

IMASL

Internal Medicine Associates
of Sugar Land

PATIENT REGISTRATION AND INFORMATION

PATIENT INFORMATION

Name: _____ Date: _____
Address: _____ Apt # _____ City/State/Zip _____
Date of Birth: _____ SS# ____-____-____ Male ___ Female ___ Race/Ethnicity _____
Home Phone # _____ Work # _____ Cell # _____ Email: _____
Employer: _____ Occupation: _____ DL# _____
Single ___ Married ___ Divorced ___ Widowed ___

POLICY HOLDER INFORMATION FOR INSURANCE (IF DIFFERENT FROM ABOVE)

___ Parent ___ Spouse ___ (If self, GO to Insurance Section)
Parent or Spouse's Name _____
Date of Birth: _____ Age: _____ SS# ____-____-____
Employer: _____ Work Phone: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE)

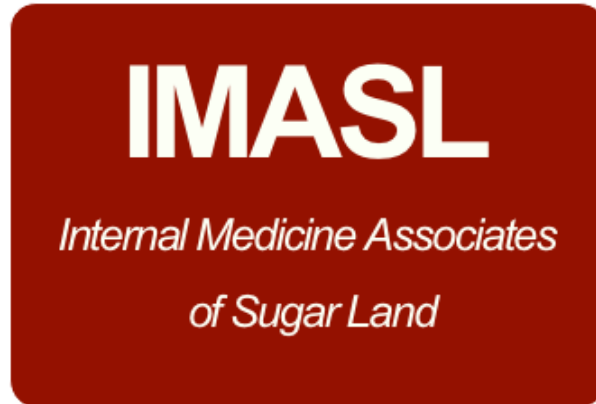
Name: _____ Relationship to you: _____
Street Address: _____ Phone # _____
City/State/Zip _____

Please read and sign below: I directly assign all medical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance. *It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account.*

I HEREBY GIVE AUTHORIZATION FOR TREATMENT. IF I AM REFERRED TO AN OUTSIDE PHYSICIAN FOR FURTHER CARE, I GIVE LIMITED AUTHORIZATION TO RELEASE MEDICAL RECORDS TO THE PREFERRED PHYSICIAN.

SIGNED: _____ DATE: _____

PRIMARY INSURANCE INFORMATION



DATE: _____

A copy of your insurance card and the information listed below will be required to file insurance claims.

PRIMARY INSURANCE COMPANY

Patient's Name: _____

Subscriber's (Policy Holder's) name if different from above _____

Subscriber's Date of Birth: _____ Subscriber's Group Number: _____

INFORMATION BELOW TO BE COMPLETED BY INTERNAL MEDICINE ASSOCIATES' PERSONNEL

PPO AFFILIATION: _____

IN OR OUT OF NETWORK: _____

DESIGNATED LABORATORY: _____

YOUR INSURANCE:

Please be familiar with your insurance benefits. If you expect insurance to pay for your services be sure that our office is a provider on your insurance plan. Also, please notify the office whether your plan covers preventative medicine or wellness care (physicals), and what the limitations of this coverage are. Also, if you want to have multiple procedures done on the same visit, please check with your insurance company to see if they will cover multiple procedures on the same day. Many insurance companies do not, and will use this tactic to avoid payment. Insurance company coverage is very difficult to predict, so it is important for you to be involved in insurance issue.

IMASL

Internal Medicine Associates
of Sugar Land

CONFIDENTIAL MEDICAL HISTORY

NAME: _____ AGE: _____ TODAY'S DATE _____

REASON FOR VISIT: _____

GENERAL HEALTH: _____

CHILDHOOD ILLNESSES: CHECK ALL THAT APPLY

MEASLES _____ MUMPS _____ WHOOPING COUGH _____ RHEUMATIC FEVER _____
CHICKEN POX _____ OTHER _____ INJURIES _____

DATES OF ANY OF THE FOLLOWING IMMUNIZATIONS:

MEASLES _____ MUMPS _____ PERTUSSIS _____ TETANUS _____ POLIO _____
RUBELLA _____ INFLUENZA _____ PNEUMONIA _____ OTHER _____

DATES OF ANY TRANFUSIONS _____

ADULT ILLNESSES:

Allergies _____
Asthma _____
Arthritis _____
Back Injury _____
Breast Disease _____
Broken Bones _____
Change in Bladder Habits _____
Change in Bowel Habits _____
Cancer _____
Coma _____
Convulsions _____
Diabetes _____
Diverticulosis _____
Emotional Problems _____

CHECK ALL THAT APPLY

Heart Trouble _____
High Blood Pressure _____
High Cholesterol _____
Kidney Trouble _____
Liver Disease _____
Lung Disease _____
Abnormal Mammogram _____
Abnormal Pap Smear _____
Abnormal PSA _____
Neurologic Problems _____
Pneumonia _____
Ulcers _____
Surgeries _____
Depression _____

EXPLAIN ANY CHECKED ITEMS FROM ABOVE

FOR WOMEN: NAME OF GYNECOLOGIST _____
DATE OF LAST MENSTRUAL PERIOD _____ DATE OF LAST PAPSMEAR _____
DATE OF LAST MAMMOGRAM _____ DO YOU PERFORM SELF BREAST EXAMS _____

FAMILY HISTORY:

MOTHER: AGE _____ ILLNESSES _____
FATHER: AGE _____ ILLNESSES _____
SISTERS: AGE (s) _____ ILLNESSES _____
BROTHERS: AGE (s) _____ ILLNESSES _____
CHILDREN: AGE (s) _____ ILLNESSES _____

SOCIAL HISTORY:

TOBACCO: NUMBER PER DAY _____ NUMBER OF YEARS: _____ DATE QUIT: _____
ALCOHOL: TYPE _____ AVERAGE NUMBER PER DAY _____
TYPE OF EMPLOYMENT: _____
MEDICATIONS: _____
ALLERGIES: _____

IMASL

*Internal Medicine Associates
of Sugar Land*

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, (patient's name) _____, hereby authorize the following physician and/or practice _____ to use and disclose the health information described below for the following purpose:

_____ Continuing Medical Care, _____ Personal Records, _____ Insurance Review, _____ Legal Review, _____ or other (please explain) _____

Patient Name: _____

Date of Birth: _____

Social Security Number _____

Please release this protected health information (PHI) to: _____

Address: _____

or fax number: _____

This authorization shall be in force and effective until the following event and/or date: _____

AUTHORIZATION

_____ (Physician/Practice/Other) and the employees are released from legal responsibility and liability for the release of the above information including release of any medical, psychiatric or psychological diagnosis, evaluation, examination or treatment.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice of _____ at the following address:

Signed:

_____ (Patient or guardian) Date: ____/____/____

_____ (If guardian, relationship to patient)

_____ (Witness) Date: ____/____/____

IMASL

*Internal Medicine Associates
of Sugar Land*

PATIENT RECORD OF DISCLOSURES

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential information of their protected health information (PHI) be sent to an alternate address. The HIPAA privacy rule is **federal law** and applies to all healthcare facilities, i.e. doctor's offices, hospitals, clinics, etc.

I authorize Internal Medicine Associates to disclose my protected health information (PHI) in the following manner: (please check all that apply)

Home Telephone Number _____

Leave message with detailed information

Leave a call back number only

Work Telephone Number _____

Leave message with detailed information

Leave a call back number only

Written Communication (Example: prescriptions, laboratory results, receipts, etc)

Mail to my home address:

Mail to an alternate address:

I authorize Internal Medicine Associates to share my protected health information (PHI) with the following: (check all that apply)

Self Spouse (Name) _____

Parents' (Name(s)) _____

Immediate Family Members (Brother, sister, grandparent, etc)

Caretaker (Name) _____

Other – Specify: _____

The HIPAA Privacy Rule generally requires providers to take reasonable steps to limit the use/disclosure of your protected health information (PHI). These provisions do not apply to uses or disclosures authorized by the individual in writing. NOTE: Uses and disclosures for treatment records, payment information and healthcare operations may be permitted without prior consent in an emergency.

Patient's Signature: _____ Date _____

IMASL

*Internal Medicine Associates
of Sugar Land*

Internal Medicine Associates of Sugar Land Patient Information Sheet

After-hours EMERGENCIES:

- ⤴ In case of a major emergency, call 911 or proceed to the nearest emergency room. If necessary, the emergency room will contact the physician.
- ⤴ For other after-hours problems that require a doctor (weekends, holidays or week days 4:30 p.m. - 8:30 a.m.) our telephone number is 281-494-4004. The physician or his representative will return your call.
- ⤴ Prescription refills are handled only during office hours to maintain quality of care and reduce prescribing errors

What to bring to the office each visit:

- ⤴ Current health insurance card
- ⤴ Means of paying for services or co-payments
- ⤴ Photo identification
- ⤴ Any change of address, phone number, employment or insurance
- ⤴ List of all medications including occasional medications, “over the counter” medication or supplements (vitamins, herbs, etc) Please include dosages, and how often taken.

Appointments

- ⤴ When you schedule your appointment, please provide the complete list of reasons for your appointment so that we can schedule an appropriate amount of time for your appointment. If you are coming for an annual exam, but have other medical issues for the doctor to review, please inform us when scheduling the appointment. To keep your waiting time to a minimum, we need to know how much time to schedule for whatever issues you may need to discuss with the doctor.
- ⤴ Please provide at least 24 hours notice if it becomes necessary for you to cancel or reschedule an appointment.

Phone calls during business hours:

- ⤴ While the physicians or the nurses are seeing patients, a “desk nurse” is on duty to handle medical calls. However, if the desk nurse is assisting another patient at the time of your call, you may be asked to leave a message on her voice-mail and she will return your call as soon as possible.
- ⤴ In order to provide proper medical care, beginning January 1, 2006 it is our office policy that if the patient is ill enough to require a prescription for an antibiotic, he/she will need to schedule an appointment for an office visit within a reasonable time period. Antibiotics will no longer be prescribed over the phone without an office visit being scheduled within a day or two.
- ⤴ When leaving a message, please state the reason for your call, your name and your phone number. Please also spell your last name and repeat your phone number slowly. If your message is not clear and understandable on the voice-mail, we will not be able to respond to your requests. This will allow the nurse to pull your chart so we can provide quality of care.
- ⤴ Routine Calls – Expect a return phone call by the end of the same business day, but on occasion there may be a delay until the next following business day.
- ⤴ Urgent Medical Calls – Will be returned as promptly as possible, and may require phone triage as we handle hundreds of messages each day. If you cannot wait for a return call, urgent care clinics or various emergency rooms are available.

Prescription Refills:

- ⤴ Please call your pharmacy at least THREE (3) business days before you need your refill. The pharmacist will call or fax our office for approval of refills. To provide the best patient care, our office may limit or not authorize refills if we have not seen you in the office in an appropriate time period.
- ⤴ If you need a prescription written for your mail-order pharmacy, please notify us at the time of your appointment.

Your Insurance:

Please be familiar with your insurance benefits. If you expect insurance to pay for your services, please be sure that our office is a provider your you insurance plan. Also, please notify the office whether your plan covers preventative medicine or wellness care (physicals), and what the limitation of this coverage are. Also, if you want to have multiple procedures done on the same visit, please check with your insurance company to see if they will cover multiple procedures on the same day. Many insurance companies do not, and will use this tactic to avoid payment. Insurance company coverage is very difficult to predict, so it is important for you to be involved in insurance issues.



PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and healthcare operations. Following are examples of the types of uses and disclosures of your protected healthcare information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by Our Office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care

services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between Our Office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research, Death, Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request a copy of your protected health information, we may charge you a reasonable fee for the copying, postage, labor and supplies used in meeting your request. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you

a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Mrs. Frances M. Zimmer
Office Manager

Internal Medicine Associates of Sugar Land
4660 Sweetwater Boulevard
Suite No. 190
Sugar Land, Texas 77479

281-494-4004 Phone
281-494-8899 Fax

Website: www.imasl.info