St. Michael Medical Clinic, P.A. 12609 Louetta Rd, Cypress, TX 77429 **Patient Registration** 3-2-23

Patient last name: _____ First: _____ Middle: _____

Birthday(M/D/Y): _____ Age:_____ Year: _____ Month: _____ **Sex:** ☐ Male ☐ Female **Marital Sts:** ☐ Single ☐ Married ☐ Div ☐ Wid

Email: _____ Height: _____ SSN: _____ Driver Lic.#:_____

Address / Apt#:_____ City/St/Zip: _____ OCCUPATION: _____

Cell: _____ We TEXT reminder (please let us know if OPT-OUT) Home: _____ 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: _____ Home: _____ Cell: _____

Health Saving Account?

☐ **Yes**

☐ **No**

Primary Ins:_____ Policy ID#: _____ Provider Service Tel.: _____

Group #: _____ Billing Addr.,City, St, Zip: _____

Secondary Ins: _____ Policy ID#: _____ Provider Service Tel.: _____

Group #: _____ Billing Addr.,City, St, Zip: _____

Census Data *(required by insurance)* **Pt. Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused .

Pt. Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Refused ☐ Other_____.

Pt. Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Black Hispanic/Latino ☐ Native Hawaiian/Other Pacific ☐ White Hispanic/Latino ☐ White ☐ Refused

Emergency Contact Name: _____ Relation to Pt: _____ Tel: _____ 2nd Tel: _____

Pharmacy & Addr.: _____ Tel.: _____

Guarantor Last Name: _____ First: _____ Birthday (M/D/Y): _____ Address: _____ Tel: _____

How did you hear about us: ☐ Friend _____ ☐ Hospital follow-up ☐ newspaper _____ ☐ Insurance ☐ other _____

I GIVE CONSENT FOR RELEASE MR regarding my medical treatment fax to St Michael Clinic @ 888-990-2119.

☐ Colonoscopy..... Previous Dr Name: _____Phone #_____ Fax#:_____

☐ GYN-PAP/Mammo... Previous Dr Name: _____Phone #_____ Fax#:_____

☐ Eye Exam ..... Previous Dr Name: _____Phone #_____ Fax#:_____

Signature: _____ Date:_____ (NOTE: Entire Medical Chart from previous family Dr consent to release MR is on different page.

Patient or Parent/Guardian Signature if minor.

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. *If patient is minor, 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 the Financial and billing policies given to me by St. Michael Medical Clinic PA. See Stmichaelclinic.com (include: call 24hrs ahead to avoid the No-show fee of $30; call for a refill at least 10days prior to being out of med; med refill require 3-6month follow-up and blood-work; new and med adjustments require 1-3month follow-up; narcotics, antibiotics, and new med require an appointment…)

Signature: _____ Date:_____

Patient or Parent/Guardian Signature if minor.

I hereby acknowledge the Notice of Privacy Practices given to me by St. Michael Medical Clinic PA. See Stmichaelclinic.com

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 Health History. HAVE YOU EVER HAD BLOOD TRANSFUSIONS? □No □Yes Date: _____

SYMPTOMS √= Since your last visit, Check or Circle all symptoms that have or have had. ☐ None (patient initialize _____)	
General	☐Chills ☐Depression ☐Dizziness ☐Fainting ☐Fever ☐Forgetfulness ☐Loss of Sleep ☐Loss of weight ☐Nervousness ☐Numbness ☐Sweats ☐Headache
WOMEN only	**Date:** Last menstrual period _____ Are you pregnant: ☐Yes ☐No ☐Abnormal Pap Smear ☐Bleeding between periods ☐Breast lump ☐Hot flashes ☐Extreme menstrual pain ☐Nipple discharge ☐Painful intercourse ☐Vaginal discharge ☐Other_____
MEN only	☐Breast lump ☐Erection difficulties ☐Lump in testicles ☐Penis discharge ☐Sore on penis ☐Other _____
Muscle/Joint/Bone	☐Arms ☐Back ☐Feet ☐Hands ☐Hips ☐Legs ☐Neck ☐Shoulders
GENITO-URINARY	☐Blood in urine ☐Frequent Urination ☐Lack of bladder control ☐Painful urination
Gastrointestinal	☐Appetite poor ☐Bloating ☐Bowel changes ☐Constipation ☐Diarrhea ☐Excessive hunger ☐Excessive thirst ☐Gas ☐Hemorrhoids ☐Indigestion ☐Nausea ☐Rectal Bleeding ☐Stomach pain ☐Vomiting ☐Vomiting Blood
Cardiovascular	☐Chest pain ☐High blood pressure ☐Irregular heart beat ☐Low blood pressure ☐Rapid heartbeat ☐Swelling of ankles ☐Varicose veins ☐Poor circulation
Eye, Ear, Nose, Throat	☐Bleeding gums ☐Blurred vision ☐Crossed eyes ☐Difficulty swallowing ☐Double vision ☐Earache ☐Ear discharge ☐Hay fever ☐Hoarseness ☐Loss of hearing ☐Nosebleeds ☐Persistent cough ☐Ringing in ears ☐Sinus problems ☐Vision – Flashes ☐Vision – Halos ☐Sore throat
Skin	☐Bruise easily ☐Hives ☐Itching ☐Change in moles ☐Rash ☐Scars ☐Sore that won't heal

CONDITIONS ☐ None ____	☐AIDS	☐Alcoholism	☐Anemia	☐Anorexia	☐Appendicitis	☐Arthritis	☐Asthma	☐Bleeding disorders
☐Breast lump	☐Bronchitis	☐Bulimia	☐Cancer	☐Cataracts	☐Chemical dependency	☐Chicken Pox	☐Cholesterol	☐Diabetes ☐Down syndrome
☐Emphysema	☐Epilepsy	☐Glaucoma	☐Goit	☐Gonorrhea	☐Gout	☐Heart disease	☐Hepatitis	☐Hernia ☐Herpes ☐High cholesterol
☐HIV positive	☐Kidney disease	☐Liver disease	☐Measles	☐Migraine headaches	☐Miscarriage	☐Mononucleosis	☐Multiple sclerosis	
☐Mumps	☐Pacemaker	☐Pneumonia	☐Polio	☐Prostate problem	☐Psychiatric Care	☐Rheumatic fever	☐ Stroke	☐Scarlet fever
☐Suicide attempt	☐Thyroid problems	☐Tonsillitis	☐Tuberculosis	☐Typhoid fever	☐Ulcers	☐Vaginal infections	☐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

Father health: ☐Good ☐Fair ☐Poor ☐Decease.Cause: _____	☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐other _____
Mother health:☐Good ☐Fair ☐Poor ☐Decease.Cause: _____	☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐other _____
Brother health:☐Good ☐Fair ☐Poor ☐Decease.Cause: ____	☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐other _____
Sister health :☐Good ☐Fair ☐Poor ☐Decease.Cause: _____	☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐other _____

HOSPITALIZATION: Year Hospital Reason

PREGNANCY HISTORY: NO of childrens: _____ Year Sex of birth Complications if any

SERIOUS ILLNESS / INJURIES

Per Week: Drink alcohol □less than 13 □greater than 13 □less than 14 □greater than 14 Per occasion: Drink alcohol □less than 3 □greater than 3 □less than 4 □greater than 4	USE DRUGS: □No □Yes Type: _____

□ NON Tobacco user □ Current user □ Former-tobacco user. (□ cig / □ pipe / □ chew): # of pack/day: ___ # of year used tobacco : ___ Yr quit:_____

Colon cancer screening: MM/DD/YY_____ □ FOBT □cologuard □colonoscopy # of polyps= __ result: □ Normal / □ Abnormal Yr Return: _____

FLU vaccine Aug-March: MM/DD/YY_____ Refuse: □ Yes	Dilated eye exam: MM/DD/YY_____ result: □ Normal / □ Abnormal
Mammogram: MM/DD/YY_____ result: □ Normal / □ Abnormal	PAP smear: MM/DD/YY_____ result: □ Normal / □ Abnormal
Prostate PSA lab: MM/DD/YY _____ Discuss with dr if needed test.	Bone Density: MM/DD/YY_____ result: _____

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.

Name(Last,First): _____ DOB: _____ Signature: _____ Date: _____

St. Michael Medical Clinic Medication List Name(Last,First): _____ DOB: _____ Age: _____

	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 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:

- **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)
- You are encouraged to **verify specific LABs/other procedures** covered and not covered.
  - What is covered: portion 100%, 80%, 20%, other; preventatives benefits & screening; EKG/XRay/MRI/CT radiology test; mental health office visit; consult/specialist evaluation.
- 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.
- Once your benefits have been determined, payments of any copays, coinsurance, deductible, and fees are required at time services are rendered.
- 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.
- **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.
- 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.
- SELF-PAY patient: Full payment for your visit is expected on the day of the visit.
- Any outstanding balance owe to our office is also due, unless payment arrangements have been made in advance with our office.
- 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.
- 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.
- 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.
- 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.
- RETURNED CHECKS will incur a $25 fee.
- Call 24hrs ahead to avoid the NO-SHOW $30 fee.

General MEDICATION Refill POLICIES: (Please read carefully. Thank you)

- **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.

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 purposed 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 you prescriptions, and to family members who are helping with your care.
- Payment: We will use and disclose you r 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 ro an appropriate subpoena or court order.
- Law Enforcement Purposes: Subject to certain restrictions, we any disclose information required by law enforcement official.
- 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 requ ired 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. The 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 you 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.

St. Michael Medical Clinic

Tom-Thuan K. Nguyen, MD ✦ Mike-Huy K. Nguyen, MD ✦ Lisa Chan, MD ✦ Martin Nobleza, FNP
12609 Louetta Road ◆ Cypress, Texas 77429 ◆ Phone: 281-655-5100 ◆ eFax: 888-990-2119 ◆ Fax: 281-655-1415

Authorization for Release of Protected Confidential Health Information

Patient (Last, First) _____ DOB(mdy): _____

I authorize **St. Michael Medical Clinic, P.A.** ☐ to release to ☐ receive from

Doctor Name / Organization: _____

Address: _____

Phone: _____ Fax: _____

information and records regarding my treatment, medical and/or behavioral health conditions.

Information to be released or exchanged includes (check all that applies): ☐ Entire Chart (not including billing)

☐ History & Physical ☐ Discharge/Consultation Summary ☐ Behavioral Health

☐ Laboratory Reports ☐ Medication Records ☐ HIV or Communicable Diseases

☐ Diagnostic Testing ☐ Immunization Records ☐ Other _____

_____

I understand that I may revoke this authorization in writing at any time, except to the extent that caption has been taken in alliance on it and that in any event that authorization shall expire (365) days from the date of my signature, unless specified in writing. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider; the release information may no longer be protected by federal or state privacy regulations.

Patient/Guarantor Signature: _____ Date: _____

In about 1-2 weeks, we ask patient to call us @ 281-655-5100 to check if we received the MR.

Please include this Authorization form when sending MR information back to St Michael Medical Clinic efax 888-990-2119.

If more than 10pages, please do not fax, send on CD

or PLEASE email MR **to STMICHAELCLINIC@myupdox.com**

TO THE RECEIVING PARTY: This information has been disclosed to you from records whose confidentially may be protected by Federal Law. If so, federal regulations prohibit you from making any, without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general further disclosure of it authorization for the release of information is not sufficient for this purpose. This message is intended only for the use of the individual to whom, or entity to which is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you have received this communication in error, please notify us immediately by phone. 201604

Instruction for Staff:

1. SMMC Staff fax-out and enter message into AzC using template "Release MR". Save to Pt Chart.
2. Filed Auth Release MR form with prgnotes folder dated: _____ BY: _____