INTEGRITY
MEDICAL CLINIC

Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ☐ NEVER DATE:	

Release the following information:

☐ All Records ☐ Chart Notes ☐ Radiology Reports ☐ Operative Reports ☐ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

INTEGRITY MEDICAL CLINIC

Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:**

Allergies

☐ NONE/No Known Allergies ☐ Adhesive Tape ☐ Anesthesia ☐ Aspirin ☐ Codeine
☐ Dairy Products ☐ Iodine/Shellfish/Contrast Dye ☐ Latex ☐ Morphine ☐ Penicillin
☐ Sulfa Drugs ☐ Wheat

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems	☐	☐	☐
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Problems	☐	☐	☐
Hypertension	☐	☐	☐
Stroke	☐	☐	☐
Thyroid Disorder	☐	☐	☐

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

☐ NONE of the problems listed
☐ allergies
☐ anemia
☐ arthritis conditions
☐ asthma
☐ arterial fibrillation
☐ bleeding problems
☐ BPH
☐ CAD coronary artery disease
☐ cancer
☐ cardiac arrest
☐ celiac disease
☐ chest pain
☐ CHF congestive heart failure
☐ chronic fatigue syndrome
☐ depression
☐ diabetes
☐ drug/alcohol abuse
☐ erectile dysfunction
☐ fibromyalgia
☐ Gerd
☐ heart disease
☐ high cholesterol
☐ hyperinsulinemia
☐ hyperlipidemia
☐ hypertension
☐ hypogonadism male
☐ hypothyroidism
☐ infection problems
☐ insomnia
☐ irritable bowel syndrome
☐ kidney problems
☐ menopause
☐ migraines/headaches
☐ neuropathy
☐ onychomycosis
☐ organ injury
☐ osteoporosis
☐ pulmonary embolism/blood clot in legs
☐ seizure disorders
☐ shortness of breath
☐ sinus conditions
☐ stroke
☐ syndrome X
☐ tremors
☐ wheat allergy

Other:_____

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

Patient Acknowledgement

Appointment Cancellation Policy and Credit Card Transaction Fee Policy

Integrity Medical Clinic has instituted the following policies.

Appointment Cancellation Policy.

A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

To remain consistent with our mission, we have instituted the following policy:

1. Please provide our office a 24 hour notice in the event that you need to reschedule you appointment. A voicemail can always be left after hours this can avoid any unnecessary charges for missed appointments.
2. A **"No Show" or "No Call" or missed appointment, without proper 24 hours notification may be assessed a $25 fee.**
3. This fee is not billable to your insurance.
4. If you are 15 minutes late to your appointment, the appointment may be cancelled and rescheduled.
5. As a courtesy we send out text messages for appointments one to three days in advance. Please note that if a reminder call is not received, the cancellation policy will remain in effect.
6. 3 missed appointments may result in termination from this practice.

CREDIT CARD TRANSACTION FEE POLICY:

There will be a ***3% transaction fee*** added to all credit card transactions.

As always, cash and checks are gladly accepted.

If you have any questions regarding these policies, please let our staff know and we will gladly clarify any questions you may have. We thank you for your understanding.

_____ _____

Signature of patient/parent/guardian or authorized representative Date

_____

Printed name of patient/parent or authorized representative

INTEGRITY
MEDICAL CLINIC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Integrity Medical Clinic

Address: 109 Bois D'arc St

City, State, Zip: Whitesboro TX, 76273

☐ **Please mail records.**
☒ **Please fax records.**

Fax: 1-877-414-2191 **Phone:** 903-564-3366

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

INTEGRITY
MEDICAL CLINIC

You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, ***Integrity Medical Clinic***, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts, regardless of whether you incur charges as a result.

X_____

Signature of Patient / Parent / Guardian or Authorized Representative Date

(Guardian or Authorized Representative must attach documentation of such status.)

X_____

Printed name of Authorized Representative

X_____

Date

_____

Relationship / Capacity to patient

INTEGRITY
MEDICAL CLINIC

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.