Baytown Family Clinic

Haider Afzal M.D., P.A
1690 West Baker Road Ste B Baytown, TX 77521
Phone (281) 428-8203 Fax (281) 428-0624

Today's Date:	Primary Care Doctor:	Social Security Number:

PATIENT INFORMATION

Patient's Name: First Middle Last	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Home Phone Number: ( )	Cell Phone Number: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work Phone Number: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

Language Spoken:	Email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person Responsible for Bill:	Birth Date: / /	Address (if different):	Home Phone Number: ( )

Is this person a patient here? ❑ Yes ❑ No	Occupation:	Employer:

Employer Address:	Work Phone Number: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ Aetna	❑ Cigna	❑ United Health Care

❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Other

Subscriber's Name:	Subscriber's Social Security Number:	Birth Date: / /	Group Number:	Policy Number:	Co-payment: $

Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group Number:	Policy Number:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to Patient:	Home Phone #: ( )	Cell Phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Haider Afzal, MD, PA or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

This authorization expires _____. (if date not specified, authorization will expire in one year)

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HIPAA 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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other
purposes that are permitted by law. It also describes your rights to access and control your protected health information. . "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use as required by law.

Treatment: We will use and disclose your protected information to provide, coordinate, and manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital stay.

Healthcare Operations: We may use or disclose, as needed, your protected health information in orders to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: As Required by Law, Public Health issues as regarded by law, Communicable Diseases, Health Oversight, Abuse Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Active and National Security, Workers' Compensation, Inmates, Required uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of
The Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.50

Other Permitted Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization, at anytime, in writing, except to the extent that your physician of the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to Inspect and Copy Your Protected Health Information: This means you may ask us not disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You Have the Right to Request to Receive Confidential Communications from us by Alternative means or at an Alternative location. You Have the Right to Obtain a Paper Copy of This Notice From Us, Upon Request even if you have Agreed to Accept This Notice Alternatively. i.e. electronically.

You may have the right to have your Physician Amend Your Protected Health Information.
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You Have the Right to Receive an Accounting of Certain Disorders We Have Made, if any, of Your Protected Health Information. We reserve the right to make any changes to this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only an acknowledgement that you have received this Noticed of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

BAYTOWN FAMILY CLINIC
Haider Afzal M.D., P.A.

ASSIGNMENT OF BENEFITS
And
INSTRUCTION FOR DIRECT PAYMENT

Patient Name: _____ Soc. Sec. #: _____ D.O.B:_____

Card Holder Name: _____ Soc. Sec. #: _____ D.O.B:_____

Insurances ID #: _____ Group #: _____

Employer: _____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to be under my current insurance policy to:

Baytown Family Clinic
1690 W. Baker Rd Ste B
Baytown, Tx 77521

As payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor/clinic, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Baytown Family Clinic

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my claim to any insurance company, adjuster, attorney involved in this matter.

_____ _____
Patient or Insured Signature Date

_____ _____
Witness Date

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HEALTH HISTORY QUESTIONNAIRE

NAME:	☐ M ☐ F	DOB:

PERSONAL HEALTH HISTORY

Height:	Weight:
Are you currently on blood thinners? ☐ Yes ☐ No	
Do you have any metals in you body (i.e. surgical pins)? ☐ Yes ☐ No	
Do you have Diabetes: ☐ Yes ☐ No	

LIST YOUR PRESCRIBED MEDICATIONS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name of Medication	Strength	Frequency Taken

ALLERGIES (CHECK ALL THAT APPLY)

☐ Adhesive/Tape	☐ Anticoagulant Therapy	☐ Aspirin
☐ Codeine	☐ Demerol	☐ Iodine
☐ Local Anesthetics	☐ Novocaine	☐ Penicillin
☐ Other:	☐ Other:	☐ Other:
☐ Other:	☐ Other:	☐ Other:

Conditions

Check if you have, or have had, any of the following conditions.

☐ AIDS	☐ Anemia	☐ Bleeding Disorder(s)
☐ Breast Lump	☐ Cancer	☐ Diabetes
☐ Hepatitis	☐ Herpes	☐ HIV
☐ Kidney Disease	☐ Liver Disease	☐ Pregnant (Currently)
☐ Tuberculosis	☐ Other:	☐

Pharmacy Information

Preferred Pharmacy:	Pharmacy Phone Number:
Address or Brief Location Description (i.e. intersection):	