



**Patient Information (PLEASE PRINT)**

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home / Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Driver's License \_\_\_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_

Patient Employed by \_\_\_\_\_

Business Address \_\_\_\_\_

In case of emergency who should be notified? (Someone not living with you) \_\_\_\_\_

Phone number \_\_\_\_\_

**Primary Insurance**

Full Name of Responsible Person \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_

Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

**Additional Insurance**

Is patient covered by additional insurance? Yes \_\_\_ No \_\_\_ Subscriber Name \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ SSN \_\_\_\_\_



## Health History Form

Full Name \_\_\_\_\_ M \_\_\_ F \_\_\_ Date \_\_\_\_\_  
 Medical Allergies \_\_\_\_\_

Disease (Check all that apply)	Self	Mom	Dad	Sis	Bro	GM	GF	Hospitalizations
Allergic Rhinitis/Hay Fever								Reason: _____ Yr.: _____
Anemia								Reason: _____ Yr.: _____
Arthritis								Reason: _____ Yr.: _____
Asthma								Reason: _____ Yr.: _____
Blood Transfusion								Reason: _____ Yr.: _____
Breast Cancer								Reason: _____ Yr.: _____
Cataracts								Reason: _____ Yr.: _____
Colon Cancer								Reason: _____ Yr.: _____
Depression/Anxiety/Mental Illness								Surgeries
Diabetes								_____ Yr.: _____
Drug/Physical/Alcohol Abuse								_____ Yr.: _____
Emphysema/Lung Problems								_____ Yr.: _____
Endometriosis								_____ Yr.: _____
Hearing Problems								_____ Yr.: _____
Heart Disease/Heart Attacks								_____ Yr.: _____
High Blood Pressure								_____ Yr.: _____
High Cholesterol								Do you use any form of Tobacco?
Irritable Bowel Syndrome								Yes _____ No _____
Kidney Problems								Type & Amount: _____
Migraines								Do you drink Alcoholic Beverages?
Neurological Disease								Yes _____ No _____
Peptic Ulcer Disease/GI Problems								Amount: _____
Positive TB Test/Tuberculosis								Treated for Substance Abuse?
Sexually Transmitted Diseases								Yes _____ No _____
Stroke								When? _____
Thyroid Problems								Sexually Active?
Other:								Yes _____ No _____
Current Medications				Dosage			Frequency	
1.								
2.								
3.								
4.								

**Women Only:**

Age Menses Began \_\_\_\_\_ Regular Menses Y \_\_\_ N \_\_\_ LMP \_\_\_\_\_ Last PAP \_\_\_\_\_ Last Mamm \_\_\_\_\_  
 Ob/Gyn Dr \_\_\_\_\_ Pregnancies \_\_\_\_\_ Form of Contraception \_\_\_\_\_

I certify that the above information is correct and true to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Assignment and Release

### With Insurance

I, \_\_\_\_\_ the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ (Insurance Company) and hereby assign/ transfer and set over to Alpha Primary Healthcare all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that full payment (including co-payment) is expected at time of service. I hereby authorize Alpha Primary Healthcare to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

### Without Insurance

I, \_\_\_\_\_ the undersigned certify that I (or my dependent) do not have insurance coverage with any company. I understand that I am responsible for all charges. I understand that full payment is expected at time of service. I understand my responsibility and acknowledge it by signature on this form.

Signature of Responsible Party \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## Acknowledgment of Receipt

I, \_\_\_\_\_ have received a copy of Alpha Primary Healthcare's Office Policy and Notice of Privacy Practices.

Signature of Responsible Party \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_



Insurance Verification Notice

Today's Date \_\_\_\_\_

Full Name \_\_\_\_\_

I understand that my insurance has not been verified and I may be responsible to cover some or all of the costs of my visit. I understand that I am responsible for any costs that are not covered by my insurance. I understand that I will be notified within several days if there is a payment required and will make this payment promptly.

Signature of Responsible Party \_\_\_\_\_

Relationship \_\_\_\_\_

For Office Use Only:

CPT 1: \_\_\_\_\_ \$ \_\_\_\_\_
CPT 2: \_\_\_\_\_ \$ \_\_\_\_\_
CPT 3: \_\_\_\_\_ \$ \_\_\_\_\_
CPT 4: \_\_\_\_\_ \$ \_\_\_\_\_
HCPC 1: \_\_\_\_\_ Units: \_\_\_\_\_ \$ \_\_\_\_\_
HCPC 2: \_\_\_\_\_ Units: \_\_\_\_\_ \$ \_\_\_\_\_
Lab/ Test: \_\_\_\_\_ \$ \_\_\_\_\_
Lab/ Test: \_\_\_\_\_ \$ \_\_\_\_\_
Total Fees \$ \_\_\_\_\_

Total Owed: \$ \_\_\_\_\_

\_\_\_ Paid In Full Date \_\_\_\_\_

Signature of Checkout Person \_\_\_\_\_

Signature of Billing Person \_\_\_\_\_



**PATIENT CONSENT FOR TREATMENT:**

I hereby give my consent for evaluation, testing and treatment as directed by Alpha Primary Healthcare.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Parents/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parents/Guardian Name: \_\_\_\_\_

**Patient Consent for Release of Protected Health Information (PHI)**

I, \_\_\_\_\_, give my consent to Alpha Primary Healthcare to release protected health information (PHI), such as; lab results, medication changes, appointments, billing information, etc., to the following individuals:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This will expire only with written notification from me.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date: \_\_\_\_\_



## Office Policy

1. Appointment times are approximate only, as each patient requires individualized attention by the Provider and their staff for whatever time period that may be necessary. The Provider may also be confronted with emergency cases during the day, which may cause delay in our schedule. If this happens we will try to contact our patients to give them the option to come in at a later time or to reschedule at their convenience. Please try to understand if you are asked to wait for the Provider.
  - a. Failure to give at least 24 hours advance notice to cancel or reschedule appointments will result in a charge to your account for a broken appointment. Our fee is \$25.00 and will have to be paid before your next appointment.
  - b. We have a 10-minute grace period for all appointments. If you are late you will most likely be asked to reschedule to a later time. We ask that all our patients be on time so that we can stay on schedule, minimizing patient inconvenience.
2. Phone calls are returned within 24 hours. If you are having an acute problem we will call you back during the business day.
3. After hours calls will be returned the next day if it is not an emergency. The Provider will not return an after hours message if it is about prescription refills.
4. Prescriptions are given to patient at their visit and it is the patient's responsibility to take them to the pharmacy. If you lose your prescription we will mail another to you or you can pick up another at our office. If you have a mail order prescription program through your insurance plan we will mail the prescription to you if approved by the Provider. If you wish a prescription called in and it is not an EMERGENCY, we will call it in to your pharmacy within 48 hours.
5. You must pay your co-pay at the time of any visit with Alpha Primary Healthcare, unless arrangements have been made with our office prior to the appointment.
6. Sometimes your insurance company will refuse payment of a claim for any of the following reasons:
  - a. A pre-existing condition, which they do not cover.
  - b. You have not met your deductible for the year.
  - c. The type of medical service required is not covered.
  - d. Your insurance was not in effect at the time of service.
  - e. Your insurance plan changed and you failed to notify our office.
7. You are responsible for knowing what your insurance plan covers; we cannot keep up with what every insurance policy states.
8. If your insurance company denies the claim for any of the above, or any other reason, our office cannot be responsible for the bill. It is the responsibility of the patient or guardian to pay the amount in full.



## Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Effective Date of the Notice: November 1, 2008

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

PLEASE REVIEW THIS NOTICE CAREFULLY.

### OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintain the privacy of your personal health information (PHI). In conducting our business we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

1. How we may use and disclose your PHI.
2. Your privacy rights in your PHI.
3. Our obligations concerning the use and disclosure of your PHI.

**The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

1. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
2. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (iv) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to PHI of the decedents.
3. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances we will only make disclosures to a person or organization able to help prevent the threat.
4. Military. Our practice may disclose your PHI if you are a member of the U. S. or foreign military forces (including veterans) and if required by the appropriate authorities.
5. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to other official or foreign heads of state or to conduct investigations.
6. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate.



**IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Privacy Officer  
Alpha Primary Healthcare  
2875 Main Street Suite 102  
Frisco, Texas 75034  
Tel 972.591.1900  
Fax 888.886.9508

**WE MAY USE AND DISCLOSE YOUR PRIVATE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:**

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests) and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment. We may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your PHI to bill you directly for services and items benefits, and we may provide your insurer with details regarding your treatment. We may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as PHI to federal officials in order to protect the to conduct investigation order to protect the President, enforcement officials if you are an inmate.
3. **Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs as family members. Also we may use your PHI to bill you directly for services and items
4. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. We may use and disclose your information for our operations to

**YOUR RIGHTS REGARDING YOUR PHI:**

You have the following rights regarding your PHI that we maintain:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance you may ask that we contact you at home rather than work. To request a type of confidential communication you must make a written request to Privacy Officer, Alpha Primary Healthcare, 2875 Main Street Suite 102, Frisco, TX 75034 specifying the requested method of contact or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. You have the right to request that we restrict our disclosure of your PHI to certain individuals involved in you care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI you must your request in writing to (Privacy Officer, Alpha Primary Healthcare, 2875 Main Street Suite 102, Frisco, TX 75034). Your request must describe in a clear and concise fashion:
  - a. the information you wish restricted;
  - b. whether you are requesting to limit our practice's use, disclosure or both; and to a communicable disease
  - c. to whom you want the limits to apply
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to (Privacy Officer, Alpha Primary Healthcare, 2875 Main Street Suite 102, Frisco, TX 75034) in order to inspect and/or obtain a copy of you PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your



request. Our practice may deny evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example a babysitter may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example a babysitter may have access to this child's relevant medical information.
8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

### **USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your PHI.

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
  - a. Maintaining vital records, such as births and deaths
  - b. Reporting child abuse or neglect
  - c. Preventing or controlling disease, injury or disability
  - d. Notifying a person regarding potential exposure to a communicable disease
  - e. Notifying a person regarding a potential risk for spreading or contracting a disease or condition
  - f. Reporting reactions to medications or problems with medical products or devices
  - g. Notifying individuals if a product or medical device they may be using has been recalled request to inspect and/or copy in certain limited circumstances. You may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
2. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to (Office Manager, Alpha Primary Healthcare, 2875 Main Street Suite 102, Frisco, TX 75034). You must provide us with a reason that supports your request for an amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. We may deny your request if you ask us to amend information that is in our opinion is: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of PHI which you would be permitted to inspect and copy; or (d) not created by our practice unless the individual or entity who created the information is not available to amend the information.
3. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit you request in writing to (Office Manager, Alpha Primary Healthcare, 2875 Main Street Suite 102, Frisco, TX 75034). All requests for an "accounting of disclosures" must state a time period which may not be longer than six (6) years from the date of disclosure and may not include dates before November 1, 2008. The first list you request with a 12-month period is free of charge but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with the additional requests, and you may withdraw your request before you incur any costs.
4. Abuse or Neglect. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to do so.
5. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.



6. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
7. Law Enforcement. We may release PHI if asked to do so by a law enforcement official
  - a. Regarding a crime victim in certain situations if we are unable to obtain the person's agreement
  - b. Concerning a death we believe has resulted from criminal conduct
  - c. Regarding criminal conduct at our office
  - d. In response to a warrant, summons, court order, subpoena or similar legal process
  - e. To identify/locate a suspect, material witness, fugitive or missing person
  - f. In an emergency to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
8. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary we also may release information in order for funeral directors to perform their jobs.
9. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact Office Manager of Alpha Primary Healthcare, 972.591.1900.
10. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Office Manager, Alpha Primary Healthcare, 2875 Main Street Suite 102, Frisco, TX 75034. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
11. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization we will no longer use or disclose your PHI for the reasons described in the authorization. We are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact (Privacy Officer, Alpha Primary Healthcare, 2875 Main Street Suite 102, Frisco, TX 75034).