payment of medical benefits to be paid directly to **REAP - Victoria** for services described on the claim form.

Patient Signature (or authorized representative) **(Date)**

ASSIGNMENT OF BENEFITS

I hereby assign to Heart of Texas Internal Medicine / Regional Employee Assistance Program any insurance or other third-party benefits available for health care services provided to me. I understand that Heart of Texas Internal Medicine / Regional Employee Assistance Program has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Heart of Texas Internal Medicine / Regional Employee Assistance Program, I agree to forward to Heart of Texas Internal Medicine / Regional Employee Assistance Program all helath insurance and other third-party payments that I have received for services rendered to me immediately upon receipt

Patient Signature (or authorized representative) **(Date)**

Patient Consent and Agreement:

- I consent to participation in the facility Patient Portal (Portal), and understand that my personal health and individually identifying information is made available to me in the Portal.
- I understand that the use of the Portal is for non-emergency purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal.
- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

Patient Name		
Patient Signature	Date	Time

☐ Patient Refused Access to the Portal

Clinical Staff Signature (witness to refusal)	Date	Time

Patient Label

Electronic Prescribing Notice

What is electronic prescribing? Why does your provider E-Prescribe?
E-Prescriptions, or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Your provider participates in E-prescribing because he/she cares about your health and wellbeing and E-prescribing has multiple safety benefits.

How does E-Prescribing work?
Instead of writing out your prescription on a piece of paper, your provider enters it directly into the computer. Your prescription travels from your provider's computer to the pharmacy's computer. E-prescriptions are sent electronically through a private, secure, and closed network, so your prescription information is not sent over the open Internet or as e-mail. Your e-prescription arrives at the pharmacist's computer faster and may help to save you time. The e-prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept e-prescriptions, your provider can print your prescriptions for you.

Privacy
The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared for treatment, payment and healthcare operations. E-prescriptions meet this requirement.

PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medication I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized Representative	**Date**
Relationship to Patient	**Interpreter if Utilized**
Witness Signature	

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name	Date of Birth	Medical Record #
		N/A

Address _____ Telephone # _____

I authorize the use and disclosure of health information about me as described below:

FROM: _____ _____

Facility Authorized to Release my Health Information Telephone #

Address _____

TO: Heart of Texas Internal Medicine 325-643-3300 / fax #: 325-641-8714

Doctor, Agency or Individual(s) Authorized to Receive my Health Information **Telephone/Fax #**

Health Information that may be used/disclosed is limited to the following:

Entire Record History & Physical Consultation(s) Lab Pathology Report Operative Note(s) Imaging/X-Ray Discharge Summary

Other: _____

Health Information that may be used/disclosed is limited to the following Treatment Dates: _____

Health Information to be released to the above named agency/individual is to be used/disclosed for the following purpose(s):

Treatment/Consultation At Request of Patient Billing or Claims Payment Research Marketing Other: _____

Health Information identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnosis compiled during my visit, encounter or hospitalization, or make copiers thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment and eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability and Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. *There may be a charge for copying Medical Records

Patient's or Authorized Personal Representative's Signature	Date	Time

Relationship to Patient/Authority to Act on Patient's Behalf	Interpreter, if Utilized

Witness Signature	Expiration Date or Event

NOTICE OF PRIVACY PRACTICES:

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I was provided a copy of the Facility's Notice of Privacy Practices.

Patient's Signature or Legal Representative			Date	Time
Relationship to Patient		Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time		

Physician Practice

Notices of Privacy Practices Acknowledgement Form

Patient Label