ANDERSON MEDICAL GROUP
OF TEXAS
YOUR HEALTH. OUR CARE.

Patient Registration

Patient Name _____ _____ _____
Last Name | Frist Name | Middle Name

Thank you for entrusting your care to the Anderson Medical Group of Texas, PLLC. We are committed to providing you with the highest quality medical care possible. In order to best serve your medical needs, we ask that you complete the following registration information as completely as possible. The Patient - Provider relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.

CONSENT TO TREATMENT

I hereby voluntarily consent to outpatient care and telehealth services at **Anderson Medical Group of Texas, PLLC.** encompassing routine diagnostic procedures, examinations and medical treatment rendered by the medical staff and their assistants or their designees as is necessary in the medical staff's judgment. I authorize the release of medical information about treatment here only to anyone designated by me. I understand that this consent will remain in effect as long as I receive medical care at this medical practice.

FINANCIAL POLICY

Efforts are made for collection of insurance deductibles, co-payments and any other charges not covered by a patient's insurance plan at the time of service. All accounts not collected at the time of service are due within 30 days from the date of service, unless prior arrangements have been made. New patients to the office who live out-of-area, that are uninsured or carry a non-contracted insurance, will be asked to pay for their services at the time of their appointment. **AMG** reserves the right to request payment at the time of service at the discretion of Business Office personnel. Patients are responsible for payment of their account regardless of insurance coverage. **AMG** does not accept responsibility for collecting on a disputed **claim**. Delayed payment by an insurance carrier is not a valid reason for delayed payment on an account. **AMG** does accept Visa, MasterCard, and Discover Card. Please contact Patient Account Services at **(469) 981.2648** for more information.

CANCELLATION POLICY

Providing timely care is one part of our commitment to providing the highest quality of care. If you are unable to keep an appointment, please contact our office promptly so that the time can be made available to other patients and your appointment can be rescheduled to a more convenient time. ***Failure to cancel appointments at least 24 hours in advance will result in a cancellation fee of $25.00***.

Signature of Patient/Legal Guardian: _____ Date: _____

If the person completing this form is not the patient, please write your name, your relationship to the patient, and why you are completing the form for this patient.

Name: _____ **Relationship** _____ **Reason:** _____

Patient Information

Patient Name _____ _____ _____ **Gender** □ M □ F
Last First Middle

Date of Birth (MM/DD/YYYY) _____/_____/_____

Patient's Personal Contact Information (Address and Phone)

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____
Email:_____

Preferred Method of Contact: _____

Emergency Contact(s)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Have you completed a Living Will OR designated a Durable Power of Attorney for Health Care? □ Yes □ No
If yes, please provide a copy for your health care provider.

Do you have any religious or cultural beliefs that may impact your health care? □ Yes □ No
If yes, please describe.(ex. Blood products, etc)

_____

Preventive Health History

Preventive exams (*Check all that apply, and specify when last received.)*

PAP Smear *(females 21-64)* □ Yes □ No Date: _____ Physician: _____
Mammogram *(females 40-69)* □ Yes □ No Date: _____ Physician: _____
Colonoscopy *(≥ 50)* □ Yes □ No Date: _____ Physician: _____
Bone density test *(females ≥ 65)* □ Yes □ No Date: _____ Physician: _____
Eye Exam □ Yes □ No Date: _____ Physician: _____

Have you had any of the following vaccinations? (*Check all that apply, and specify when last received.)*

□ Yes □ No Influenza Date Last Given: _____
□ Yes □ No Pneumovax 23 Date Last Given: _____
□ Yes □ No Prevnar 13 Date Last Given: _____
□ Yes □ No Shingles Vaccine Date Last Given: _____

Medication and Allergy History

Please list and describe allergic reactions you have had to food, medications or insect stings.

Check if you are you allergic to: ☐ **Shellfish** _____ ☐ **IV Contrast Dye** _____ ☐ **Penicillins** _____

Please list Food, Medication or Insect Allergies:	Reaction:

Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.

☐ See Attached List (Please check box if including separate list of medications.)

Medication Name / Dose	Frequency (How often taken)	Medication Name / Dose	Frequency (How often taken)

Pharmacy Information (Local)

Name: _____ Phone: _____ Zip: _____

Pharmacy Information (Mail Order)

Name: _____ Phone: _____ Zip: _____

Names and Phone Numbers for Health Care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months)**, AND ANY Health Care Providers from whom you are obtaining prescriptions.**

Physician: _____ Contact #:_____

Physician: _____ Contact #:_____

Physician: _____ Contact #:_____

Medical History

Medical Condition (check all that apply):		Date Diagnosed:	For Office Use Only
Alzheimer's	☐ Yes ☐ No		G30.9
Anxiety Disorder (GAD/Unsp)	☐ Yes ☐ No		F41.1
Arthritis (Poly/General)	☐ Yes ☐ No		M15.9/M15.0
Asthma	☐ Yes ☐ No		J45.909
Atrial Fibrillation/Flutter	☐ Yes ☐ No		I48.91/I48.92
Cancer (if yes, please circle from below)	☐ Yes ☐ No		
Bladder – C67.9 Breast (Female) – C50.919 Breast (Male) – C50.929 Colon – C18.9	Esophagus – C15.9 Kidney – C64.9 Liver – C22.9 Lung – C34.90	Ovarian – C56.9 Pancreas – C25.9 Prostate – C61	Testicular – C62.90 Uterine – C55
Cerebrovascular Accident (Stroke)	☐ Yes ☐ No		I63.9
Coronary Artery Disease (Heart Attack)	☐ Yes ☐ No		I25.10
Diabetes (Type II, Type I)	☐ Yes ☐ No		E11.9 / E10.9
DVT/Pulmonary Embolus	☐ Yes ☐ No		I82.409 / I26.99
GERD (Reflux problems)	☐ Yes ☐ No		K21.9
Heart Procedures (if yes, describe below)	☐ Yes ☐ No		
Hyperlipidemia (Cholesterol)	☐ Yes ☐ No		E78.2
Hypertension	☐ Yes ☐ No		I10
Hyperthyroidism	☐ Yes ☐ No		E05.90
Hypothyroidism	☐ Yes ☐ No		E03.9
Obstructive Sleep Apnea	☐ Yes ☐ No		G47.33
Rheumatoid Arthritis	☐ Yes ☐ No		M06.9
Seizure Disorder	☐ Yes ☐ No		G40.309
Sickle Cell	☐ Yes ☐ No		D57.80
Other _____	☐ Yes ☐ No		

Surgical History

Type of Surgery	Date	Surgeon

Family Medical History

Please list all known medical problems in your immediate family.
(Specify M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

	Family Member(s)	Age of Onset	Current Status (Living/Deceased)
High Blood Pressure			
Diabetes			
High Cholesterol			
Heart Attack			
Stroke			
Cancer (please specify)			
Arthritis			
Glaucoma			
Other *(please specify)*			

Social History

Do you have a history of alcohol use? □ Yes □ No
If yes, check all that apply: □ Beer □ Liquor □ Wine

If yes, specify _____ # drinks per □ Day □ Week □ Social

1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor (80 proof) or 5 oz wine

Have you ever felt you should cut down on your drinking? □ Yes □ No
Have people annoyed you by criticizing your drinking? □ Yes □ No
Have you ever felt bad or guilty about your drinking? □ Yes □ No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? □ Yes □ No

PHQ-9 DEPRESSION SCREENING

In the Past 2 weeks:	Not at All	1 – 3 Days	Half the Days	Everyday
I have little interest or pleasure in doing things	0	1	2	3
I'm feeling down, depressed, or hopeless	0	1	2	3
I'm having trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
I'm feeling tired or have little energy	0	1	2	3
I haven't had an appetite or am overeating	0	1	2	3
I'm feeling bad about myself, I feel I've let my family or myself down	0	1	2	3
I have trouble concentrating on things such as reading the paper or watching TV	0	1	2	3
People have noticed that my speech slowed down or is rushed like I am restless	0	1	2	3
I have thoughts I would be better off dead or have thought about hurting myself in someway	0	1	2	3
(OFFICE USE ONLY) **TOTALS**	=	+	+	+

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.	Not at All ☐	Somewhat Difficult ☐	Very Difficult ☐	Extremely Difficult ☐

TOBACCO USE ASSESSMENT

Have you used any form of tobacco products in the past 6 months?	☐ Yes ☐ No
How many years have you used tobacco products?	_____ years
What form of tobacco do you use?	☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe ☐E-Cig
If you do smoke, would you like to quit?	☐ Yes ☐ No

ACTIVITIES OF DAILY LIVING

During the past 4 weeks, was someone available to help you if you needed and wanted help?	☐ No, Not at all ☐ Yes, Sometimes ☐ Yes, Always

In the past 4 weeks, have you had any trouble doing any of the following? If applicable, please list an individual who helped complete the task.

Take medications	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Getting around the home	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Bathing and Dressing	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Using the Telephone	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Traveling	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Grocery Shopping	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Preparing Meals	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Housework	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Managing Money	☐No difficulty	☐Yes, Sometimes	☐Yes, Require Assistance from
Do you have a living will?	☐Yes ☐No		

FALL RISK ASSESSMENT

During the last 12 months, have you fallen 2 or more times?	☐Yes ☐No
During the last 12 months, have you had a fall that resulted in an injury?	☐Yes ☐No
Do you think that you are at high risk for falling?	☐Yes ☐No
Do you use any assistive devices such as a walker, wheelchair or cane?	☐Yes ☐No
Are you having trouble with walking or balance?	☐Yes ☐No
Do you require assistance getting up from a sitting position?	☐Yes ☐No

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Patient HIPAA Consent Form

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I authorize that your office may contact me in the following manner (check all that apply):

Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email ☐

I give the Anderson Medical Group of Texas, PLLC. (AMG) permission to email my laboratory results or clinical information to me at the listed email address. I understand that email is not a secure route of delivering information and may be viewed by other individuals. I will not hold AMG responsible for any information pertaining to my health records being viewed by unauthorized individuals.

Patient Initials _____

NOTICE OF PRIVACY PRACTICES

Consent to the use & disclosure of healthcare information for treatment, payment, or healthcare operations and acknowledgment of receipt of notice of privacy practices

I understand that as part of my healthcare, **Anderson Medical Group of Texas** originates and maintains health records describing my history, symptoms, examination and test results, diagnosis, treatment, and plans for future care of treatment.

I understand that this information serves as:

A basis for planning my care and treatment. A means of communication among the healthcare professionals who contribute to my care. A source of information for applying my diagnosis and medical services information to my bill. A means by which a third-party payer can verify that services billed were actually provided. A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right to:

Request restrictions as to how my information may be used or disclosed to carry out treatment, payment, or healthcare operations (see below), and that AIM Center for Health and Wellness is not required to agree with the restrictions requested, in which case I will be notified. Revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

I request the following restrictions to the use of disclosure of my health information: (Please list below)

_____

_____

_____

I have read the **PATIENT HIPPA CONSENT FORM** and received a copy of **Anderson Medical Group's NOTICE OF PRIVACY PRACTICES**.

Patient Name	Signature of Patient	Date

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but:

- ☐ Individual refused to sign ☐ An Emergency precluded obtaining the acknowledgment
- ☐ Communication barriers precluded obtaining the acknowledgment
- ☐ Other_____

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Release of Information and Assignment of Benefits

Commercial Insurance

I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me.

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian _____

Medicare Insurance

Beneficiary _____ Medicare Number _____

I requested that payment of authorized Medicare benefits be made either to me or on my behalf Anderson Medical Group of Texas, PLLC. for any service furnished to me by their physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits payable for related services.

Beneficiary Signature _____

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Anderson Medical Group of Texas, PLLC. for services furnished me by their physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the standard 1500 claim form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Anderson Medical Group of Texas, PLLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature _____ Date _____