Date/Time_______________

HUNTSVILLE MEMORIAL HOSPITAL

PATIENT INFORMATION FORM

Patient Name: ____
(LAST) (FIRST) (MI)

Social Security Number: __________________ Date of Birth: ________________ Gender: ☐ Male ☐ Female

Permanent Address: ____
Street City State Zip Code

Mailing Address: ____
Street City State Zip Code

Primary Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Widowed

Day Phone: ( ) ____________________ **Cell Phone:** ( ) ____________________

E-mail address: ____

Race: ☐ Black/African American ☐ White/Caucasian ☐ American Indian ☐ Other: ______________

Ethnicity: ☐ Latino or Hispanic ☐ Non-Hispanic ☐ Unknown Ethnicity

GURANTOR INFORMATION

Name of Guarantor/Guardian (if different from patient): ______________________________

Address: ______________________________________ Gender: ☐ Male ☐ Female

Day Phone: ( ) ____________________ **Cell Phone:** ( ) ____________________

SSN: ________________ Date of Birth: ________________ Relation to Patient: ______________

INSURANCE INFORMATION

Insurance Coverage: ☐ Self Pay ☐ Medicaid ☐ Medicare ☐ Other ____________________

Name of policy holder (if different from guarantor): ______________________________

Address: ______________________________________ Gender: ☐ Male ☐ Female

Day Phone: ( ) ____________________ **Cell Phone:** ( ) ____________________

SSN: ________________ Date of Birth: ________________ Relation to Patient: ______________

EMERGENCY CONTACT INFORMATION

Emergency Contact Person: ________________________ Relation to patient: ________________

Phone Number: ( ) ____________________

AUTHORIZATION TO DISCLOSE INFORMATION
(HIPAA)

I, ______________________(patient name if over the age of 18, or parent/guardian name if minor) acting on behalf of __________________________ (leave blank if you are over the age of 18 or patient's name if they are a minor and you are the parent or guardian) give my authorization to release my protected health information including results of my laboratory tests, x-ray, and/or other test results to the following designated representative(s):

Initials (Patient or Legal Guardian)

________ My Spouse (Name) ____

________ My child (Name) ____

________ Other (Name) ____

________ Personal Representative ____

________ May be left on my home answering machine. ______________________________

________ May be left on my work answering machine. ______________________________

________ May be left on my cell phone. ______________________________________

________ **MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.**

____ ________________

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE/TIME

____ ________________

SIGNATURE OF WITNESS DATE

*HEALTH CARE INFORMATION MEANS ANY INFORMATION RECORDED IN ANY FORM OR MEDIUM THAT IDENTIFIES THE PATIENT AND RELATES TO THE PATIENT'S HISTORY, DIAGNOSIS, TREATMENT OR PROGNOSIS. IT IS KNOWN COMMONLY AS YOUR MEDICAL RECORD. NOTE: THE TEXAS LAW AUTHRORIZES THE RELEASE OF MEDICAL INFORMANTION WITHOUT THE AUTHORIZATION OF THE PATIENT IN A NUMBER OF SITUATIONS INCLUDING BUT NOT LIMITED TO INSURANCE COMPANIES IF THE DISCLOSURE IS TO REIMBURSE THE HOSPITAL OR OTHER HEALTH CARE PROVIDERS OR THE PATIENT FOR MEDICAL SERVICES OR SUPPLIES.

CONSENT FOR MEDICAL TREATMENT

1. CONSENT FOR TREATMENT: I, ______________________________, hereby authorize and consent to medications being administrated, diagnostic studies and/or procedures considered necessary of advisable in the judgment of the physician, physician assistant (PA) or nurse practitioner (NP) on duty. I understand that the treatment provided during the published hours of operation and that no responsibility will be taken for long-term patient care.
2. CONSENT TO THE PHYSICIAN ASSISTANT/NURSE PRACTITIONER MEDICAL CARE: HMH Medical Clinic is staffed by physician assistants and nurse practitioner who are supervised and monitored in all medical care delivered by a physician. Where indicated, a physician is available for direct or indirect consultation. The PA or NP is not a doctor but a physician assistant and nurse practitioner and is a certified health care professional who has received training in the provision of medical services. A PA or NP has three or more years of college level training in a health care center of medical school setting. Physician assistants and nurse practitioners are certified by the Texas State Board of Medical Examiners.
3. PAYMENT GUARANTEE: I hereby guarantee that I, the undersigned, will be responsible to the HMH clinic for all charges incurred for services rendered in my medical or surgical care. The total account is due in full at discharge with allowance for charges covered or approved under Medicare Medicaid or the indigent health care plans that are verifiable and assigned to the clinic prior to dismissal.
4. PATIENT'S AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the SSA and/or its intermediaries or carriers for information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf.
5. DISCLOSURE OF REQUIRED HIV/AIDS TESTING: Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to HIV, the virus associated to AIDS, in the following situation: if a donation of blood, blood products, organs or tissues is contemplated,(2) if a health care worker is accidently exposed to a patient's blood or bodily fluids, such as through a needle stick; or (3) if a medical or surgical procedure is to be preformed which could expose health care workers to the patient's blood or fluids. This disclosure is to inform you that you will be tested if any of these situations occur.

The undersigned certifies that he/she has read and expressed understanding of this document by the signature below, does hereby agree to be attended, treated, and followed by a physician assistant.

PATIENT NAME: ____

SIGNATURE: ____

PATIENT REPRESENTATIVE NAME: ______________________________

SIGNATURE: ____

RELATION: ___________________________ DATE/TIME OF SIGNATURE: ___________________________

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

This hospital is required by federal law to provide written information to you about your rights under state law to make decisions about medical care and the right to execute advance directives.

1. I have been given written materials about my right to accept or refuse medical treatments.
2. I have been informed of my rights to formulate advance directives such as a living will.
3. I will understand that I am not required to have an advanced directive to receive medical treatment from Huntsville Memorial Hospital.
4. I understand that the terms of my advance health directive may only be followed by Huntsville Memorial Hospital and my health care professional to the extent permitted by law.

Please check the following statements as appropriate:

______I have executed an advance directive

______I have not executed an advance directive

______I have made a durable power of attorney for my health care decisions and my health care agent is :________________________________.

______I have not made a durable power of attorney for health care decisions.

I have received the information handout about advance directives

Name:____________________________________ Date/Time:____________________

Signature:_________________________________ Relations:____________________

HUNTSVILLE
MEMORIAL HOSPITAL

Fair Patient Billing Act concerning Out-of-Network Providers

Huntsville Memorial Hospital, in compliance with the "Fair Patient Billing Act" concerning out-of-network providers, would like to notify the patients of the following:

1. You may receive separate bills for services provided by healthcare professionals affiliated with HMH.
2. Some healthcare professionals may not be participating providers in the same insurance plans and networks as HMH
3. You may have greater financial responsibility for services provided by healthcare professionals at HMH who are not under contract with your healthcare plan
4. You should direct questions about coverage or benefit levels to your healthcare plan and certificate of coverage.
5. Itemized bills are available upon request.
6. If you are uninsured, you may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients.

IF YOU WOULD LIKE TO ASK QUESTIONS, DISPUTE YOUR ACCOUNT, REQUEST AN ITEMIZED STATEMENT, NEED ASSISTANCE IN MAKING ARRANGEMENTS OR NEED TO SPEAK WITH A PATIENT FINANCIAL SERVICES REPRESENTATIVE, PLEASE CALL (936)291-4500.

With my signature, I understand that I am responsible for any charges that may be incurred, that are applied toward my deductibles or are considered out-of-pocket expenses, such as out-of-network bills or co-pays.

_______________________	_______________________
SIGNATURE	**DATE/TIME**

HMH Medical Clinic

Self-Pay Agreement Form

Patient Name: ____ DOB: ________________

Welcome to the HMH Medical Clinic, where our staff is committed to providing you with quality medical services.

The following is a statement of our self-pay financial policy, which we require you to read and sign prior to receiving services.

Please be aware as a new patient, your office visit will range from $104 to $200. Established patient charges range from $70 to $139.50 Charges are based on the complexity and duration of your visit.

In addition to the office visit charge, there may be additional charges for in-office testing, immunizations, etc.

______**At time of registration, you are required to pay the minimum as noted above. If any other charges incur during the visit, you are responsible to pay the remaining balance at check out.**

I have read and fully understand the Self-Pay Agreement form as outlined above. In the event it is necessary to turn my account over to collections, I have been made aware that I am completely responsible for any and all costs associated with the collections process.

By signing this form, I understand I am financially liable for all services provided to me, my dependents or any other person for which I have assumed responsibility.

______________________________ Print Patient Name/Responsible Party Name

______________________________ Patient/Responsible Party Signature

______________________________ HMH Employee Signature

______________________________ Date/Time of Agreement

Patient Name ______________________ Date/Time______________

MEDICAL HISTORY

Please circle the conditions that apply to your personal medical history.

Do you have a history of, or current diagnosis of any of the following?

HEAR TROUBLE MURMURS RHEUMATIC FEVER STROKE BLOOD TRANSFUSION

HIGH BLOOD PRESSURE LOW BLOOD PRESSURE DIABETES ASTHMA COPD

OTHER RESPIRATORY TROUBLES: ________________________________ GERD ACID REFLUX

INDIGESTION ANXIETY PANIC ATTACKS MAJOR DEPRESSIVE DISORDER

BIPOLAR DISORDER EPILEPSY SEIZURE DISORDER CONVULSIONS

ANEMIA CANCER- WHAT KIND? ________________ WHEN/WHERE DIAGNOSED?________________

Have you ever been diagnosed with, or treated, for Tuberculosis/TB? Yes / No
Were you born in a country, or traveled to a place, where the BCG vaccine is administered? Yes / No

Surgical History: Please list types of surgery, date, hospital where you had the surgery, & the doctor who performed the procedure.

Do you take prescription medications? Yes/ No Do you take Over the Counter meds/vitamins? Yes/No
If YES: Please list

Name of Med: Dosage: How many times a day?

Are you allergic to any medications? Yes/No If yes, please list medication and reaction

Patient Name ______________________ Date/Time______________

Do you diet? Y/N

What kind of diet?

LOW FAT LOW SALT VEGETARIAN HIGH / LOW PROTEIN

OTHER: ______________

Are you under the care of any other physician or specialists? Yes / No

If yes, please list the contact information for the other doctors you see.

Name:	Address:	Phone#:	Fax#:

Please list the most recent date you have had any of the following tests, procedures, or vaccines:

PAP SMEAR ______ MAMMOGRAM ______ COLONOSCOPY ________

DEXA BONE SCAN ________ PSA TEST ________ PNEUMONIA VACCINE __________

TDAP / TETANUS ________ FLU VACCINE __________

FAMILY HISTORY: Please tell us about your immediate family.

If deceased, please list age at time of death and the cause of death.

MOTHER: ALIVE / DECEASED ____

FATHER : ALIVE / DECEASED ____

BROTHER(S): ALIVE / DECEASED ____

SISTER(S): ALIVE / DECEASED ____

SEXUAL HISTORY:

Are you currently sexually active? Y/N

Do you use birth control? Y/N What kind? ______________________

Do you have any history of, or current concerns for STDs? ______________________________

Do you have a low sex drive? Y/N If YES: How long have you been affected by it ? ______________

Are you currently having any vaginal / penile discharge? Y/N

If YES: What color? ___________ Does it have a odor? _________________

Of Male Partners? ____________ # Of Female Partners? ______________________

Patient Name ______________________ Date/Time______________

SOCIAL HISTORY:

TOBACCO USE

______ **CURRENT SMOKER?**

CIGARETTE   CIGAR   PIPE   DIP/SMOKELESS   SNUFF

DAILY USE? Y/N   HOW MUCH /MANY? _______   FOR HOW MANY YEARS? _____

______ **FORMER SMOKER/TOBACCO USER?**

WHAT KIND? ______________________   HOW MUCH? ______________________

AGE/YEAR WHEN QUIT? ________________   HOW DID YOU QUIT? ________________

______ **NEVER SMOKED**

Are you exposed to Second-hand smoke? Y/N

CAFFEINE USE:

DO YOU DRINK CAFFEINATED DRINKS? Y/N

WHAT KIND? COFFEE   TEA   SODAS

HOW MANY GLASSES / CUPS PER DAY? _____________

ALCOHOL USE:

DO YOU CURRENTLY DRINK ALCOHOL? Y/N

WHAT KIND?

BEER   WINE   LIQUORS   WHISKEY   VODKA   RUM

HOW OFTEN?

DAILY   WEEKLY   MONTHLY   OCCASIONALLY   RARELY   SOCIALLY

FORMER ALCOHOL USE? Y/N   WHEN DID YOU QUIT? ________________________________

WHAT DID YOU DRINK? _________________________________HOW MUCH? ______________

ILLEGAL DRUG USE:

DO YOU CURRENTLY USE ANY TYPE OF DRUG? Y/N

MARIJUANA   COCAINE   METHAMPHETAMINES   PRESCRIPTION PILL ABUSE   HEROIN

ARE YOU A FORMER DRUG USER? Y/N   WHEN DID YOU QUIT? _____________

WHAT TYPE OF DRUG DID YOU USE? ____

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:______________________________ Date/Time:___________

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature:______________________________

Physician Signature:______________________________ Date :_______________

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