Contemporary Medicine Associates PLLC - Patient Registration Form

Patient Information:

Last Name:	First Name:	Middle Name:	Suffix: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security #:	Birth Date:	Age:	Sex: ☐ M ☐ F

Street Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Work Phone:	Occupation:	Employer:

Insurance and Payment Information:

Is patient covered by insurance: ☐ Yes ☐ No

Insured Subscriber Information: ☐ Same as Patient Information

Relationship with Insured: ☐ Self ☐ Spouse ☐ Other: _____ ☐ Child

Information of Insured or Responsible Party:

Last Name:	First Name:	Middle Name:	Birth Date:	Social Security Number:

Street Address:	City:	State:	Zip:

Daytime Phone:	Occupation:	Employer Address:	Employer Phone:

Insurance Company:	Group Number:	Policy Number:	Co-Payment:

Referral Information:

Who were you referred by: ☐ Referred By Another Doctor ☐ Insurance Plan ☐ Hospital ☐ Family/Friend ☐ Yellow Pages ☐ Internet ☐ Employer or EAP ☐ Other - Explain: _____

Referring Doctor's Name: _____

Name of Practice: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Person to contact in event of an emergency:	Relationship to Patient:	Primary Phone:	Work 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 Contemporary Medicine Associates and my insurance company to release any information required to process my claims.

X _____ _____

Signature of Patient or Guardian Date Signed

Psychiatric History

Current Psychiatric Diagnoses:		**(If you need additional space you may use the back of this page)**
Diagnoses	Details and Additional Comments Regarding Diagnoses	Date Of Onset:

All Current Medications			**(If you need additional space you may use the back of this page)**
Medication	Dose	Frequency	Prescribing Doctor

Previous Psychiatrists or Medications:		**(If you need additional space you may use the back of this page)**
Physician Name or Medication	What was the outcome of the treatment?	Date

Previous Psychiatric Hospitalizations:			**(If you need additional space you may use the back of this page)**
Hospital or Facility	Date	Was Admission Voluntary?	What was the outcome of the treatment?

Family Psychiatric History:		**(If you need additional space you may use the back of this page)**
Family Member	Diagnoses	Details and Additional Comments

Medical History

Current Medical Diagnoses: (If you need additional space you may use the back of this page)

Medical Diagnoses	Details and Additional Comments Regarding Diagnoses	Date Of Onset:

Medical Hospitalizations: (If you need additional space you may use the back of this page)

Hospital Name	What was the reason for hospitalization?	Date

Medication Allergies: (If you need additional space you may use the back of this page)

Medication or Allergen	Reaction

Drug and Alcohol Use: (If you need additional space you may use the back of this page)

Substance	Amount	Frequency	Duration of Use
Tobacco Use	☐ Cigarette or "eCigarette" ☐ Dip /Chew or Snuff ☐ Cigar or Pipe	___ times a day	

In-Patient or Out-Patient Addiction Rehabilitations: (If you need additional space you may use the back of this page)

Hospital or Facility	Date	Was Admission Voluntary?	What was the outcome of the treatment?

Family Medical History: (If you need additional space you may use the back of this page)

Family Member	Nature of Medical Problems	Details and Additional Comments

Family Addiction or Chemical Dependency History: (If you need additional space you may use the back of this page)

Family Member	Nature of Dependency	Details and Additional Comments

Other Areas of Concern

Indicate witch of the following symptoms you have experienced: **(If you need additional space you may use the back of this page)**

- ☐ Fatigue / Lack of energy
- ☐ Weakness
- ☐ Lack of sleep
- ☐ Sleeping too much
- ☐ Increase / Decrease in appetite
- ☐ Increase / Decrease in weight
- ☐ Fainting / Feeling faint
- ☐ Tremors
- ☐ Trembling or Shakiness
- ☐ Seizures / Convulsions
- ☐ Skin rash
- ☐ Memory problems
- ☐ Sweating
- ☐ Dizziness / Light headedness
- ☐ Double vision
- ☐ Difficulty in focusing vision
- ☐ Dry Mouth
- ☐ Unusual taste sensations
- ☐ Eye discomfort in bright light
- ☐ Other:_____
- ☐ Other:_____

- ☐ Eye pain
- ☐ Sinus Pain or Congestion
- ☐ Increase / Decrease in tearing
- ☐ Increased sensitivity to sounds
- ☐ Ear infections
- ☐ Joint Pain or Stiffness
- ☐ Backache
- ☐ Muscle tension
- ☐ Muscle Pain / Soreness
- ☐ Swelling of Hands / Feet / Ankles
- ☐ Leg cramps
- ☐ Numbness / Tingling of Fingers or Limbs
- ☐ Foot Problems
- ☐ Trouble walking
- ☐ Balance problems
- ☐ Cold / Clammy Hands
- ☐ Chest Pain / Discomfort
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Other:_____
- ☐ Other:_____

- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Bruising easily
- ☐ Diarrhea / Constipation
- ☐ Indigestion / Heartburn
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Black or Tarry Stool
- ☐ Food Intolerance
- ☐ Inability to control bowels
- ☐ Inability to control urine
- ☐ Allergies / Hay Fever
- ☐ Cough / Coughing blood
- ☐ Frequent / Painful urination
- ☐ Penile / Vaginal discharge
- ☐ Penile / Vaginal sores
- ☐ Painful Breasts / Breast discharge
- ☐ Increase / Decrease in sex drive
- ☐ Difficulty in sexual function
- ☐ Other:_____
- ☐ Other:_____

Social History

Education: **(If you need additional space you may use the back of this page)**

High School	College	Trade Schools / Special Training
☐ Graduate / Diploma ☐ Received GED ☐ Did Not Graduate ☐ Special Education ☐ Other Accommodations:	☐ Attended Non-Graduate ☐ College Graduate ☐ Degree Achieved: ☐ Other Accommodations:	_____ _____

Employment / Income History: **(If you need additional space you may use the back of this page)**

Employment Status	Occupation	Time at Current Job	Monthly Income
☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled		Years Months	

Legal History: **(If you need additional space you may use the back of this page)**

Current / Active Offences			Past Offences		

Current Legal Situation:

Are you on probation?	Are you on parole?	Probation / Parole Officer
☐ Yes ☐ No	☐ Yes ☐ No	Name: Phone #:

History Of Incarceration: **(If you need additional space you may use the back of this page)**

City Jail		County Jail		State Prison		Federal Prison	
Date:	Duration:	Date:	Duration:	Date:	Duration:	Date:	Duration:
Date:	Duration:	Date:	Duration:	Date:	Duration:	Date:	Duration:
Date:	Duration:	Date:	Duration:	Date:	Duration:	Date:	Duration:

Home / Living Situation: **(If you need additional space you may use the back of this page)**

Housing Status	Who lives in your home with you?			Time at Current Residence
☐ Own ☐ Rent ☐ Living with Family ☐ Living with Friend ☐ Group Home / Shelter				Years Months

List any support systems or activities you have: **(If you need additional space you may use the back of this page)**

- ☐ Family
- ☐ Friends
- ☐ Children
- ☐ 12 Step Groups
- ☐ Therapist
- ☐ Gym / Sports Team
- ☐ Volunteering
- ☐ Clubs / Organizations
- ☐ Religious Groups
- ☐ Exercise

Other:_____	Other:_____	Other:_____
Other:_____	Other:_____	Other:_____

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

Purpose: Contemporary Medicine Associates (CMA) and its professional staff and employees follow the privacy practices described in this Notice. Contemporary Medicine Associates maintains your medical information in records that will be maintained in a confidential manner, as required by law. However, Contemporary Medicine Associates must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, we must share your medical information as necessary for treatment, payment and health care operations.

1. **What are Treatment, Payment and Health Care Operations?** Treatment includes sharing among health care providers involved in your care. For example, your physician may share information about your condition with the pharmacist to discuss appropriate medications, or with radiologists or other consultants in order to make a diagnosis. CMA may use your medical information as required by our insurer, managed care or other personal health plan to obtain payment for your treatment. **We also may use and disclose your medical information to improve the quality of care, e.g., for review and training purposes.**

2. **How will the Clinic Use My Medical Information?** Your medical information may be used, unless you ask for restrictions on a specific use or disclosure, for the following purpose:

- Family members or close friends involved in your care or payment for your treatment.
- To inform you of treatment alternatives or benefits or services related to your health. (You will always have an opportunity to refuse to receive this information)
- As required by law
- Public health activities, including disease prevention, injury or disability, reporting births and deaths; reporting child abuse or neglect; of suspected abuse, neglect or domestic violence (if you agree or as required by law).
- Health oversight activities, (e.g. audits, inspection, investigations, and licensure).
- Lawsuits and disputes.
- Law enforcement (e.g., in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances, about a death that may be the result of criminal conduct; about criminal conduct that occurred on CMA's premises; and in emergency circumstances relating to reporting information about a crime.)
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation.
- Certain research projects.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities.
- Protection of the President or other authorized persons or foreign heads of state, or to conduct special investigations
- Inmates. (Medical information about inmates of correctional institutions may be released to the institution.)
- Worker's Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
- To carry out health care treatment, payment, and operations functions through business associates, (e.g., to install a new computer system).
- Your authorization is required for other disclosures. Except as described above, we will not use or disclose your medical information unless you authorize (permit) CMA in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation. Alcohol and drug abuse information has special privacy protections.
- CMA will not disclose any information identifying an individual as being a patient or provide any medical information relating to the patient's substance abuse treatment unless: (i) the patient
- consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluations; or (v) it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

3. **You Have Rights Regarding Your Medical Information**. You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by CMA.

- **Right to request restriction**. You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular treatment), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- **Right to confidential communications**. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
- **Right to inspect and copy**. You have the right to inspect and copy your medical information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by CMA. CMA will comply with the outcome of the review.
- **Right to request amendment**. If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by CMA, which requires specific information. CMA is not required to accept the amendment.
- **Right to accounting of disclosures**. You may request a list of the disclosures of your medical information that have been made to persons or entities other than for health care treatment, payment or operations in the past six (6) years, but not prior to April 14, 2003. After the first request, there may be a charge.
- **Right to a copy of this Notice**. You may request a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

4. **Requirements Regarding This Notice**. CMA is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. CMA may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you register at CMA for health care services, you may receive a copy of the Notice in effect at the time.

5. **Complaints**. If you believe your privacy rights have been violated, you may file a complaint, in writing, with CMA or with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint to CMA or the Department of Health and Human Services.

Contact our Privacy Officer at Contemporary Medicine Associates, (713) 661-7888 if:

- You have a complaint;
- You have any questions about this Notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operation; or
- You wish to obtain a form to exercise your individual rights described in paragraph 5.

Notification of EHR, ERX, Digital Lab Transmission and Transmission of Patient Electronic Health Records

As part of our commitment to provide our patients with integrated, high quality health care services, the physicians and staff of Contemporary Medicine Associates utilize Practice Fusion & Patient Fusion, a web based electronic health record (EHR) system to comply with a recent Federal Mandate. The EHR system allows our physicians and staff to consolidate, store, retrieve and share medical information about a patient's medical history. The EHR is endorsed by the Department of Health and Human Services of the US government as a way to increase accuracy, improve efficiency, and reduce medical errors. Medical records are created when you receive treatment from a health professional, as you do from our office. Records may include your medical history, details about your lifestyle (such as smoking or involvement in high-risk sports), and family medical history. In addition, your medical records contain chart notes, consultation notes, laboratory test results, medications prescribed, and reports that indicate the results of operations and other medical procedures. Information will be entered directly or scanned into a web based medical record system in the computer. This chart is connected to a network of physicians, insurance companies, and public health agencies, and required federal and state organizations. The EHR has levels of security to protect against inappropriate access or disclosure, and all users adhere to strict HIPAA criteria. Should you have any questions, please address them with our office manager or your personal physicians.

I have read, understand, and acknowledge the Contemporary Medicine Associates Privacy Policy & the notifications regarding Electronic Health Records and agree to participate by signing this document and receiving services at Contemporary Medicine Associates PLLC

Printed Name:_____ **Signed:**_____ **Date:**____/____/____