# Attention All Patients!

We have some changes to our admission packet in compliance with Centers for Medicare and Medicaid.

We are now collecting information on race, ethnicity, and preferred language.

*Note: The full description of race and ethnicity is available at the US Bureau of Census*

We are also doing medical photography.

*Note: This consent does not authorize the use of the images for other purposes, such as teaching or publicity. A separate consent for photography form should be used for such purposes.*

**Thank you for your cooperation!**

## SOUTH HOUSTON INTERNAL MEDICINE, LLC

### PATIENT INFORMATION

**Last Name:** _____ **First Name:**_____ **MI:** ____ **Preferred Name:** _____

**Date of Birth:** _____ **Age:** _____ **Male/Female** **SS#:** _____

**Race:** *(Per US Census Bureau categorization)* **Ethnicity:** **Preferred Language:**

__ American Indian/Alaskan Native
__ Asian
__ Black or African American
__ Black Hispanic or Latino
__ Native Hawaiian or Pacific Islander
__ White
__ White Hispanic or Latino
__ Some other race or 2 races

__ Hispanic or Latino
__ Non-Hispanic or Latino

___ English
___ Spanish
___ Sign Language
___ Other _____

**Address:** _____ **Home Phone:** _____

**City/State/Zip**_____ **Work Phone:** _____

___ **Single** ___ **Married** **Widowed** ___ **Divorced** **Cell Phone:** _____

**Spouse Name:** _____ **Email Address:** _____

**Employer Name:** _____ **Emergency Contact Person:** _____

**Primary Insurance:** _____ **Relationship to Patient:** _____

**Secondary Insurance:** _____ **Contact Number:** _____

**SPOUSE INFORMATION**

**Name:** _____ **Work Phone:** _____

**SS#:** _____ **Employer:** _____

**Date of Birth:** _____ **Work Address:** _____

**MUST COMPLETE IF UNDER 18**

*Father/Guardian*

**Name:**_____

**Address:** _____

**SS#:** _____

**Date of Birth:** _____

**Employer:** _____

**Address:** _____

*Mother/Guardian*

**Name:** _____

**Address:** _____

**SS#:** _____

**Date of Birth:** _____

**Employer:** _____

**Address:** _____

## SOUTH HOUSTON INTERNAL MEDICINE, LLC

### PATIENT HEALTH QUESTIONNAIRE

**PATIENT'S NAME:**_____ **DOB:**_____

**ALLERGIES***Medications and Reactions i.e. rash, nausea, shock, etc.* _____

_____

**MEDICATIONS:** _____ _____

_____ _____

_____

_____

**MEDICAL HISTORYFAMILY HISTORY** *Please indicate relative*

- **Diabetes** **Colon Cancer** _____
- **Hypertension** **Prostate Cancer** _____
- **High CholesterolBreast Cancer** _____
- **Others** _____ **Heart Disease** _____

_____ **High Cholesterol** _____

_____ **Diabetes** _____

_____ **Depression** _____

_____ **Others** _____

**SOCIAL HISTORY**

**Smoking: ___ Never ___Quit Smoking ___ Current Smoker ___ No. of packs per day**

**___ No. of years smoked**

**Alcohol: ___ Never ___ Occasionally: What kind and how much** _____

**Illicit Drugs: ___ Never ___ Past Use ___ Present Use**

**PAST SURGERIES/OPERATIONS** *Please indicate dates*

_____ _____

_____ _____

_____ _____

**HEALTH MAINTENANCE***Please indicate the last time that the following were performed or received*

Pap Smear _____ Prostate Exam _____

Mammogram _____ Colonoscopy _____

Bone Density Test _____ Flu Vaccine _____

Tetanus Vaccine _____ Pneumonia Vaccine _____

How did you find out about our practice? _____

Previous Physician or Medical Provider _____

Pharmacies _____

## SOUTH HOUSTON INTERNAL MEDICINE, LLC

### NOTICE OF PRIVACY PRACTICE

1. This office is authorized to release my health information to the following member of my family without further permission from me. I will notify this office if this individual changes
   Full name: _____ Date of Birth: _____ Relationship: _____
   Full name: _____ Date of Birth: _____ Relationship: _____
   Full name: _____ Date of Birth: _____ Relationship: _____
2. The following person is authorized to sign or act on my behalf should I become unable to sign or act for Myself.
   Full name: _____ Date of Birth: _____ Relationship: _____
   Full name: _____ Date of Birth: _____ Relationship: _____
   Full name: _____ Date of Birth: _____ Relationship: _____
3. I have the right to review the Notice of Privacy Practice and I understand the Notice of Privacy Practice is available for further review upon request
4. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that South Houston Internal Medicine, LLC will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in South Houston Internal Medicine, LLC's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.
5. We may make your medical information available electronically through state, regional, or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants.

*Note: This consent does not authorize the use of the images for other purposes, such as teaching or publicity. A separate consent for photography from should be used for such purposes.*

**Print Name:** _____ **Signature:** _____ **Date:** _____

### COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

SOUTH HOUSTON INTERNAL MEDICINE, LLC
1018 KEITH DRIVE SUITE A
PERRY, GEORGIA 31069
478-987-7444

## IDENTITY THEFT PREVENTION POLICY:

Effective immediately, the staff of South Houston Internal Medicine, LLC will be required under the Federal Trade Commission to verify your identity. Upon time of patient registration/check in you will be requested to provide either a driver's license or other photo id, current health insurance cards, and proof of address such as a utility bill if the photo id does not show your current address. The parent or legal guardian of a minor (under the age of 18) should bring the above stated information.

South Houston Internal Medicine, LLC reserves the right to decline services if you fail to provide the necessary information. This is a requirement by the FTC to protect your identity. South Houston Internal Medicine, LLC is bound to protect all sensitive patient health information under the HIPAA security standards.

I hereby acknowledge I have provided South Houston Internal Medicine, LLC with the correct proof of identification. By signing this form, I certify I have read and fully understand this policy.

_____ _____

Date Patient Signature

_____ _____

Printed Name Parent or Legal Guardian

## SOUTH HOUSTON INTERNAL MEDICINE, LLC

### AUTHORIZATION

*****PLEASE PRESENT INSURANCE CARDS AND PICTURE ID TO THE RECEPTIONIST*****

I hereby authorize and request the medical treatment necessary to care for the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow the fax transmittal of my medical records if necessary.
I acknowledge full financial responsibility for services rendered by SOUTH HOUSTON INTERNAL MEDICINE, LLC. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductible and co-insurance fees.
I understand that insurance companies have agreements with certain laboratories for lab work and that it is responsibility to know which laboratory my insurance authorizes and to inform the staff of SOUTH HOUSTON INTERNAL MEDICINE, LLC as to which my insurance covers.
I further authorize and request that insurance payments be made directly to SOUTH HOUSTON INTERNAL MEDICINE, LLC for services rendered,

**I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.**

| Patient / Parent / Guardian (Please print name) | Signature of Patient / Parent / Guardian | Date |
|---|---|---|

### PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry' out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to protect that privacy. We strive to always take reasonable precautions to protect your privacy, when it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your persona] medical records. We may have indirect treatment relationship with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing, under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or pan of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections with this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our Privacy notice, or request restrictions and revoke consent in writing after you have reviewed our privacy notice.