OFMST dba KIRKWOOD MEDICAL ASSOCIATES - PATIENT REGISTRATION FORM (eCW)

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2231 Center Street Ste. D Deer Park, TX 77536 | P: 281-249-2273 F: 281-249-2282

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*)

(Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:_-_____-_____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

OFMST dba
Kirkwood
Medical
Associates
Health History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____

Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you or have you used the following in the last three months? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Crack ☐ Methamphetamine

Are you allergic to any medications? Yes or No (If yes, please list.) ☐ ☐

Current Medications	Dosage

Previous Surgery	Date

Have you ever had any of the following? Circle all that apply: Asthma ☐ Stomach Problems ☐ Bladder problems ☐ Jaundice-Liver ☐ Gout ☐ Alcoholism ☐ Kidney Disease ☐ Prostate ☐ Skin Disease ☐ Joint Disease ☐ Stroke ☐ Epilepsy-Seizures ☐ Depression-Anxiety ☐ Thyroid ☐ Blood Clot ☐ High Blood Pressure ☐ Tuberculosis ☐ Diabetes ☐ Cancer ☐ Lung Disease ☐ Heart Disease ☐ Psychiatric Disorder ☐

Do any of these conditions run in your family? Circle all that apply: Alcoholism ☐ Addiction ☐ Joint Disease ☐ Stroke ☐ Blood Clots ☐ Diabetes ☐ Psychiatric Disorder ☐ Heart Disease ☐

Primary care physician information:

Name: _____ Phone number: _____

Address: _____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

How did you hear about us? Circle any that apply:

Website ☐ Family/Friend ☐ Internet Search ☐

☐ Former or current patient (please provide name so we can thank them!) _____

☐ Physician (pleasespecify): _____

☐ Other Healthcare facility (please specify): _____

☐ Insurance Network (please specify): _____

☐ Other (specify): _____

Patient name: _____

Date of birth: _____

OFMST dba Kirkwood Medical Associates
Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, OFMST KIRKWOOD MEDICAL ASSOCIATES may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge OFMST KIRKWOOD MEDICAL ASSOCIATES may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to OFMST KIRKWOOD MEDICAL ASSOCIATES any insurance or other third-party benefits available for health care services provided to me. I understand OFMST KIRKWOOD MEDICAL ASSOCIATES has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to OFMST KIRKWOOD MEDICAL ASSOCIATES I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to OFMST KIRKWOOD MEDICAL ASSOCIATES by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for OFMST KIRKWOOD MEDICAL ASSOCIATES or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that OFMST KIRKWOOD MEDICAL ASSOCIATES or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or OFMST KIRKWOOD MEDICAL ASSOCIATES or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify) _____

OFMST DBA KIRKWOOD MEDICAL ASSOCIATES
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

OFMST DBA KIRKWOOD MEDICAL ASSOCIATES
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date