Confidential Health Questionnaire

Patient Name:________________________________DOB:________________Today's Date:________________

Please mark with a (✓) any of the following illnesses and medical problems you have or have had and indicate the year when each started.

ILLNESS

☐ Vision Loss/Blindness______________________
☐ Glaucoma________________________________
☐ Cataracts_________________________________
☐ Hearing Loss or Ear Problems_______________
☐ COPD or Emphysema______________________
☐ Pneumonia_______________________________
☐ Seasonal Allergies_________________________
☐ Asthma__________________________________
☐ Tuberculosis______________________________
☐ Other Lung Problems______________________
☐ Vascular Disease (plaque in arteries)_____________
☐ Heart Murmur_____________________________
☐ Heart Disease_____________________________
☐ High Cholesterol___________________________
☐ High Blood Pressure_______________________
☐ Other Heart Conditions_____________________
☐ Hernia___________________________________
☐ Hemorrhoids______________________________
☐ Anemia__________________________________
☐ Cancers _________________________________
☐ Other Health Problems _____________________

☐ Stomach/Duodenal Ulcer________________
☐ Colitis or Diverticulosis________________
☐ Liver disease or Hepatitis________________
☐ Stroke or TIA__________________________
☐ Seizures_______________________________
☐ Depression or Anxiety___________________
☐ Headaches_____________________________
☐ Dementia or Memory Loss______________
☐ Arthritis or Gout_______________________
☐ Thyroid Nodules_______________________
☐ Hypo or Hyperthyroid___________________
☐ Diabetes ______________________________
☐ Diabetic Nerve Pain/Numbness___________
☐ Diabetic Foot Infections________________
☐ Diabetic Eye Disease __________________
☐ Amputation(s)_________________________
☐ Kidney Disease_________________________
☐ Recurrent Bladder Infections______________
☐ Bladder Incontinence___________________
☐ Other Kidney problems__________________

MALES ONLY:

☐ Prostate Enlarged or Cancer_________________
☐ Impotence or Erectile Dysfunction____________

FEMALES ONLY:

☐ Gynecological/Obstetrical________________
☐ Breast Problems________________________

Cancer Screenings and Routine Health Maintenance:

Females Only:

Last PAP__________________________

Last Mammogram__________________

Last Pelvic exam____________________

MEN and **WOMEN** Colon Cancer Screening with stool cards **OR** colonoscopy (date)____________________

Please list name of physician who performed Colonoscopy____

(Over)

VACCINES: (Year) Tetanus:________ Pneumonia:________ Zostavax (Shingles):_________Flu:______

Last Primary Physician name/address/number:____
Please sign a release today for these records ____
Please list all Specialists you currently see: ____
____
____

Please list all times you have been hospitalized, operated on, or injured.

Year	Operation, Illness or Injury	Hospital and City

Current Medications: ____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

ALLERGIES ____________________ ____________________

Non-prescription drugs or supplements:____
____

Smoking or Tobacco products: Packs per day_______Years______ Quit date:______________________
Alcohol drinks per day or month:____________________ Drug use:____________________________
Sexual Orientation:______________________________

Your Family's Health History

	Age if Living	Age at Death	Did/Do they have High Blood Pressure, Heart Disease, Strokes, Cancers or Diabetes?	State of health or Cause of death
Father				
Mother				
Siblings				
Spouse				
Children				

Do you have an **Advanced Directive** or **Living Will**? ____

Do you have a **Medical Power of Attorney**? ________ Who is it?________________________________

Patient Signature ____ Date _________________

Name/Relationship of Individual Completing Form (if other than patient) ____________________________

PATIENT REGISTRATION INFORMATION

Name: ___________________________________ Date of Birth: __________________ Social Security #: ____________________

Marital Status: M____S____W____D_____Sep____ Sex: M____F___Other (Please Specify)________________________________

Race: ____________ Ethnicity: _______________ Preferred Language: ______________ Full Time student? Yes___No_____

Home Address: ____City: _______________ State: ______ Zip: ___________

Home Phone ___________________Work/Daytime Phone: ________________Email: ______________________________________

Name of Employer: ____Occupation____________________________

Address of Employer:____

Preferred Pharmacy ____Pharmacy Phone ________________________

Address____State__________Zip______________

How did you hear about us? _______Friend ______Newspaper ________Radio ________Billboard _______Other

OTHER REGISTRATION INFORMATION

If married:

Name of Spouse_______________________________________Social Security #______________________Date of Birth______________

Name of Employer____Occupation______________________________

Address of Employer____

If a child:

Father's Name____Social Security #______________________Date of Birth______________

Mother's Name____Social Security #______________________Date of Birth______________

Father's Employer____Work/Daytime Phone (________)_______________________

Address of Employer____Occupation______________________________

Mother's Employer____Work/Daytime Phone (________)_______________________

Address of Employer____Occupation______________________________

CLOSEST RELATIVE OR FRIEND IN CASE OF EMERGENCY

Name:____ Relationship to Patient__________________________

Address: Street____Phone: _________________________________

City____State__________Zip______________

HEALTH INSURANCE INFORMATION

INSURED: Name ____Relationship to Patient __________________

Marital Status: M____S____W____D____Sep____ Social Security #_____________________________Date of Birth ________________

Insured's Address____

City____State________ Zip____

Home Phone (_________)_________________________________Work/Daytime Phone (________)________________________________

Name of Insurance:____Telephone #:____________________

Claims Address: ____

Effective date_______________________Group # ______________________________Certificate # ________________________

Name of Employer Group___________________________________Primary Care Physician_________________________________

Do you have other insurance? If yes, please provide information____

I consent and authorize **HealthTexas Medical Group of San Antonio** to release all information contained in my financial and medical records to my insurance company or health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities, and ultimately responsible for payment in full if my insurance company does not pay in a timely manner. I also understand that my prescription history from non-HTMG providers and pharmacies will be available to HTMG. I permit a copy of this authorization to be used in place of the original.

Signature: ____ Date: ____

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment are considered a **NO SHOW**. Patients who No-Show three (3) or more times may be dismissed from the practice, thus they will be denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

HealthTexas believes that a good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the clinic manager at ____________________.

Please sign that you have read and understand this Cancellation and No Show Policy.

Patient Name: ____

Signature ____ Date ____________________

(patient/guardian)

Form 1021 – Authorization for Use and Disclosure of Protected Health Information

Patient Identification – Please Print

Full Name:____________________Date of Birth:____________

Home Address:______________________________

City:____________________State:________Zip:__________

Home Telephone #:______________Mobile Telephone #: (______) ______________

Information To Be Released – Covering the Periods of Healthcare

Facility:______________________________

Address:______________________________

From: (date)______________ To: (date)______________

Type of Information To Be Released – Please check only those that apply

❒ Complete health record
❒ History and physical exam
❒ Laboratory test results
❒ Photographs, videotapes
❒ Diagnosis and treatment codes
❒ Consultation reports
❒ X-ray reports
❒ Complete billing record
❒ Discharge summary
❒ Progress Notes
❒ X-ray films / images
❒ Itemized bill
❒ Other (please be specific):______________________________

Purpose of Request

❒ Treatment or Consultation ❒ At the request of the patient ❒ Billing or Claims Payment
❒ Other (please be specific)______________________________

Who and Where to Send/Release Information

Attn: HealthTexas Medical Group (❒) OR - Other (Please Specify) (❒) ______________

Street Address______________**City**__________**State**________**Zip**__________

Phone____________ **Fax**____________

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

	Initial One:
I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and treatment, that I have been afforded the opportunity to sign a specific authorization.	❒ Yes ❒ No ❒ Not Applicable
I understand if my medical or billing records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment that I have been afforded the opportunity to sign a specific authorization.	❒ Yes ❒ No ❒ Not Applicable
I decline the specific authorization.	❒ Yes ❒ No ❒ Not Applicable

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, I can, at any time, revoke this authorization by submitting a notice in writing to the Privacy Officer at *HealthTexas Medical Group of San Antonio*. Unless revoked, this authorization will expire on the following date or event______________________________, or 180 days from the date of signature.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment of services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize the release of this information to any *HealthTexas Medical Group of San Antonio* facility which may need the information for treatment, payment or healthcare operations.

I authorize *HealthTexas Medical Group of San Antonio* to release the protected health information specified above.

Signature:______________________________Date:____________

Signing Authority (if not patient):____________________Relationship: ____________

Identity of Requestor Verified via: ❒ Photo ID ❒ Matching Signature ❒ Other (specify):______________

Verified by:____________________Printed Name:____________________

Permission to Communicate

Authorization for Use and Disclosure of Protected Health Information

Patient Name: ____ Date of Birth: ________________

Home Address: __________________________ City: ________________ State: _____ Zip: __________

Home Telephone #: (______) ________________ Cell Telephone #: (_____) ________________________

Period of Healthcare of information to be released: From: (date) ____________ To: (date) ________________

Type of Information to Be Released (Please check only those that apply)

- ❐ Complete health record
- ❐ Photographs, videotapes
- ❐ X-ray reports
- ❐ Progress Notes
- ❐ History and physical exam
- ❐ Diagnosis and treatment codes
- ❐ Complete billing record
- ❐ X-ray films / images
- ❐ Laboratory test results
- ❐ Consultation reports
- ❐ Discharge summary
- ❐ Itemized bill
- ❐ Other (please be specific): ____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

Initial One:

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and treatment, that I have been afforded the opportunity to sign a specific authorization.

_____ Yes _____ Not Applicable

I understand if my medical or billing records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment that I have been afforded the opportunity to sign a specific authorization.

_____ Yes _____ Not Applicable

I decline the specific authorization:

_____ Yes ______ No

Purpose of Request:

- ❐ Treatment or Consultation
- ❐ At the request of the patient
- ❐ Billing or Claims Payment
- ❐ Other (please be specific): ____

Individual(s) Authorized to Send/Release Information:

Name: ________________________________ Relationship: ____________________

Date of Birth: __________________________ Phone Number: ____________________

Name: ________________________________ Relationship: ____________________

Date of Birth: __________________________ Phone Number: ____________________

Except to the extent that action has already been taken in reliance on this authorization, I can, at any time, revoke this authorization by submitting a notice in writing to the Privacy Officer at *HealthTexas Medical Group of San Antonio*. Unless revoked or otherwise indicated below, this authorization will expire on **December 31, 2030**.

Expiration date ____________________ (enter a specific date – “indefinite” or “forever” are not acceptable)

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I do not have to sign this authorization, and my treatment or payment of services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize the release of this information to any *HealthTexas Medical Group of San Antonio* facility which may need the information for treatment, payment or healthcare operations.

I authorize *HealthTexas Medical Group of San Antonio* to release the protected health information specified above.

Signature:____Date:________________

Signing Authority (if not patient):____________________________Relationship: ________________

Identity of Requestor Verified via: ❐ Photo ID ❐ Matching Signature ❐ Other (specify):____________________

Verified by:______________________________Printed Name:______________________________

Notice of Privacy Practices & Communication Consent Form

Patient Name: _______________________________ Date of Birth: ____________________________

I have received a copy of HealthTexas Medical Group of San Antonio's Notice of Privacy Practices.

____ _____________________

Signature of Patient or Personal Representative Date

The patient or personal representative received a Notice of Privacy Practices but refused to sign above. After a good faith effort to obtain this acknowledgement I was unable to because:

____

____

________________________ ________________________________ ____________

Printed Name of Associate Signature of Associate Date

Communication Consent Form

HealthTexas Medical Group has offered to communicate with you via-patient portal, secure messaging, and telephone voice mail and text[1]. This communication may include any of the following:

- Appointment information/directions/reminders
- Recommendation for follow-up
- General educational/treatment information
- Financial/billing information such as invoices and receipts
- Wellness Report
- Treatment summary for insurance purposes
- Test result data
- Specific treatment information
- Medication list

By acknowledging and signing this consent form, you are granting permission to HealthTexas Medical Group and any related affiliates or third-parties to contact you on the mobile and/or land line number(s) listed below. Please note that contacts may be made as a direct dial call or through the use of text messages, pre-recorded or artificial voice messages, and/or the use of an automated telephone dialing system or auto-dialer. In addition, depending on your mobile service plan, message and data rates may be assessed by your mobile provider.

You may withdraw consent or opt-out at any time by providing written notice to any HealthTexas Medical Group Clinic location or administration office.

Patient Signature _________________________ Patient Email Address ______________________

Patient (Print Name) ______________________ Patient Phone Number ______________________

Patient Cell Number ______________________ Date _______ / _______ / ______

If patient under 18 years of age, Parent/Guardian Signature _____________________________

Parent/Guardian (Print Name) ___________________________

[1] Be advised that email, telephone voice mail and text communications are not secure and may be intercepted or disclosed to third parties.

DEC 2019