Personal Information

Patient Name: ____ Today's Date: _________________

Date of Birth: ___________________ Age: ________ Social Security # ___________________________

Gender: Male / Female Marital Status: Single / Married / Divorced / Separated / Widow

Home Address: ______________________________________ City: _______________________________

State: __________________________________ Zip: _____________________

Occupation: __________________________________ Employer: ________________________________

Home Phone: ______________________________ Cell Phone: ___________________________________

Work Phone: ______________________________ Email: _______________________________________

Emergency Contact information

Name: _______________________________________ Relationship to you: _________________________

Home Phone: ______________________________ Cell Phone: __________________________________

Address (if different): ____

Insured/Subscriber information

Name: ____ Relationship to you: _______________________

Date of Birth: _______________________ Social Security # _____________________________________

Phone # ____________________________

Address: ____

Employer: ______________________________________ Work Phone: ___________________________

Insurance Company Name: ____

ID # ____ Group # __________________________________

FOR PATIENT OR GUARANTOR

ASSIGNMENT OF BENEFITS AND RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize Castaneda Quick Care clinic to release and disclose Protected Health Information (PHI) about me or my minor dependent, in accordance to the policy of the clinic and Texas Law, to facilitate reimbursement by a Health Benefit Plan or Third-Party Payor, including but not limited to my insurance carrier, Medicare, or any other payor or agency.

I also hereby authorize payment of insurance benefits under the terms of my policy directly to Castaneda Quick Care clinic for services rendered. I understand that I am financially responsible and will pay for charges not covered by my insurance plan. INITIALS ________________

FINANCIAL AGREEMENT AND STATEMENT OF RESPONSIBILITY

For and in consideration of services rendered or to be rendered by Castaneda Quick Care clinic, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance, and non-covered charges. Payment in full is due at the time services are rendered. I give this office the right to seek the services of a bill collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid for services that were rendered. INITIALS ________________

CONSENT TO MEDICAL TREATMENT BY FAMILY NURSE PRACTITIONER

I, or legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services which may include routine diagnostic procedures and such medical treatment from a Family Nurse Practitioner (FNP) or a Physician's Assistant (PA). I fully understand that the FNP or PA is NOT A PHYSICIAN but does work in collaboration with a Texas Licensed Physician. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatments or examinations at Castaneda Quick Care clinic.

INITIALS________________

RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize Castaneda Quick Care clinic to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to healthcare providers to facilitate reimbursement by some health benefit plan or personnel of another healthcare entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail, or electronic submission. INITIALS_________________

Do you have an Advanced Directive (Living Will)? YES / NO

If YES, please bring a copy to the clinic for our files. If NO and you would like information about an Advanced Directive, please speak with the healthcare provider.

****THE ABOVE AUTHORIZATIONS ARE VALID UNLESS YOU SPECIFY OTHERWISE OR REVOKE THEM IN WRITING****

DISCLAIMER

I agree to hold Castaneda Quick Care clinic, healthcare providers and staff, harmless for any and all non-medical related accidents occurring at 914 E. Fordyce Ste A, Kingsville, Texas 78363. Patients, parents, and/or guardians are responsible for all damages to the property. INITIALS_________________

Patient/Guarantor Signature: ____ Date: _______________________

Printed Name:____

Patient Name: __________________________________ D.O.B.: _______________ Date: _____________

MEDICAL HISTORY--Circle any of the following medical problems you have or may have had:

- Alcohol Abuse
- Anemia – Type _________________________
- Arthritis – Type_________________________
- Asthma
- Autoimmune Disorder – Type __________________
- Blood Clots
- Cancer – Type ________________________________
  *Currently receiving chemo or radiation? Y or N
- Chronic diarrhea or constipation
- Chronic Obstructive Pulmonary Disease (COPD)
  Type: Chronic Bronchitis / Emphysema
- Chronic Pain-type_____________________________
- Crohn's Disease
- Depression / Anxiety
- Diabetes—Pills / insulin / both
- Diverticulosis / Diverticulitis
- Drug Abuse
- Ear or hearing problems________________________
- Eating Disorder-type___________________________
- Eye or vision problems
- Fibromyalgia
- Other:____

* Gall Bladder Problems
* Heart Attack
* Heart Disease
* High Blood Pressure
* High Cholesterol
* HIV / AIDS
* Hypoglycemia (low blood sugar)
* Kidney disease / failure
* Liver problems- type _______________
* Menopause
* Psychiatric Disorder – type_________
* Seizures / Epilepsy
* Sexually Transmitted Diseases-type
  ____
* Skin problems-type_______________
* Stroke / TIA (mini-stroke)
* Thyroid problem: Hyper / Hypo / Cncr
* Tuberculosis
* Ulcer / Heartburn
* Ulcerative colitis
* Urine Infections

HOSPITALIZATIONS OR SURGERIES: Please list ALL surgeries that you have had with dates:

____
____
____
____

ALLERGIES/SENSITIVITIES WITH REACTIONS:

____
____
____
____

IMMUNIZATIONS: Circle all that apply:

Immunizations Up To Date   Immunizations Out of Date   Influenza   Pneumonia

Shingles   Hepatitis   Date of most recent Tetanus shot: ________________________

SOCIAL HISTORY: Circle all that apply:

Do your use tobacco products? Never / Quit ___________________

Smoke ________ cigarettes / cigars / pipes / packs per day for _____ years   Dip / Chew

Do you consume alcohol? Never / Rarely / Special occasions only / Daily / Weekly

MEDICATIONS/SUPPLEMENTS THAT YOU CURRENTLY TAKE: (Please write name, dose, and frequency)

____

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____

____

____

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____

____

FEMALE PATIENTS: Are you or could you be pregnant? YES / NO   Date of FIRST DAY of last period ____________

Pharmacy of choice______________________________________ Zip code located if not in Kingsville__________

Name or your family doctor____

Signature of Patient/Legal Guardian____

Printed name of Patient/Legal Guardian____

Date_______________________________ Relationship to patient_______________________________________

HIPAA Privacy Rule Receipt / Notice of Privacy Practices Acknowledgement Form

I, ____ (Patient's Name) understand that as part of my health care, this facility originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices which provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review the facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address that I have provided if requested.

Printed Name of Patient/Legal Guardian____

Signature of Patient/Legal Guardian____

Relationship to patient_____________________________________ Date signed_____________________________

For Office Use Only

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

_____ Individual refused to sign

_____ Communication barrier prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (please specify)____

Office Staff Sign____ Date__________________________