Texas Health®

PATIENT REGISTRATION

Date: _____

PATIENT DEMOGRAPHICS

Legal Name: _____
First MI Last Preferred Name

_____ DOB: _____ Mobile: _____
Parent/Legal Guardian Name

SS#: _____ DOB: _____ Legal Sex: ❑ Male ❑ Female

_____
Address Apt. # City State Zip

_____
Home Phone Work Phone Mobile Phone

Email: _____ ❑ No Email

Marital Status: ❑ Divorced ❑ Legally Separated ❑ Married ❑ Significant Other ❑ Single ❑ Widowed

Need Interpreter: ❑ Yes ❑ No Preferred Language: _____ Written Language: _____

Race: ❑ Asian ❑ Black ❑ Native American ❑ Native Hawaiian/Pacific Islander ❑ Two or More Races ❑ White

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

PARENT / LEGAL GUARDIAN INFORMATION (IF APPLICABLE)

Parent/Legal Guardian Name _____ DOB _____ Mobile _____

COMMUNICATION PREFERENCES

By checking one of the boxes for Preferred Communication Method, I agree to receiving correspondence from Texas Health.

Preferred Communication Method: ❑ No Preference ❑ Mail ❑ Phone ❑ Email ❑ MyChart ❑ Accept Text Messages

Do you have any communication difficulties/special needs?

Visually Impaired: ❑ Yes ❑ No Hearing Impaired: ❑ Yes ❑ No ❑ Special Needs: ❑ Yes ❑ No

If yes, please list: _____

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet.

PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physician: _____ ❑ No Primary Care Physician

EMERGENCY CONTACT

_____
Name Relationship to Patient Home Phone Mobile Phone

EMPLOYMENT

Employer Name: _____

Employment Status: ❑ Disabled ❑ Full Time ❑ Part Time ❑ Retired ❑ Student ❑ Unemployed

FOR OFFICE USE ONLY:

Patient Name: _____

MRN: _____

FINANCIALLY RESPONSIBLE PARTY – GUARANTOR

❑ Same as Patient Information (If different, please complete section below)

Name: _____
First MI Last Preferred Name

Relationship: ❑ Spouse ❑ Father ❑ Mother ❑ Other (please specify) _____

_____
Address Apt. # City State Zip

_____
Home Phone Work Phone Mobile Phone

Employer Name: _____

Employment status: ❑ Student ❑ Part Time ❑ Full Time ❑ Retires ❑ Disabled ❑ Unemployed

INSURANCE INFORMATION

Primary Insurance: _____ ID: _____ Gp: _____

_____ Sex: ❑ M ❑ F _____
Subscriber Name Patient Relationship to Subscriber

_____ _____
Subscriber's DOB Employer

Employment Status: ❑ Disabled ❑ Full Time ❑ Part Time ❑ Retired ❑ Student ❑ Unemployed

Secondary Insurance: _____ ID: _____ Gp: _____

_____ Sex: ❑ M ❑ F _____
Subscriber Name Patient Relationship to Subscriber

_____ _____
Subscriber's DOB Employer

Employment Status: ❑ Disabled ❑ Full Time ❑ Part Time ❑ Retired ❑ Student ❑ Unemployed

HOW YOU HEARD ABOUT US

❑ Family/Friend ❑ Email ❑ Newspaper/Magazine Ad ❑ Organizations Website
❑ Internet Search ❑ Television Commercial ❑ Organization Newsletter ❑ Other _____
❑ Referring Physician _____ ❑ Coach _____ ❑ Trainer _____

ACKNOWLEDGMENT

I certify the information provided herein is complete and accurate. I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by from Texas Health Resources or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

_____ _____ _____ _____
Patient or Legal Guardian Printed Name Patient or Legal Guardian Signature Date Time

AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION TO OTHERS

Patient Information

Legal Name: First_____ MI: _____ Last: _____

DOB: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Phone: Home_____ Work: _____

Mobile: _____

I authorize the release of information to the following individuals.

Effective Date: _____

Name: _____ Relationship to Patient: _____

Home Phone: _____ May We Leave a Message? ❑ Yes ❑ No

Mobile: _____ May We Leave a Message? ❑ Yes ❑ No

You may release the information regarding the following services to the person named above:
❑ **Appointments** ❑ **Billing** ❑ **Medical Care**

Name: _____ Relationship to Patient: _____

Home Phone: _____ May We Leave a Message? ❑ Yes ❑ No

Mobile: _____ May We Leave a Message? ❑ Yes ❑ No

You may release the information regarding the following services to the person named above:
❑ **Appointments** ❑ **Billing** ❑ **Medical Care**

I authorize Texas Health and its representatives to use the additional contact information listed above to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care as indicated. This authorization will remain in effect until I provide written notification to Texas Health of changes or updates.

I have read, fully understand, and agree to the above release of medical information to others.

Patient Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

FACILITY NAME MUST BE FILLED IN BLANK BELOW

THPGAUTHOTH

Texas Health®

AUTHORIZATION TO VERBALLY RELEASE INFORMATION - OTHERS

Patient Name: _____

DOB: _____

MRN: _____

I authorize the Texas Health Resources facilities, Texas Health Physicians Group and Texas Health Urgent Care to use my medical information as described in the Notice of Privacy Practices for my continuing medical treatment and to release my medical information to my health care providers using the Health Information Exchanges in which facilities participate. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the Texas Health Resources HIE, however some information may be included. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient provider and no longer protected. A Health Information Exchange is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. Your information will be stored with the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the Health Information Management Department (Medical Records Department) of the Texas Resources facilities, Texas Health Physicians Group or Texas Health Urgent Care for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing. Obstetric patients only: I also give this authorization for any child(ren) born to be during this hospitalization.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

❑ I authorize ❑ I do NOT authorize
the release of my medical information to the Health Information Exchanges in which facilities participate:

Acknowledgment:
I, the undersigned, certify that I have read and fully understand the information in this Consent for Health Information Exchange form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

Signature	Printed Name	Date	Time
_____	_____	_____	_____

If the person signing this form is not the patient, please give full name, relationship to patient, phone number and address:

Name	Relationship
_____	_____

Phone Number	Address
_____	_____

FACILITY NAME MUST BE FILLED IN BLANK BELOW

HIE

Texas Health®

CONSENT FOR HEALTH INFORMATION EXCHANGE
CF-0767-HIE (12/20)

Patient Name: _____

_____

DOB: _____

MRN: _____

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

- Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.
- I authorize direct payment of my insurance benefits to Texas Health for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- Out of Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- Texas Health or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.
- I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by from Texas Health Resources or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.
- I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

- Texas Health is committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.
- I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Texas Health.

I have read, fully understand and agree to the above **financial and payment guideline, release of information & assignment of benefits, and privacy practices.**

Patient Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

FACILITY NAME MUST BE FILLED IN BLANK BELOW

THPGPAYPRIACK

Texas Health®

PAYMENT AND PRIVACY ACKNOWLEDGEMENT

CF-0767-068 Rev. 09/20

Patient Name: _____

DOB: _____

MRN: _____

Texas Health®

CONSENT TO TREAT

I hereby authorize employees and agents of Texas Health (including physicians, physician assistants, and nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photos or videos may be taken. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of emergency.

Today's Date: _____

Print Patient's Name: _____

Patient Date of Birth: _____

Legal Guardian: (if different than patient) _____

Patient or Legal Guardian Signature: _____

Texas Health®

General Consent for Telehealth Services/Virtual Visit and Acknowledgements

Consent for Telehealth Services/Virtual Visit Care and Treatment

General Consent: I consent for Patient, which may be defined as me, my child or a person for whom I have legal responsibility, to receive care and treatment at a Texas Health Physicians Group facility, entity or program (collectively referred to as "THPG") through Telehealth Services (which may also be referred to as a Virtual Visit or Telehealth). Telehealth Services may be provided by physicians, advanced practice providers, and other health care providers employed or contracted by or affiliated with Texas Health Physicians Group ("Telehealth Providers") and may include the evaluation, diagnosis, consultation on, and treatment of Patient's medical or health condition using advanced telecommunications technology. I understand that photos or video of Patient may be taken in connection with Telehealth Services and for operational, quality improvement, research, and education purposes. I understand that THPG practices may be a teaching facility and agree that residents, fellows, students and other approved individuals may observe and participate in the Telehealth Services under appropriate supervision.

I understand that Telehealth Services include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via Telehealth. Telehealth Providers (i) may be in a location other than where Patient is located, (ii) will examine Patient face-to-face via a remote presence but will not perform a "hands-on" physical examination, and (iii) must rely on information provided by Patient. I further understand that Telehealth Services may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate data to perform the Telehealth Services, or distortions of images or other information from electronic transmissions. I acknowledge that the Telehealth Providers cannot be held liable for advice, recommendations and/or decisions based on factors not within their control, such as incomplete or inaccurate data provided by Patient/others or distortions of diagnostic images or specimens that may result from electronic transmission.

If the Telehealth Providers determine that Telehealth Services do not adequately address Patient's medical needs, Patient will be referred for on-site medical evaluation. If Patient's condition is urgent / emergent, or if the Telehealth session is interrupted due to a technological or equipment failure, I agree Patient will obtain follow up care and treatment as needed.

I understand that precautions are taken to protect the confidentiality of Patient's medical information by preventing unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering.

Independent Providers: The Telehealth Providers are independent physicians or providers who work for THPG and not Texas Health Resources.

No Guarantee: I acknowledge that no guarantees or warranties have been made as to treatment or services provided at Texas Health Physicians Group.

Notice of Complaints: To file a complaint or grievance with THPG, you may call 214-860-6427. A complaint regarding a physician Telehealth Provider may reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, or by calling 1-800-201-9353, or by visiting their website at www.tmb.state.tx.us.

Text / Voice / Automated Messaging: I authorize THPG to send communications by text message, voice and automated calls to the cell phone number I provide. I acknowledge that standard data rates and fees will apply, full security is not guaranteed over telephone networks, and I will need to protect my phone with a password or PIN to prevent unauthorized access. I understand that text and automated messaging may not be used by me to notify THPG of Patient's health care needs.
Duration of Consent: I understand and agree this Consent for Telehealth Services Care and Treatment is valid for all Telehealth Services/ Virtual Visits, for the present and future visits for one year from the date of signature below unless I revoke the consent prior to that time.

I have read and understand the information in this Consent for Telehealth Services/Virtual Visit Care and Treatment form, and understand that by not signing this Consent I will not be treated.

Patient Name		Date of Birth	
Signature of Patient/Parent or Legally Authorized Representative	Printed Name Patient/Parent or Legally Authorized Representative	Date	Time
Relationship to Patient			

***Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.**
**** Witness must be an adult, over the age of eighteen (18) years, of sound mind and not a participant in the medical treatment.**

Patient Name _____ Date of Birth _____

Protected Health Information - Notice of Privacy Practices: THPG Notice of Privacy Practices addresses how THPG may use and disclose Patient's Protected Health Information (PHI) for treatment, payment, and healthcare operations and for other purposes allowed or required by law. I acknowledge that I have received or been offered THPG Notice of Privacy Practices and that any questions or concerns may be directed to the THPG Privacy Officer, prior to this visit.

Use and Disclosure of information: I understand that Patient's medical records are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices. I understand that Patient's medical information includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment/psychiatric care and alcohol/substance abuse diagnosis or treatment (collectively, "Medical Information"). I authorize release of that Medical Information as part of Patient's medical and billing records. I understand that THPG must keep Patient's medical records for a time period required by law and then may dispose of such medical records as permitted or required by law.

Electronic Sharing of Medical Information: I authorize THPG to use Patient's Medical Information for treatment, payment, and healthcare operations (collectively referred to as "Purposes"), or as otherwise allowed by law. I acknowledge that THPG will release and send, electronically or otherwise, Patient's Medical Information to third parties for the Purposes set forth above, or as otherwise allowed by law. I understand that Medical Information may no longer be protected by federal and state privacy laws once it is disclosed, and therefore, may be subject to re-disclosure by the recipient. Medical Information may become part of Patient's medical records kept by non-THPG healthcare providers and may be further disclosed.
I have read and understand the information in the Acknowledgments for Protected Health Information and Financial Responsibility and have received THPG's Notice of Privacy Practices.

Patient/Parent or Legally Authorized Representative Signature _____ Patient/Parent or Legally Authorized Representative _____ Date _____ Time _____

Relationship to Patient _____

***Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.**
**** Witness must be an adult, over the age of eighteen (18), of sound mind and not a participant in the medical treatment**

Name: _____ Date of Birth: _____ Date: _____

HEALTH HISTORY FOR NEW PATIENTS

Main reason for today's visit: _____

Previous PCP: _____ **ALLERGIES:** _____

Personal Medical History	Current	Past	Personal Medical History	Current	Past
Allergy Symptoms (Seasonal; Environmental)			High Cholesterol		
Anemia			History of Blood Transfusion		
Anxiety			HIV - Human Immunodeficiency Virus		
Arthritis			HTN - Hypertension		
Asthma			Kidney Disease		
CAD- Coronary Artery Disease			Liver Disease		
Cancer			Meningitis		
Cataract			Mitral Valve Disease		
Cerebrovascular Accident (Stroke)			Myocardial Infarction (Heart Attack)		
Clotting Disorder			Osteoporosis		
Congestive Heart Failure			Seizures		
COPD - Chronic Obstructive Pulmonary Disease			Sickle Cell		
Depression			Sleep Apnea		
Diabetes			Substance Abuse		
Emphysema			Thyroid Disease		
Gastric Ulcers			Tuberculosis - TB		
GERD - Gastroesophageal Reflux Disease			Other		
Glaucoma					

Surgical Procedure	Year	Comments/Locations	Surgical Procedure	Year	Comments
Appendectomy			Hernia Repair		
Brain Surgery			Hysterectomy		
Breast Surgery			Joint Replacement		
Cholecystectomy (Gall Bladder removal)			Prostate Surgery		
Colon Surgery			Small Intestine Surgery		
Biopsy (location)			Spine Surgery		
Coronary Artery Bypass Graft			Tonsillectomy		
Cosmetic Surgery			Tubal Ligation		
C-Section			Valve Replacement		
Eye Surgery			Vasectomy		
Fracture Surgery			Other		

SOCIAL HISTORY - Circle all that apply

Tobacco
Never / Past / Active
Cigarette / Cigar / Pipe
Snuff / Dip / Chewing
Start _____ Stop_____
Packs per day_____

Alcohol
Never / Past / Active
Liquor / Wine / Beer
_____ Drinks per
Day / Week / Month
AA / Alcohol Rehab

Illicit Drugs
Never / Past / Active
Cocaine / Marijuana
Heroin / Amphetamine
Barbiturate / LSD / PCP
IV Drug Abuse / Drug Rehab

Caffeine
Never / Past / Active
Coffee / Tea / Soda
_____ Can / Cups per day

Sexually Active?
Yes / Not Currently / Never
Birth Control / Protection:
_____
Gender(s) of Partner(s)
Male / Female

FACILITY NAME MUST BE FILLED IN BLANK BELOW

PATIENT IDENTIFICATION

Texas Health Resources® _____

Name: _____ Date of Birth: _____ Date: _____

FAMILY MEDICAL HISTORY - Please indicate which relative has or had the following diseases

Are you adopted? Yes _____ No _____ Do you have an Advanced Care Directive? Yes _____ No _____

	Mother	Father	Sister	Brother	Other		Mother	Father	Sister	Brother	Other
Alive						Hyperlipidemia					
Deceased						Hypertension					
Age currently or at death						Kidney Disease					
Diseases and Conditions	**Mother**	**Father**	**Sister**	**Brother**		Learning Disabilities					
No significant history known						Mental Illness					
Alcoholism / Drug abuse						Mental Retardation					
Arthritis						Recurrent Miscarriage					
Asthma						Stroke					
Birth Defects						Visual loss					
Cancer						Aneurysm					
COPD						Heart Disease					
Depression						Rheumatoid Arthritis					
Diabetes						Thyroid Disease					
Drug Use / Abuse						Other					
Early Death						Other					
Hearing Loss						Other					
Heart						Other					

OTHER FAMILY HISTORY (children, aunts, uncles etc.)

Relationship: _____ Condition: _____

Relationship: _____ Condition: _____

CURRENT MEDICATIONS / VITAMINS / SUPPLEMENTS

Medication	Dose (mg/pill)	How many times per day?	Medication	Dose (mg/pill)	How many times per day?

IMMUNIZATIONS AND SCREENINGS - Please indicate the year you last had any of the following immunizations or tests

Flu Vaccine _____ Hepatitis Vaccine _____ Pneumonia _____

Tetanus Vaccine _____ Zostavax (Shingles) _____

COVID: Dates: _____ _____ Booster Date: _____ ❑ Phizer ❑ Moderna ❑ J&J

Colonoscopy _____ Mammogram _____ Pap Smear _____ Eye Exam _____

FACILITY NAME MUST BE FILLED IN BLANK BELOW

PATIENT IDENTIFICATION

Texas Health Resources® _____

Name: _____ Date of Birth: _____ Date: _____

DEPRESSION SCALE: PHQ-2/9

Instructions: Please rate questions 1 and 2 below (if the sum of items 1 and 2 is two or more proceed to answer the remainder of the statements)

1) Little interest or pleasure in doing things	
2) Feeling down, depressed, or hopeless	
3) Trouble falling or staying asleep, or sleeping too much	
4) Feeling tired or having little energy	
5) Poor appetite or overeating	
6) Feeling bad about self- feeling like a failure, letting self or family down	
7) Trouble concentrating on things, such as reading newspaper or watching TV	
8) Noticeable lethargy or excessive agitation in speech or movement	
9) Thoughts of being better off dead, or hurting self in some way	
Key: **0** = Not at all 1 = Several days **2** = More than half the days **3** = Nearly every day PHQ-2 Total Score (sum of questions 1-2) PHQ-9 Total Score (sum of questions 1-9) See below for interpretation	

10) How difficult have these problems made it for you to perform daily routines and get along with others?

Circle one that applies: Not difficult at all Somewhat difficult Very difficult Extremely difficult

Scale Interpretation

1-4 = Minimal Depression **5-9** = Mild Depression **10-14** = Moderate Depression **15-19** = Moderately Severe Depression **20-27** = Severe Depression

If you rated number 9 as 1-3, please assess suicidal risk/severity:

11) Attempted to harm self in the past	
12) Thoughts about how to hurt self	
13) Likelihood of hurting self or ending life during the next month	
Key: **1** = Unlikely 2 = Somewhat likely **3** = Likely **4** = Very likely **5** = Most likely	

14) Is there anything that would prevent or keep you from harming yourself?