CHI St. Luke's Health

REGISTRATION FORM - (PLEASE PRINT)

Date:	**PCP's** last name:	First:	Middle:	PCP Ph:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ 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

Race:	Ethnicity:	Religion Preference:
Email:	Language:	Interpreter Needed: ☐ Yes ☐ No
Street address: Apt #	Social Security:	Home ph: ( ) Cell ph: ( ) Work ph: ( ) To which # do you wish to receive appointment reminders?

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

Employment Status: ☐ Full Time ☐ Part Time ☐Unemployed ☐ Student ☐ Other:	Employer:	Employer ph: ( )
Pharmacy's Name	Pharmacy's Ph: ( )	
How did you hear about us:		

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different from patient):	Home ph: ( ) Cell ph: ( )

Occupation:	Employer:	Employer address:	Employer ph: ( )

PRIMARY INSURANCE

Name of primary insurance:_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy#:_____

Co-payment: $ _____

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

SECONDARY INSURANCE

Name of secondary insurance :_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy #:_____

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

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home ph: ( ) Work ph: ( ) Cell ph: ( )

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 my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

_____ _____

Patient/Guardian signature *Date*

CHI St. Luke's Health

NEW PATIENT HISTORY AND PHYSICAL QUESTIONNAIRE

NAME: _____ DOB:_____ AGE: ____ DATE: _____

REASON FOR VISIT: _____

INSTRUCTIONS: Be as complete as possible & add comments to help us care for you

Section 1: VACCINATIONS

Section 1 - please check off all vaccines and year last received

	Date		Date		Date
Tetanus/Td		Tdap:		MMR:	
Flu		Tetanus?		Red Measles	
Pneumonia		Diphtheria		Mumps	
Hepatitis B		Whooping C.		Measles	
Hepatitis A					
Meningitis					
Chicken Pox					
TB					

Section 2: REVIEW OF SYSTEMS

Section 2 - please check off the symptoms you have had in the past 4 weeks

CONSTITUTIONAL

_____ fever
_____ chills
_____ weight gain
_____ weight loss
_____ fatigue weakness
_____ night sweats
_____ Other

NOSE

_____ congestion
_____ bleeding
_____ sinus pain
_____ do you snore?
_____ hay fever
_____ Other

MUSCULOSKELETAL

_____ joint pain
_____ joint swelling
_____ joint redness
_____ joint stiffness
_____ muscle stiffness
_____ muscle weakness
_____ muscle pain
_____ morning stiffness

EYES

_____ double vision
_____ blurred vision
_____ date/last eye exam
_____
_____ Other

THROAT/MOUTH

_____ pain
_____ hoarseness
_____ dental problems
_____ neck pain
_____ Other

GENITOURINARY

_____ bedwetting
_____ birth control type
_____
_____ Other

RESPIRATORY

_____ Pleurisy
_____ Shortness of breath
_____ in last week
_____ on exertion
_____ lying flat

EARS

_____ decreased hearing
_____ ear pain
_____ ringing
_____ Other

PULMONARY

_____ cough
_____ shortness of breath
_____ stop breathing during sleep?
_____ dose-off easily during the day?
_____ Other

INTEGUMENTARY

_____ rashes
_____ hives
_____ Other

HEMOTOLOGICAL

_____ fatigue
_____ easy bruising
_____ excessive bleeding
_____ Other

_____ date/bone density
_____ Other

_____ affects work life
_____ Other

CONTINUED ---- Section 2: REVIEW OF SYSTEMS

PSYCOLOGICAL/EMOTIONAL

_____ depression
_____ loss of interest in things you used to enjoy
_____ decreased motivation
_____ decreased energy
_____ memory loss
_____ phobias
_____ concentration problems
_____ agitation
_____ insomnia
_____ thoughts of dying
_____ irritable or anxious
_____ crying spells
_____ decreased / increased appetite
_____ hallucinations / hearing voices
_____ decreased libido/interest in sex
_____ worry a lot
_____ obsessive or compulsive
_____ Other

ENDOCRINE

_____ diabetic
_____ checking blood sugars
_____ numbers _____
_____ cold intolerant
_____ heat intolerant
_____ hot flashes
_____ thirsty all the time
_____ urinate a lot
_____ hungry all the time
_____ hair loss-progressive
_____ hair loss-recent
_____ Other

CARDIOVASCULAR

_____ chest pain
_____ palpitations
_____ ankle swelling
_____ night time urination
_____ swollen ankles
_____ irregular pulse
_____ varicose veins
_____ phlebitis
_____ bruise easily

NEUROLOGICAL

_____ numbness
_____ weakness
_____ pain
_____ headache
_____ dizziness
_____ loss of coordination
_____ loss of balance
_____ passing out
_____ tremor
_____ Other

UROGENITAL SYSTEM

_____ urine frequency
_____ urine burning urgency
_____ night time urination
_____ hesitancy
_____ dribbling incontinence
_____ weak stream
_____ discharge (vaginal or penile)
_____ sores/ulcers
_____ vaginal odor
_____ abnormal bleeding
_____ sexual problems
_____ menstrual problems
_____ Other

GASTROINTESTINAL

_____ indigestion
_____ heart burn
_____ abdominal pain
_____ nausea
_____ excessive belching
_____ bloating
_____ excessive gas
_____ diarrhea
_____ constipation
_____ hemorrhoid pain
_____ difficulty swallowing
_____ bloody, tarry stools
_____ test date _____
_____ Other

_____
_____ cold, numb feet
_____ Other

Section 3: PAST MEDICAL HISTORY

Section 3 - please check off past and present medical problems and surgeries

HEAD AND NECK PROBLEMS

_____ glaucoma
_____ cataracts; any surgery?
_____ other eye surgery
_____ ear surgery
_____ mastoiditis
_____ Meniere Disease
_____ inner-ear infection
_____ chronic sinusitis
_____ chronic nasal allergies
_____ nasal polyps
_____ nose or sinus surgery
_____ dental surgery
_____ tonsillectomy
_____ carotid artery surgery
_____ Other

GASTROINTESTINAL PROBLEMS

_____ esophagitis/reflux/GERD
_____ hiatal hernia
_____ stomach or duodenal ulcer
_____ gastritis or duodenitis
_____ colon polyps
_____ last colonoscopy? (month/year)
_____ diverticulosis
_____ colitis (Crohn's or Ulcerative)
_____ hemorrhoids (any surgery?)
_____ stomach or bowel surgery
_____ gall stones/surgery
_____ pancreatitis
_____ hepatitis
_____ jaundice
_____ spleen problem/surgery
_____ groin hernia/surgery
_____ ventral or umbilical hernia/surgery
_____ appendicitis/surgery
_____ Other

BREASTS PROBLEMS

_____ breast cancer/surgery
_____ fibrocystic breast disease
_____ breast biopsies
_____ mammogram (month/year)

CARDIAC PROBLEMS

_____ heart attack; when?
_____ angina (heart pain)
_____ cardiac stress test
_____ coronary angiography (heart cath)
_____ heart bypass surgery; when?
_____ other heart surgery
_____ heart murmur
_____ heart failure
_____ hypertension (high blood pressure)
_____ pericarditis
_____ high cholesterol
_____ pacemaker
_____ rheumatic fever
_____ Other

PULMONARY PROBLEMS

_____ asthma
_____ chronic bronchitis
_____ emphysema
_____ interstitial lung disease
_____ pneumonia
_____ valley fever
_____ tuberculosis
_____ Other

ENDOCRINE PROBLEMS

_____ hypothyroid
_____ hyperthyroid
_____ diabetes
_____ menopause
_____ thyroid surgery (when?)
_____ Other

PSYCHIATRIC PROBLEMS

_____ depression
_____ anxiety disorder
_____ panic disorder
_____ manic depressive or bipolar disorder
_____ schizophrenia
_____ obsessive/compulsive disorder
_____ suicide attempts
_____ Other

_____
_____ Other

CONTINUED ------- Section 3: PAST MEDICAL HISTORY

UROGENITAL PROBLEMS

_____ frequent bladder infections
_____ kidney infection/STONES
_____ other kidney problems
_____ incontinence
_____ bladder surgery
_____ kidney surgery
_____ prostate exam (month/year)
_____ PSA (month/year)
_____ prostate surgery
_____ kidney cancer/surgery
_____ bladder cancer/surgery
_____ prostate cancer/surgery
_____ ovarian cancer/surgery
_____ uterine/endometrial cancer
_____ hysterectomy: with or w/o ovary removal?
_____ cervical cancer/surgery
_____ genital warts
_____ herpes
_____ gonorrhea/chlamydia/syphilis
_____ HIV/AIDS
_____ PMS (premenstrual tension syndrome)
_____ endometriosis
_____ impotence
_____ menopause (age of onset)
_____ last pap smear (month/year)
_____ pregnancy
_____ miscarriages
_____ (list dates and how many weeks)

_____
_____ Other

MUSCULOSKELETAL PROBLEMS

_____ rheumatoid / osteo arthritis
_____ gout
_____ lupus
_____ scleroderma
_____ fibromyalgia
_____ joint surgery
_____ herniated disc
_____ osteoporosis
_____ other back problems
_____ Raynaud's disease
_____ foot problems

HEMATOLOGY/LYMPHATIC PROBLEMS

_____ anemia
_____ bleeding
_____ hypercoagulable disorder
_____ lymphoma
_____ Hodgkin's disease
_____ leukemia
_____ Other

CHILDHOOD DISEASES

_____ whooping Cough
_____ measles
_____ mumps
_____ rubella
_____ chicken Pox
_____ polio
_____ rheumatic Fever
_____ Other

DERMATOLOGICAL PROBLEMS

_____ eczema
_____ psoriasis
_____ seborrhea dermatitis
_____ warts
_____ melanoma
_____ basal cell skin cancer
_____ squamous cell skin cancer
_____ actinic keratosis (pre-cancer sun damage)
_____ athlete's foot
_____ Other

NEUROLOGICAL PROBLEMS

_____ stroke
_____ TIAs (pre-stokes)
_____ neuropathy
_____ carpal tunnel syndrome
_____ multiple sclerosis
_____ epilepsy/seizures
_____ Parkinson's disease
_____ vitamin B12 deficiency
_____ migraine headaches
_____ tension headaches
_____ cluster headaches
_____ sinus headaches

_____ Other

_____ dementia (e.g. Alzheimer's)

_____ Other

Section 4: SOCIAL HISTORY AND HABITS (check all that apply)

Section 4 - please document your social and family history

Smoke:

Yes/no Previously Smoked
packs/day? ____ # years? ____ Date quit?____

Yes/no Currently smoke:
packs/day? ____# years you have smoked? ____

Alcohol:

Yes/no Used to drink alcohol
days/week? ____ # per day? ____ Date quit? ____

Yes/no Currently drink alcohol
days/week? ____ # per day? ____

Recreational Drugs:

Yes/no Ever inject recreational drugs what years? _____

Yes/no Currently inject recreational drugs

Yes/no Any HIV or Hepatitis risk factors?
Please List

Yes/no Occupation history (list occupations and any chemical exposures):

Other

Yes/no Do you have a living will?

Yes/no Do you have a medical power of attorney?

Yes/no Do you have a durable power of attorney for your finances? Yes/no Who?

Circle all that apply: single, married, divorced, widowed

Religious preference: _____

Family Members	Alive or Death A / D	Current Age or age at death	Heart Disease	Cancer Type	Stroke	High BP or Cholesterol	Diabetes	Other
Father								
Mother								
Siblings:								
Children:								

Patient Name (print) _____ Date: _____

SECTION 5: MEDICATIONS, VITAMINS AND HERBALS

Section 5 - please list all of your medications, doses and when you take them.
Include all over-the-counter medications and herbals

Medication Allergies: _____

Food Allergies: _____

Other Allergies: _____

Pharmacy Name: _____ Phone: _____

	MEDIATION	DOSE (mg, grams, units, etc)	# PILLS AND WHEN YOU TAKE
	Example: Tylenol	*500 mg (ex strength*	*2 pills at 8am and 10pm*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

_____ _____

Patient Signature Date

Patient Name (print) _____ Date: _____

Patient Name (print) _____ Date: _____

CHI St. Luke's Health

Imagine better health.

PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of the Practice, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize the Practice and its personnel to deliver medical care to my (our) child listed below:

Name of Minor: _____ Date of birth: _____

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

1. Parent's name: _____

   Phone (office/home): _____

2. Parent's name: _____

   Phone (office/home): _____

3. Other (relationship): _____

   Phone (office/home): _____

Signature: _____

Date: _____

Print name and relationship: _____

NOTE: If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.

Signature: _____ Date: _____

Printed name: _____ Phone: _____

CHI St. Luke's Health

Authorization and Assignments

Thank you for choosing CHI St. Luke's Health Medical Group. We realize you have a choice in selecting healthcare and we are honored you have chosen us. Our staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with information regarding our office policies. Please feel free to contact or office anytime Monday – Friday during routine business hours if you have questions, concerns, or suggestions.

Office Policy

Our providers participate with many health plans and as a courtesy to our patients, we file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

Check In

Please be prepared to submit the following documents when checking in for each visit. These documents will be scanned and saved as part of your patient record.

- Current Insurance Card
- Current Photo Identification
- Update to contact information such as home address, phone numbers, contact information, email address, employer information, etc.

Verification of Benefits

We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit for a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services received.

Payment of Patient Responsibility

Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include known deductibles, copays, and coinsurance amounts applicable for each visit and or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits. For your convenience we accept cash, checks, most major credit cards and debit cards.

NSF Checks/Denied Credit Card Payments

You will be charged a $25.00 fee should a payment be returned for insufficient funds. This fee applies to payments made at our front desk, mailed in to the Business Office, electronically via the internet, or payments by phone.

Past Due Amounts

In the event your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.

Additional Services Identified During Treatment

Please be aware additional charges may be incurred if during the course of a physical exam a physician addresses, diagnoses, or treats problem-focused health concerns unknown at time of check in.

Non Covered Services

Please be aware certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic", or simply "non-covered" by your health plan. You are responsible for payment of these services. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. This clinic will provide medically necessary care based on patient's needs, not a patient's insurance coverage. This clinic is not responsible for knowing your plant's specific benefit and coverage limitations.

Third Parties Insurance

We do not file insurance claims to non-contracted third parties involving automobile accidents, accidental injury, property insurance, etc. You will need to pay in full at the Time of Service and file the claim with your insurance company. An itemized statement may be obtained by calling our business office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

Appointment Scheduling

Please be advised, as a courtesy, an automated service will call the primary phone number listed on file to remind you of your appointment date and time. You must notify the office within 24 hours of your scheduled appointment if you are unable to keep your appointment. Failure to notify the office within 24 hours may result in a $25.00 assessment to your account. Repeated failure to call and cancel your scheduled appointment without the proper 24 hour notice may result in your dismissal as a patient.

Forms/Medical Letters

We are happy to assist you by completing forms and generating medial letters for you upon your request. The fee for this service varies depending on the form or letter, but most do not exceed $25.00 per form. Payment is collected when you pick up the documents. Please allow 10 business days.

Medical Records

Requests for your medical records must be in writing via a special release form. Release of records is managed via an outside vendor. The cost is $25.00 for the 1st 20 pages and $.50 for each additional page. You will pay the outside vendor for these copies.

Office Hours

While appointment times vary for each provider, our office staff is available by telephone 8:00am to 5:00pm Monday through Friday. Because our providers and nurses are often tending to patients, it is typically necessary for you to leave a message. So we may assist you in a timely manner, please leave pertinent information to include the reason for your call and best number to call. We have an answering service to take your calls before and after our scheduled office hours.

- Emergency Needs – always call 911
- Prescription Refills – call during regular office hours and if leaving a message, provide your name, the medication, your pharmacy name, location, and phone number. Refills of controlled substances and/or narcotics MUST be filled by speaking with a medical staff member.

Authorization to Release Information

I hereby authorize CHI St. Luke's Health Medical Group to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of an examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked in writing.

Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), include Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to CHI St. Luke's Health Medical Group for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility

I acknowledge I have requested medical services from CHI St. Luke's Health Medical Group, on behalf of myself and/or my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I agree to pay CHI St. Luke's Health Medical Group for all services and products administered. I understand and acknowledge that any monies collected prior to the date services are rendered or products are administered will be applied as a deposit towards total charges assessed for the services rendered. The deposit shall not be considered payment in full. If I participate in a managed care plan, such as an HMO or PPO, I promise to pay for any services or products administered that are not covered under the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the clinic and for any out-of-network charges.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

My signature certifies I have read and understand the above content of this document.

Print Patient Name	Patient Date of Birth
Patient/Guardian Signature	Date

CHI St. Luke's Health

CHI St. Luke's Health Medical Group

HIPAA Acknowledgement of Review of Notice of Privacy Practices

Notification Form

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

Print Patient Name	Patient Date of Birth
Patient Signature	Date
Relationship (if not patient)	Witness

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

Please indicate by using a checkmark:

__ Individual refused to sign

__ Communications barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)_____

Name of Verifying Staff Member_____

ST. LUKE'S MEDICAL CLINIC

AUTHORIZATION FORM
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.
Patient Name: _____ DOB: _____
The health information you may release subject to this authorization is as follows:

☐ Complete Medical Records	☐ Laboratory Tests	☐ Prescriptions/Samples
☐ Consultation Reports	☐ Radiology Reports	☐ Speak To Over Phone
☐ Progress Notes	☐ Physicians' Orders	☐ ALL OF THE ABOVE

If **OTHER,** please specify:_____

Release my protected health information the following person(s)/entity:
Name:_____ Relationship to Patient: _____
Street:_____ City: _____ State:____ Zip:_____ Phone #:_____
This authorization shall be in force and effective indefinitely unless specified below with a term date or term event:_____

☐ **I DO NOT GIVE PERMISSION FOR YOU TO RELEASE MY INFORMATION TO ANYONE.**

I understand that I have the right to revoke this authorization in writing at any time by sending a written notification to the following clinic address:

St. Luke's Medical Clinic
6363 San Felipe, #150
Houston, TX 77057
Phone # 713-972-8900
Fax # 888-876-4946

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Print Name of Patient or Authorized Representative