

Texas Healthcare, P.L.L.C.  
P.O. Box 961205  
Fort Worth, Texas 76161-1205

Alan Johns, M.D.

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

Preferred Office for Visits: Richland Medical Center

Baylor

## **Patient Registration Information**

Social Security #: \_\_\_\_\_ Driver's License#: \_\_\_\_\_ State: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last) (First) (MI)

Birthdate: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
(Street or P.O.Box)

Home Phone: \_\_\_\_\_ Other phone (cell, etc): \_\_\_\_\_

Employment Status: **Full-time** **Part-time** **Retired** **Unemployed** **Student**

Occupation: \_\_\_\_\_

Employers name: \_\_\_\_\_

Employers address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ (Ext) \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Spouse/Significant Other Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## **Person Responsible for payment (if other than the patient)**

Relationship of patient to the responsible party: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last) (First) (MI)

Birthdate: \_\_\_\_\_ Marital Status:(circle one):

Address: \_\_\_\_\_ City: \_\_\_\_\_  
(street or P.O.Box)

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employment Status:

Occupation: \_\_\_\_\_

Employers name: \_\_\_\_\_

Employers address: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_(ext)\_\_\_\_\_ Other phone (cell, etc): \_\_\_\_\_

### **Primary Insurance**

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Group name or number: \_\_\_\_\_ Insured ID #: \_\_\_\_\_

Policy holder (circle one) : Patient      Other

Name of policy holder (if other than patient): \_\_\_\_\_

Relationship of the patient to the policy holder: \_\_\_\_\_

SS# (policy holder): \_\_\_\_\_ Birthdate (policy holder) \_\_\_\_\_

Name and address of employer of policy holder: \_\_\_\_\_

**(Please have a copy of your insurance card for the receptionist at your visit)**

### **Secondary Insurance**

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Group name or number: \_\_\_\_\_ Insured ID #: \_\_\_\_\_

Policy holder (circle one) : Patient      Other

Name of policy holder (if other than patient): \_\_\_\_\_

Relationship of the patient to the policy holder: \_\_\_\_\_

SS# (policy holder): \_\_\_\_\_ Birthdate (policy holder) \_\_\_\_\_

Name and address of employer of policy holder: \_\_\_\_\_

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**(Please have a copy of this insurance card for the receptionist at your visit)**

### **Referral Information**

Who referred you to Dr. Johns? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Please Read**

#### **Notice of Privacy Practices**

Texas Health Care, P.L.L.C. (TCH) and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in every TCH office. A copy is available from every office and is [available for download](#) at DAJMD.com. We would like your acknowledgement that you have been advised of this notice and it has been made available to you.

#### **Assignment of Benefits**

I hereby assign, transfer, and set over to THC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric, and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company.

#### **Appointment of Authorized Representative**

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

**All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.**

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(signature)

Alan Johns, M.D.

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

## General History

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

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse/Significant other in good health? \_\_\_\_\_

Religion: \_\_\_\_\_ Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

What level of education have you reached? \_\_\_\_\_

How many children do you have? \_\_\_\_\_ Ages: \_\_\_\_\_

What do you do for recreation? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ Type: \_\_\_\_\_

How often? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How often? \_\_\_\_\_

What prescription medicines do you take? \_\_\_\_\_

\_\_\_\_\_

What "over the counter" medicines do you take?

\_\_\_\_\_

What medicines are you allergic to? \_\_\_\_\_

Other allergies: \_\_\_\_\_

Current and past medical illnesses:

\_\_\_\_\_

## Hospitalization (non-obstetrical)

Hospital                      Year                      Reason

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## Hospitalization (obstetrical)

Hospital                      Year                      Sex of Infant                      Vaginal or Cesarean

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## Family History

**Mother:** Living      Deceased      Age: \_\_\_\_ Health/cause of death: \_\_\_\_\_

**Father :** Living      Deceased      Age: \_\_\_\_ Health/cause of death: \_\_\_\_\_

**Number of Brothers:** Living      Deceased      Ages: \_\_\_\_\_

Health status/cause of death: \_\_\_\_\_

**Number of Sisters:** Living      Deceased      Ages: \_\_\_\_\_

Health status/cause of death: \_\_\_\_\_

**Is there any of the following in your immediate family (mother, father, siblings, aunts, uncles)? If so who:**

Cancer: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Obesity: \_\_\_\_\_

Stroke: \_\_\_\_\_ Heart Disease: \_\_\_\_\_

High blood pressure: \_\_\_\_\_

Lung disease: \_\_\_\_\_ Alcoholism: \_\_\_\_\_

Osteoporosis: \_\_\_\_\_ Arthritis: \_\_\_\_\_

Kidney disease: \_\_\_\_\_ Anemia/Bleeding disorder: \_\_\_\_\_

Other:

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## **Other**

Any other significant history:

**TEXAS HEALTH CARE, P.L.L.C.**

**RELEASE OF PATIENT INFORMATION**

I CONSENT AND AUTHORIZE THE RELEASE OF ANY NORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

- MYSELF
- VOICE MAIL \_\_\_\_\_
- MY SPOUSE: \_\_\_\_\_
- MY CHILD(REN): \_\_\_\_\_
- MY PARENT(S): \_\_\_\_\_
- E-MAIL \_\_\_\_\_

I CONSENT AND AUTHORIZE THE RELEASE OF ANY ABNORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

- MYSELF
- VOICE MAIL \_\_\_\_\_
- MY SPOUSE: \_\_\_\_\_
- MY CHILD(REN): \_\_\_\_\_
- MY PARENT(S): \_\_\_\_\_
- E-MAIL \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES PATIENT THE RIGHT TO REQUEST ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME. THIS INFORMATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- HOME TELEPHONE \_\_\_\_\_
- O.K. TO LEAVE MESSAGE WITH DETAILED INFORMATION
- LEAVE NAME/DOCTOR WITH CALL BACK NUMBER ONLY
- WORK TELEPHONE \_\_\_\_\_
- LEAVE DETAILED MESSAGE ON WORK VOICE MAIL
- LEAVE MESSAGE WITH NAME/DOCTOR & CALL BACK NUMBER ONLY
- WHEN UNABLE TO CONTACT ME BY PHONE, A WRITTEN COMMUNICATION MAY BE SENT TO MY HOME ADDRESS
- OTHER \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
BIRTHDATE

\_\_\_\_\_  
SOCIAL SECURITY #

HEALTHCARE PROVIDERS MUST KEEP RECORDS OF PHI DISCLOSURES. INFORMATION PROVIDED WILL BE DOCUMENTED ON THE TEST RESULT, PROGRESS NOTE OR PATIENT COMMUNICATION IN QUESTION.

**TEXAS HEALTH CARE, P.L.L.C.**

**CONSENT FOR TREATMENT**

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to

Dr. \_\_\_\_\_, with Texas Health Care, P.L.L.C. unless revoked by me in writing.

Social Security # \_\_\_\_\_

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Patient/Legal Representative*

# Notice of Privacy Practices

**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.**

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the practice team liaison in this office.

## **Treatment, Payment, Health Care Operations**

### **Treatment**

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

### **Payment**

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

### **Health Care Operations**

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

## **Disclosures That Can Be Made Without Your Authorization**

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations 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, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

### **Public Health, Abuse or Neglect, and Health Oversight**

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may

disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

### **Legal Proceedings and Law Enforcement**

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

### **Workers' Compensation**

We may disclose your medical information as required by the Texas workers' compensation law.

### **Inmates**

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

### **Military, National Security and Intelligence Activities, Protection of the President**

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

### **Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors**

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

### **Required by Law**

We may release your medical information where the disclosure is required by law.

### **Your Rights Under Federal Privacy Regulations**

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

### **Requested Restrictions**

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the Practice Team Liaison in this office.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

### **Receiving Confidential Communications by Alternative Means**

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

### **Inspection and Copies of Protected Health Information**

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

#### **Amendment of Medical Information**

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

#### **Accounting of Certain Disclosures**

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

## **Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits**

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

## **Complaints**

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services  
HIPAA Complaint  
7500 Security Blvd., C5-24-04  
Baltimore, MD 21244

## **Our Promise to You**

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

## **Questions and Contact Person for Requests**

If you have any questions or want to make a request pursuant to the rights described above, please contact:

L. Timothy Knutson, Privacy Officer  
Texas Health Care  
2821 Lackland Road, Suite 300  
Fort Worth, TX 76116  
(817) 740-8400  
ltknutson@thsmso.com

This notice is effective on the following date: April 14, 2003.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

# Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

Use this button to **erase all entries** and start over.

Use this button to save a copy for your records and/or print and bring to your appointment.

Use this button to submit your information to Texas Health Care.