



Patient last name: \_\_\_\_\_
First: \_\_\_\_\_ Middle: \_\_\_\_\_
Sex: [ ] Male [ ] Female Marital Sts: [ ] Single [ ] Married [ ] Div [ ] Wid
Birthday(M/D/Y): \_\_\_\_\_ Age: \_\_\_\_\_ year \_\_\_\_\_ month
SSN: \_\_\_\_\_ Driver Lic.#: \_\_\_\_\_
Email: \_\_\_\_\_
Address / Apt#: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Home: \_\_\_\_\_ Cell: \_\_\_\_\_
Employer: \_\_\_\_\_ Work: \_\_\_\_\_

Insurer (policy holder) last name: \_\_\_\_\_
First: \_\_\_\_\_ Middle: \_\_\_\_\_
Patient's Relationship to Insurer: [ ] Self [ ] Spouse [ ] Child [ ] \_\_\_\_\_
Sex: [ ] Male [ ] Female Marital Sts: [ ] Single [ ] Married [ ] Div [ ] Wid
Birthday(M/D/Y): \_\_\_\_\_
SSN: \_\_\_\_\_ Driver Lic.#: \_\_\_\_\_
Address / Apt#: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Home: \_\_\_\_\_ Cell: \_\_\_\_\_
Employer: \_\_\_\_\_ Work: \_\_\_\_\_

Census Data (required by insurance) Pt. Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Refused
Pt. Race: [ ] American Indian/Alaskan Native [ ] Asian [ ] Black/African American [ ] Black Hispanic/Latino
[ ] Native Hawaiian/Other Pacific [ ] White Hispanic/Latino [ ] White [ ] Refused
Pt. Language: [ ] English [ ] Chinese [ ] French [ ] German [ ] Italian [ ] Japanese
[ ] Portuguese [ ] Russian [ ] Spanish [ ] Vietnamese [ ] Refused [ ] Korean [ ] Other \_\_\_\_\_

Guarantor Last name: \_\_\_\_\_ First: \_\_\_\_\_ Birthday (M/D/Y): \_\_\_\_\_ Address: \_\_\_\_\_ Tel: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Relation to Pt: \_\_\_\_\_ Tel: \_\_\_\_\_ 2nd Tel: \_\_\_\_\_
Pharmacy & Addr.: \_\_\_\_\_ Tel.: \_\_\_\_\_

Primary Ins: \_\_\_\_\_ Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Provider Svc Tel.: \_\_\_\_\_
Billing Addr. City, St, Zip: \_\_\_\_\_ \*\*\* We need ins. addr. and tel. to verify benefit.
Secondary Ins: \_\_\_\_\_ Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Provider Svc Tel.: \_\_\_\_\_
Billing Addr. City, St, Zip: \_\_\_\_\_ Health Saving Account?: [ ] Yes [ ] No

CONSENT FOR TREATMENT: I have a condition or physical checkup requiring diagnostic, medical or surgical treatment; I hereby voluntarily authorize consent to such procedures, medical/surgical care and other services under the general and specific instructions of ST. MICHAEL MEDICAL CLINIC's Physicians, Nurse Practitioners, Medical Staff or their designee as is necessary in their judgment.
\*\*\* I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment or examination by St. Michael Medical Clinic's Physicians, Nurse Practitioners, or Medical Staff. \*\*\*
Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Patient or Parent/Guardian Signature if minor.
Please PRINT Parent or Guardian NAME: \_\_\_\_\_

I authorize ST. MICHAEL MEDICAL CLINIC, P.A. (a covered entity) which includes its Physicians, Nurse Practitioners, and Medical Staff to release any identifiable health and/or accounting information to other health care providers, health plans, health care clearinghouse, public health authority and life insurers deemed necessary to carry out health care operations and/or covered transactions on my behalf.
\*\*\* I understand that I can revoke this authorization at anytime with a signed written consent except to the extent that the covered entity has already acted in reliance upon the authorization and/or for the purpose of obtaining payment for the covered transactions. \*\*\*
Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Patient or Parent/Guardian Signature if minor.

I hereby acknowledge receipt of the Notice of Privacy Practices given to me by ST. MICHAEL MEDICAL CLINIC, P.A.
Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Patient or Parent/Guardian Signature if minor.
For Office: Notice of Privacy Practices could not be obtain: [ ] Individual refused to sign [ ] Communication barriers prohibited in obtaining the acknowledgement
[ ] An Emergency situation prevented us from obtaining acknowledgement or other. Reason: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

**St. Michael Medical Clinic Policies**

We at **St. Michael Medical Clinic** are dedicated to providing the best possible medical care and service to you and your family. Your understanding of our financial responsibility policy is an essential element of your care and service. **With all the new healthcare changes, we have updated our policies.** This will prevent any misunderstandings and allow us to serve you better.

**FINANCIAL and BILLING POLICIES:** (Please read and **initialize each item** below.)

- \_\_\_\_\_ • 1) **You are ultimately responsible for knowing what your plan** does and does not cover and the administrative rules. (i.e. in-network / out-network; out-of-pocket balance, copayment, coinsurance, deductible , Health-Saving-Account balance; Labs/Radiology/EKG; authorizations and referrals)
- \_\_\_\_\_ • 2) Patient is encouraged to **verify specific LABs/other procedures** covered and not covered. What is covered: portion 100%, 80%, 20%, other; preventative benefits & screening; EKG/XRay/MRI/CT radiology test; mental health office visit; consult/specialist evaluation.
- \_\_\_\_\_ • 3) As a **courtesy, we will verify your insurance eligibility and benefits.** However, we cannot guarantee that the information received, is accurate due to insurance policy changes and real-time/up-to-date system information. **We will bill your insurance company** with whom we have a contract agreement with.
- \_\_\_\_\_ • 4) Once your benefits have been determined, payments of any **copays, coinsurance, deductible, and fees** are required at time services are rendered.
- \_\_\_\_\_ • 5) Once your insurance company has processed a claim, any **balance** as determined by your insurance plan to be **“patient’s responsibility”** and/or **“non-covered service”**, will be your responsibility.
- \_\_\_\_\_ • 6) **If you disagree** with the “patient responsibility” amounts due to our office per your insurance’s Explanation-of-Benefits(EOB), please **immediately call your insurance company and our office for further explanation.**
- \_\_\_\_\_ • 7) **Failure** to provide **current insurance** information to our office and/or **reply** back to **insurance’s request for additional** information may result in the entire bill being **your responsibility.**
- \_\_\_\_\_ • 8) SELF-PAY patient: Full payment for your visit is expected on the day of the visit.
- \_\_\_\_\_ • 9) Any outstanding balance owe to our office is also due, unless payment arrangements have been made in advance with our office.
- \_\_\_\_\_ • 10) The **independent labs**, Quest Diagnostics or LabCorp, will **also bill independently.** If you receive a bill from the lab, you will need to contact the lab for further detail and payment arrangement.
- \_\_\_\_\_ • 11) There will be a fee for ALL forms to be filled out and/or typed letters requiring a signature from our physicians, nurse practitioners or medical staff. There is a charge for re-writing lost prescriptions.
- \_\_\_\_\_ • 12) Our office **DOES NOT bill third parties** (i.e. automobile insurance). Your visit will be SELF-PAY and a receipt will be given to you to file with your auto-insurance. Our office **DOES NOT accept workman's compensation** cases.
- \_\_\_\_\_ • 13) Please notify us in advance, if you cannot make your appointment. We reserve the right to ask you to seek care from another physician, if you miss three appointments without notification. If you are more than 30 minutes late for your appointment, you may be asked to reschedule.
- \_\_\_\_\_ • 14) RETURNED CHECKS will incur a \$25 fee.

**General MEDICATION Refill POLICIES:**

- For medication refills, please call the pharmacy and speak to a technician/person.
- Allow at least one week left of medication when calling pharmacy for refill.
- Allow at least 48 hours to process requests, once we receive the request from the pharmacy.
- Refills will not be performed as an “emergency”. Please plan ahead.
- Patient is responsible for keeping track of the amount remaining and for taking the medication in the dose prescribed.
- No Refills will be made during weekends or holidays.

**\*\*\* Some medications require closer monitoring than others. A general outline is as follows:\*\*\***

- Mental Health Medications require an appointment every 1-3 months based on individual assessment.
- Narcotics require an appointment for every refill. THERE IS NO EXCEPTIONS
- Triplicate prescriptions require an appointment every 3 months (or sooner if changes are needed)
- All other maintenance medications require a 3-6 month follow-up appointment for consideration on therapeutic regimen and necessary blood-work.

*It is per the discretion of the physician if an appointment will be required before a refill is granted. Many factors and circumstances are considered before a final decision is made. Thank you.*

Patient Name(Last, First): \_\_\_\_\_ DOB: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Patient or Parent/Guardian Signature if minor.*

If patient is a minor, Please PRINT Parent or Guardian NAME: \_\_\_\_\_

Reason for visit: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

SYMPTOMS						v = Since your last visit, Check or Circle all symptoms that have or have had.						None (patient initialize _____)											
<b>General</b>				<input type="checkbox"/> Chills	<input type="checkbox"/> Depression	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Fever	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness	<input type="checkbox"/> Sweats	<input type="checkbox"/> Headache								
<b>WOMEN only</b>				<b>Date:</b> Last menstrual period _____ Last Pap Smear _____ Last mammogram _____ No. of children: ____ Are you pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Hot flashes <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____																			
<b>MEN only</b>				<input type="checkbox"/> Breast lump	<input type="checkbox"/> Erection difficulties	<input type="checkbox"/> Lump in testicles	<input type="checkbox"/> Penis discharge	<input type="checkbox"/> Sore on penis	<input type="checkbox"/> Other _____														
<b>Muscle/Joint/Bone</b>				<input type="checkbox"/> Arms	<input type="checkbox"/> Back	<input type="checkbox"/> Feet	<input type="checkbox"/> Hands	<input type="checkbox"/> Hips	<input type="checkbox"/> Legs	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulders												
<b>GENITO-URINARY</b>				<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Painful urination																
<b>Gastrointestinal</b>				<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bloating	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Gas	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Nausea	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vomiting Blood					
<b>Cardiovascular</b>				<input type="checkbox"/> Chest pain	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Poor circulation												
<b>Eye, Ear, Nose, Throat</b>				<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Double vision	<input type="checkbox"/> Earache	<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Vision - Flashes	<input type="checkbox"/> Vision - Halos				
<b>Skin</b>				<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Hives	<input type="checkbox"/> Itching	<input type="checkbox"/> Change in moles	<input type="checkbox"/> Rash	<input type="checkbox"/> Scars	<input type="checkbox"/> Sore that won't heal													
CONDITIONS						None _____																	
<input type="checkbox"/> AIDS						<input type="checkbox"/> Alcoholism																	
<input type="checkbox"/> Anemia						<input type="checkbox"/> Anorexia																	
<input type="checkbox"/> Appendicitis						<input type="checkbox"/> Arthritis																	
<input type="checkbox"/> Asthma						<input type="checkbox"/> Bleeding disorders																	
<input type="checkbox"/> Breast lump						<input type="checkbox"/> Bronchitis																	
<input type="checkbox"/> Bulimia						<input type="checkbox"/> Cancer																	
<input type="checkbox"/> Cataracts						<input type="checkbox"/> Chemical dependency																	
<input type="checkbox"/> Chicken Pox						<input type="checkbox"/> Diabetes																	
<input type="checkbox"/> Emphysema						<input type="checkbox"/> Epilepsy																	
<input type="checkbox"/> Glaucoma						<input type="checkbox"/> Goiter																	
<input type="checkbox"/> Gonorrhea						<input type="checkbox"/> Gout																	
<input type="checkbox"/> Heart disease						<input type="checkbox"/> Hepatitis																	
<input type="checkbox"/> Hernia						<input type="checkbox"/> Herpes																	
<input type="checkbox"/> High cholesterol						<input type="checkbox"/> HIV positive																	
<input type="checkbox"/> Kidney disease						<input type="checkbox"/> Liver disease																	
<input type="checkbox"/> Measles						<input type="checkbox"/> Migraine headaches																	
<input type="checkbox"/> Miscarriage						<input type="checkbox"/> Mononucleosis																	
<input type="checkbox"/> Multiple sclerosis						<input type="checkbox"/> Mumps																	
<input type="checkbox"/> Pacemaker						<input type="checkbox"/> Pneumonia																	
<input type="checkbox"/> Polio						<input type="checkbox"/> Prostate problem																	
<input type="checkbox"/> Psychiatric Care						<input type="checkbox"/> Rheumatic fever																	
<input type="checkbox"/> Stroke						<input type="checkbox"/> Scarlet fever																	
<input type="checkbox"/> Suicide attempt						<input type="checkbox"/> Thyroid problems																	
<input type="checkbox"/> Tonsillitis						<input type="checkbox"/> Tuberculosis																	
<input type="checkbox"/> Typhoid fever						<input type="checkbox"/> Ulcers																	
<input type="checkbox"/> Vaginal infections						<input type="checkbox"/> Venereal disease																	
MEDICATIONS						currently taking (write on back if needed)						None _____											
ALLERGIES						to medications or substances						None -NKDA _____											
FAMILY HISTORY						Fill in health information about your family						Disease						Relationship to you					
Relation		State of Health		Age		Cause of Death		Age		None _____													
Father						<input type="checkbox"/> Arthritis				<input type="checkbox"/> Diabetes													
Mother						<input type="checkbox"/> Gout				<input type="checkbox"/> Heart Disease													
<input type="checkbox"/> Brother / <input type="checkbox"/> Sis						<input type="checkbox"/> Asthma				<input type="checkbox"/> Strokes													
<input type="checkbox"/> Brother / <input type="checkbox"/> Sis						<input type="checkbox"/> Hay Fever				<input type="checkbox"/> High Blood Pressure													
<input type="checkbox"/> Brother / <input type="checkbox"/> Sis						<input type="checkbox"/> Cancer				<input type="checkbox"/> Kidney disease													
<input type="checkbox"/> Brother / <input type="checkbox"/> Sis						<input type="checkbox"/> Chemical Dependency				<input type="checkbox"/> Tuberculosis													
<input type="checkbox"/> Brother / <input type="checkbox"/> Sis						<input type="checkbox"/> Other				<input type="checkbox"/> Other													
HOSPITALIZATION				Reason & Outcome				PREGNANCY HISTORY				HAVE YOU EVER HAD BLOOD TRANSFUSIONS?											
Year		Hospital		None _____				Year & Sex of birth		Complications if any		<input type="checkbox"/> Yes <input type="checkbox"/> No		Approximate Date:									
HEALTH HABITS				v = Check if apply & how much																			
<input type="checkbox"/> Caffeine																							
<input type="checkbox"/> Tobacco																							
<input type="checkbox"/> Drugs																							
<input type="checkbox"/> Other																							
SERIOUS ILLNESS / INJURIES				DATE				Outcome				OCCUPATIONAL CONCERNS											
None _____												v = Check if exposes											
												<input type="checkbox"/> None _____ <input type="checkbox"/> Stress <input type="checkbox"/> Heavy Lifting											
												<input type="checkbox"/> Hazardous Substances											
												<input type="checkbox"/> Other _____											
												<b>Your Occupation:</b>											

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

**X Signature:** (Parent or Guardian if minor) \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

	Current MEDICATION List	Dose ie: 500MG	Frequency ie: 1 tab twice a day ( AM/PM, PRN)	Reason & Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				



# St. Michael Medical Clinic

12609 Louetta Road • Cypress, Texas 77429 • Phone: 281-655-5100 • Fax: 281-655-1415

## HIPPA Notice of Privacy Practices of ST. MICHAEL MEDICAL CLINIC.

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.

### Patient Health Information:

- Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

### How We Use Your Patient Health Information:

- We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

### Examples of Treatment, Payment and Health Care Operations:

- Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
- Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
- Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

### Special Uses:

- We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

### Other Uses and Disclosures:

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes.

- Required by law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.
- Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
- Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
- Death: We may report information regarding deaths to coroner, medical examiner, funeral directors, and organ donation agencies.
- Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- Research: We may use or disclose information for approved medical research.
- Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

### Individual Rights:

You have the following right with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

- Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restriction, but if we do agree, we must abide by those restrictions.
- Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
- Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There will be a small charge for the copies.
- Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
- Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

### Our Legal Duty:

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about your legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

- Changes in Privacy Practices: We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the SMMC staff.
- Complaints: If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.