Hanson Internal Medicine, P.A.

Authorization to Release Medical Records

I_____ authorize **Hanson Internal Medicine, P.A.** to request Protected Health Information (PHI)

I request to have information released <u>from</u> the following entity

_____ _____
Name of Facility/Doctor Phone

_____ _____
Address City State Zip Fax

I request to have information released <u>to</u> the following entity

Hanson Internal Medicine, P.A.
Gregory W. Hanson M.D **(817)-433-5160 - Phone**
6100 Harris Parkway Suite 240
Fort Worth TX 76132 **(817)-433-5161- Fax**

From the health records of (Identifying information of individual being disclosed)

_____ Birth Date: _____/_____/_____
Patient's Full Name

_____
Address City State Zip

_____ _____
Signature of Patient or Legal Representative Date

Relationship to Patient: _____

My authorization extends to those data elements/document below:

___History and Physical Examination ___Progress Notes/Office Visits

___Lab/X-ray/Pathology results ___Hospital Stay Information ___Hepatitis Information

___AIDS/HIV information. I consent to the release of AIDS/HIV status with my records Initials_____

___Other or All Records(Must be specific)_____

Purpose of Disclosure: Medical Care_____ Employer_____ Attorney_____ Insurance_____

This authorization is given freely with understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, excludes as otherwise provided by law.
2. A photocopy or fax authorization is a valid as the original.
3. Hanson Internal Medicine, P.A. its employees,office and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
4. Treatment,payment,enrollment, or eligibility for benefits may not be conditioned upon obtaining this authorization.
5. This authorization is valid until revoked in writing by above signature.
6. A copy of this signed authorization is available upon request.

New Patient Questionnaire

Please complete this and bring it with you to your visit. If you have it completed five days or more prior to your visit, please mail or fax it to our office.

Most recent treating primary care doctor and date of last visit

_____ _____

Ongoing specialty care

_____

_____

HISTORY OF PRESENT HEALTH OR ILLNESS:

What goals do you have for your doctor's visit today?

_____

_____

_____

PAST MEDICAL HISTORY ITEMS

A. Please include any medications (herbal, prescription, or Over-the-counter) and any supplements that you are currently taking.

Medication	Strength of dose	Times taken per day	Date started medication

B. Please include any medications (herbal, prescription, or Over-the-counter) that you **may have tried in the past and then stopped.** Please comment on why you stopped the medication.

Medication	Stop date	Reason stopped

C. Please indicate any allergies you may have, whether they are to medications or to things in the environment.

Medication or Allergen	Reaction

D. Please list any medical problems you have, and other details as able.

Medical problem	Controlled or un-controlled	Present concerns or details

E. Please list any surgeries you may have had, along with the dates as best as you can remember.

Surgery	Complications, if any	Date of Surgery (mm/yy)	Location of care

F. Recommended vaccines vary with age group and exposures. Not all vaccines are indicated in all persons. Please list your most recent dose of the following vaccines, if known.

Vaccine	Date	Any reaction
Tetanus toxoid (Td)		
TdAP		
Pnemonia (Pneumovax)		
Flu		
Pertussis		
Hepatitis A		
Hepatitis B		
Yellow Fever		
Chicken pox (varicella)		
Shingles vaccine		
MMR		

G. Do you know if you have had any of the following tests? **Only some of tests are indicated, and tend to vary with age groups.** Please identify which tests you may have had in the past.

Test performed	Date	Location & outcome
EKG		
Chest Xray		
Breathing test		
Exercise stress test		
Blood sugar test		
Liver function test		
Complete blood count		
Thyroid function check		
Colonoscopy		
Flexible sigmoidoscopy		
Stool check for occult blood		
Prostate Specific Antigen (PSA) (Men)		
Prostate exam (Men)		
Testicle exam (Men)		

Test performed	Date	Location & outcome
Clinical breast exam (Women)		
Mammogram (Women)		
Pelvic exam (Women)		
Pap smear (Women)		
Bone density scan (DEXA)		

SOCIAL HISTORY

1. Do you exercise? _____ If so, what exercises and how many times per week?

_____

2. Do you feel you are at your appropriate weight? _____

If not, are you now doing anything to lessen your weight? _____

Have you had success losing any weight in the past? _____

If so, what strategy did you use? _____

_____

Do you eat five servings of fresh fruits or vegetables a day? Yes No

3. Do you use tobacco now? _____ How much per day? _____

If you used tobacco in the past, describe your usage.

4. Do you drink alcohol now? _____ What type of liquor and how many per day? _____

5. Are you presently taking care of any young children, either as a parent, grandparent, or as a job? _____ If so, please describe _____

_____

Are you presently taking care of older persons with immunity problems? _____

If so, please describe _____

_____

6. Do you have any pets in the house? _____

7. Have you traveled outside the country in the last year? _____

8. Are you a blood donor? Yes No Double Red Donor? Yes No

If not, would you consider becoming a donor? Yes No

Family History	Brothers	Sisters	Mother	Father	Kids
Diabetes	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Went on kidney dialysis	☐	☐	☐	☐	☐
Heart disease before 55 in men	☐	✘	✘	☐	☐
Heart disease before 65 in women	✘	☐	☐	✘	☐
Breast cancer	☐	☐	☐	☐	☐
Ovarian cancer	✘	☐	☐	✘	☐
Colon cancer or colon polyps	☐	☐	☐	☐	☐

Melanoma (deadly skin cancer)	☐	☐	☐	☐	☐
Prostate cancer	☐	✘	✘	☐	☐
Genetic illnesses	☐	☐	☐	☐	☐
Bipolar	☐	☐	☐	☐	☐
Hemochromatosis	☐	☐	☐	☐	☐
Thyroid illness	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

REVIEW OF SYSTEMS

Please circle any symptoms you are experiencing.

CONSTITUTIONAL

Weight loss	no	yes
Weight gain	no	yes
Fever	no	yes
Chills	no	yes

EYES:

Itching	no	yes
Eye dryness	no	yes
Changing vision	no	yes

EARS, NOSE, MOUTH, THROAT:

Hearing loss	no	yes
Ringing of ears	no	yes
Nose bleeds	no	yes
Frequent congestion	no	yes
Frequent sore throats	no	yes
Hoarseness	no	yes

CARDIOVASCULAR:

Chest pain	no	yes
Lower extremity swell	no	yes
Awake short of breath	no	yes

PULMONARY:

Chronic cough	no	yes
Cough up blood	no	yes
Short of breath	no	yes
Wheezing	no	yes
Abnormal chest x-ray	no	yes
Positive PPD	no	yes

GASTROINTESTINAL:

Loss of appetite	no	yes
Difficulty swallowing	no	yes
Painful swallowing	no	yes
Nausea or vomiting	no	yes
Pain in abdomen	no	yes
Heartburn	no	yes
Colon polyps	no	yes
Blood per rectum	no	yes
Constipation	no	yes
Diarrhea	no	yes
Black (tarry) stools	no	yes

GENITOURINARY:

Blood or pus in urine	no	yes
Getting up nights to urinate (__times)	no	yes
Trouble starting urine	no	yes
Incontinence	no	yes
Incomplete voiding	no	yes
Penis discharge (men)	no	yes
Erectile dysfunction (men)	no	yes
Irregular menses (women)	no	yes
Vaginal discharge (women)	no	yes

MUSCULOSKELETAL:

Joint pain	no	yes
Red, hot joints	no	yes
Injury	no	yes

SKIN:

Changing moles	no	yes
Rash	no	yes
Hair changes	no	yes
Rash to lips, mucosa	no	yes
Dry skin	no	yes
Breast changes	no	yes

NEUROLOGIC:

Weakness	no	yes
Tingling	no	yes
Numbness	no	yes
Fatigue	no	yes
Insomnia	no	yes
Headache	no	yes
Tremor	no	yes
Forgetfulness	no	yes

PSYCHIATRIC:

Inability to enjoy	no	yes
Sadness	no	yes
Thoughts of self harm	no	yes
Thoughs of harm to others	no	yes

ENDOCRINE:

Excessive urine	no	yes
Excessive thirst	no	yes
Hair growth	no	yes
Heat or cold intolerance	no	yes
Growing hands/feet	no	yes

HEMATOLOGIC:

Low blood counts	no	yes
Armpit, neck or groin swelling	no	yes

ALLERGIC:

Hay fever	no	yes
Frequent infections	no	yes

HANSON INTERNAL MEDICINE, P.A.

PATIENT REGISTRATION

Patient Name:_____ Date of Birth:____/_____/_____ Sex: M/F
Last First MI

(Circle one) Married Single Divorced Widow

Social Security Number: _____-_____-_____

Address:_____
(Street) (City/State/Zip)

Home Phone: (____)_____-_____ Work/Mobile Phone(____)_____-_____

E-mail Address:_____

Would you be interested in having communications sent to you via your e-mail address? (examples:appointment reminders, administrative updates and health bulletins) Yes No

Employer Name:_____Employer Phone Number: (____)_____-_____

Employer Address:_____
(Street) (City/State/Zip)

Referred By:____ Friend/Relative _____ Emergency Room ____ Yellow Pages ____ Shopper_____Other_____

Referring Physician:_____Physician Phone_____

Person responsible for bill (Complete only if different from patient)

Subscriber's Name:_____ Social Security Number_____-_____-_____
(Name of person that holds the insurance)

Relationship to Patient:(please check):( )self ( ) spouse or ( ) parent Date of Birth: ____/___/_____

Address:_____Phone Number:(___)_____

Employer Name:_____ Employer Phone Number: (___)_____

Employer Address:_____
(Street) (City/State/Zip)

Who to call for an emergency:

Name:_____ Address:_____

Home Phone: (___)_____ Work Phone: (___)_____ Relationship:_____

FIRST INSURANCE INFORMATION

Plan Name:_____I.D. Number:_____

Address:_____Group Number:_____

Insurance Company Phone#_____Effective Date:_____

Policy Holder:_____ Sex: M/F

Policy Holder's Social Security Number:_____-_____-_____

Policy Holder's Date of Birth: _____/_____/_____

SECOND INSURANCE INFORMATION

Plan Name:_____I.D. Number:_____

Address:_____Group Number:_____

Insurance Company Phone#_____Effective Date:_____

Policy Holder:_____ Sex: M/F

Policy Holder's Social Security Number:_____-_____-_____

Policy Holder's Date of Birth: _____/_____/_____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? IF YES, PLEASE NOTIFY THE RECEPTIONIST Y_____ N_____

Prepared for:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any protected health information (PHI) necessary. PHI is usually released or shared as needed to help with treatment decisions, payment, or health care operations. Groups that may request PHI include:
A. Any third party payor covering the medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree of necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies; and
F. Other parties as otherwise required by law.

In each case, Hanson Internal Medicine, P.A. shall take reasonable steps to ensure that only the minimum necessary information is given.

I permit a copy of this authorization to be used in place of the original.

DATE: _____ SIGNATURE: _____

I hereby authorize Hanson internal Medicine, P.A. to apply for benefits on my behalf for covered services rendered. I request that payment for my insurance company be made to Hanson Internal Medicine, P.A.

I certify the information I have provided with regard to my insurance is correct. I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

DATE: _____ SIGNATURE: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

DATE: _____ SIGNATURE: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing this section I am indicating Hanson Internal Medicine, P.A. has provided a copy or offered me a copy of their notice of privacy practices (pages 9-10). I have been provided with the ability to ask questions or comment on the practice's notice

DATE: _____ SIGNATURE: _____

NOTICE OF PRIVACY PRACTICES (MEDICAL)

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.

Prepared For:

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used to disclose by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information. All identifying features are removed before use in this manner.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by your written request.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the practice.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected heath information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of September 25th 2006 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

Thank You,
Hanson Internal Medicine, P.A.

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Friends and Relatives that may be Informed of my Medical Care

Prepared for:

Physician: Gregory W. Hanson, M.D.

Please share medical information on a need-to-know basis with my family and friends as indicated below

_____

Name Relationship

_____

Address

_____ Inform / Do not inform

Phone

_____

Name Relationship

_____

Address

_____ Inform / Do not inform

Phone

_____

Name Relationship

_____

Address

_____ Inform / Do not inform

Phone

_____

Name Relationship

_____

Address

_____ Inform / Do not inform

Phone

Hanson Internal Medicine, P.A.
6100 Harris Parkway, Suite 240
Fort Worth, TX 76132
Office 817.433.5160
Fax 817.433.5161

HANSON INTERNAL MEDICINE, P.A.

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

We believe all patients should be actively engaged in their health. Besides prevention and day-to-day management of medical issues, all patients should have an understanding of the following concepts:

Living will (also known as A Directive to Physicians and Family or Surrgoates): a document, signed by a patient in the presence of witnesses, that clearly identifies a person's wishes in regards to LIFE PROLONGING PROCEDURES. A Directive to Physicians and Family or Surrogates is a form that allows you to instruct physicians to administer, withdraw or withhold life-sustaining treatment when it has been determined by your physician that you have an irreversible or terminal condition and you are not able to communicate. Life-sustaining treatment is a treatment or procedure that includes life-sustaining medications and artificial life supports, such as mechanical breathing machines, kidney dialysis and artificial nutrition and hydration, that is not expected to cure your condition or make you better, and is only prolonging the moment of death. Living wills tend to be very straightforward. Another example of a living will is the Five Wishes. We would like all members to consider completing the Five Wishes and sharing it with their families.

**Circle one: - I HAVE / HAVE NOT prepared a living will.

Medical Power of Attorney (formerly known as Durable Power of Attorney for Health Care): A Medical Power of Attorney is a form that allows you to appoint someone (your "agent") to make health care decisions for you if you are no longer able to make decisions for yourself. These decisions can include (1) agreeing to or refusing medical treatment; (2) deciding not to continue medical treatment; or (3) making decisions to stop or not start life-sustaining treatment.

**Circle one: - I HAVE / HAVE NOT designated a health care surrogate.

These topics are discussed more in the Federal PATIENT SELF DETERMINATION ACT. You are encouraged to read more about this on-line, or ask us questions if needed.

_____

Signature of Patient or Representative Date