Century Regional Health Care

(830) 980-9686 (830) 438-3423 Fax
32665 US Hwy 281 N Ste 208
Bulverde, TX 78163

Thank you for choosing our office! In order to serve you properly, we require the following information. **Please print.**

PATIENT INFORMATION

Full Legal Name _____ Sex _____ Age _____ Birth Date _____
Address _____ City _____ State _____ Zip _____
Telephone: Home ( )_____ Cell ( )_____
Email: _____ Social Security Number _____
Marital Status: _____
Employer _____ Occupation _____
Address _____ City _____ State_____ Zip_____

INSURANCE INFORMATION (Disregard if patient is same as policy holder)

Primary Insurance Company _____ Group# _____ ID # _____
Policy Holder _____ Policy Holder Social Security _____
Policy Holder's Date of Birth _____ Relationship to Patient _____

Secondary Insurance Company _____ Group# _____ ID # _____
Policy Holder _____ Policy Holder Social Security _____
Policy Holder's Date of Birth _____ Relationship to Patient _____

GUARANTOR OR RESPONSIBLE PARTY FOR PATIENTS'S FINANCIAL OBLIGATIONS, ***NOT YOUR INSURANCE COMPANY***

Full Legal Name _____ Date of Birth _____
Social Security Number _____ Relationship to Patient _____
Address _____ City _____ State_____ Zip _____
Home Phone Number ( ) _____ Alternate Number ( ) _____

IN CASE OF EMERGENCY

Contact Person _____Relationship to Patient _____
Address _____ City _____ State_____ Zip _____
Home Phone Number ( ) _____ Alternate Number ( ) _____

Federal Statistical Information: Primary Language _____ Race _____ Ethnicity_____

***Chief Complaint** _____

***Preferred Pharmacy and Location** _____

Health History

Please PRINT all information. All questions must be answered on **front and back.**

Patient Name_____ Date of Birth _____ Today's Date_____

IMMUNIZATIONS: Check any immunization(s) that you have had and the date

- ☐ Rubella _____
- ☐ Tetanus _____
- ☐ Hepatitis B _____
- ☐ Influenza _____
- ☐ Measles _____
- ☐ Pneumovax _____
- ☐ Last TB skin test _____
  - ☐ Negative ☐ Positive

SOCIAL HISTORY

Do you use tobacco products? current(every day)_____ current(some days)_____ previous_____ never_____

How many packs/cans per day? less than 1_____ 1-2_____ more than 2_____

How many years have you used tobacco products? less than 5_____ 5-10_____ 15-30_____ 40+_____

Does anyone in your home smoke? Yes____ No_____

Do you consume alcohol? current(every day)_____ current(some days)_____ previous_____ never_____

Average number of drinks per week(now or in the past)? 7 or less_____ 8-14_____ 15+_____

Do you use narcotics or other recreational drugs? currently_____ previously_____ never____

Do you exercise(times per week)? occasionally_____ never_____ 1-2_____ 3-4_____ 5+_____

Do you wear your seatbelt? Always _____ occasionally_____ never_____

MEDICATIONS: List all drugs or medications you use regularly (prescription and non-prescription).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any allergic reactions to any food or medications? YES_____ NO_____

If yes, list allergy and reaction _____

PAST MEDICAL HISTORY: Please indicate if YOU have a history of the following.

	PAST	CURRENT	PLEASE SPECIFY
Seasonal Allergies	_____	_____	_____
Diabetes	_____	_____	_____
Elevated Cholesterol	_____	_____	_____
Cancer	_____	_____	_____
Stroke or Heart Attack	_____	_____	_____
History of Infection	_____	_____	_____
Coronary Artery Disease	_____	_____	_____
Thyroid Disease	_____	_____	_____
Accidents	_____	_____	_____

Other Disease, Cancer or Significant Medical Illness (please specify) _____

WOMEN'S HEALTH

Please write the start date of your last menstrual period: _____

Are you pregnant or possibly pregnant? _____

Date of last pap smear: _____

Number of pregnancies: _____ live births____ premature births _____ miscarriages/stillbirths ____ abortions_____

Age at onset of menopause:_____

Are you currently using birth control? _____

If yes what method? Condom_____ IUD_____ pill/injection/patch/ring_____ surgical sterilization_____

Other_____

PREVENTATIVE HEALTH (BOTH MEN AND WOMEN): Please indicate when you last had each of the applicable tests:

YEARS	N/A	1-	2	3	4	5	6	7	8	9	10+	RESULTS: Normal	Abnormal	Unsure
Colonoscopy	__	__	__	__	__	__	__	__	__	__	__	_____	_____	_____
Bone Density /DEXA	__	__	__	__	__	__	__	__	__	__	__	_____	_____	_____
Prostate Cancer Screen	__	__	__	__	__	__	__	__	__	__	__	_____	_____	_____
Stool Hemoccult(blood)	__	__	__	__	__	__	__	__	__	__	__	_____	_____	_____
Eye Exam	__	__	__	__	__	__	__	__	__	__	__	_____	_____	_____

PAST SURGICAL HISTORY: List hospitalizations /surgeries and dates.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Has any <u>member of your family</u> had any of the following conditions?

	Yes	No	Relationship	(M)aternal or (P)aternal
Diabetes	_____	_____	_____	_____
Elevated Cholesterol	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Stroke or Heart Attack	_____	_____	_____	_____
Seizures	_____	_____	_____	_____
History of Infection	_____	_____	_____	_____
Coronary Artery Disease	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____

PATIENT INFORMATION

(____) initial

PAYMENT POLICY: Payment is required at the time of service unless prior arrangements were made in advance. Payment includes any and all applicable co-pays, co-insurance or deductibles. There is a $35.00 service for returned checks. Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider.

(____) initial

INSURANCE: Century Regional Health Care bills participating insurance companies as a courtesy to our patients. You are expected to submit payment for all applicable co-pays, co-insurance or deductibles at the time services are rendered, based on the requirements of your individual insurance plan. If payment is not received from your insurance company, the total balance due will be your responsibility. Due to various insurance provisions, we ask that you verify your individual benefits with your insurance provider. Century Regional Health Care acts only in an advisory capacity when sharing insurance benefits.

(____) initial

MISSED APPOINTMENTS: Century Regional Health Care is committed to providing quality services to as may patients as possible. Resources are assigned for each individual patient. Missed appointments represent a cost to Century Regional Health Care and are an inconvenience to other patients who could have been scheduled for that time.

We require a 24-hour notice to cancel your scheduled appointment. Failure to provide a 24-hour notice to cancel your schedule appointment will result in a no-show fee of $50.00. A no-show fee must be paid prior to being seen at your next visit. Please note that insurance companies do not pay for no-show fees and therefore will not be billed for that charge.

(____) initial

Physician Assistant: Century Regional Health Care employs physician assistants to support the physician with the volume of patients requiring medical care each day. The physician assistant is highly qualified and trained specifically by Dr. Michael Mann to treat the medically complex patients seen in this office. Dependent upon the daily schedule, patients may be seen by either the physician assistant, or by the physician.

The physician supervises the care of each and every patient but does require assistance to ensure patients are cared for in a timely manner.

Please sign and date this form prior to your first visit. Feel free to ask our reception staff or the office manager should you have any questions in regard to the information contained within this form. Thank you for being our valued patient.

_____ _____

Patient/Guarantor/Legal Guardian Signature Date

Printed Name of Patient _____

CENTURY REGIONAL HEALTH CARE

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative (Agent) of the Patient acknowledges that he or she personally received a copy of the CENTURY REGIONAL HEALTH CARE's Notice of privacy Policies on the date indicated below.

Signature: _____ Date: _____

Patient: _____

I give permission for the following persons to have access to my medical records/results:

_____

_____

_____

_____

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

_____

_____

_____

CENTURY REGIONAL HEALTH CLINIC
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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Organizations Covered by this Notice [Optional Language for Organized Health Care Arrangements]

This Notice contains the privacy practices for [types of organizations] listed below, with the [types of facilities] sites they maintain for delivery of healthcare products and services. Each of these organizations participates in an organized health care arrangement and may use and disclose your PHI among themselves as they shall deem appropriate for your treatment, payment or health care operations.

Our Privacy Practices

Use and Disclosure We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

Treatment. Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.

Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.

Health Care Operations. Your PHI may be used or disclosed as part of our internal healthcare operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditations, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you, in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI , as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X-rays, etc.

Facility Directories. [Optional Language for Inpatient Facilities] Our facility directory may list the following information about you: (1) your name, (2) your location in our facility, (3) your general condition without reference to specific medical information, *e.g.,* stable, serious, fair, etc., and (4) your religious affiliation, if any. Our facility directory information may be disclosed to clergymen and, except for religious affiliation, to other people. You may restrict or prohibit the release of the above information.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Continuing Care. Based upon your PHI, we may provide you with appointment reminders or information concerning health issues, benefits and services, or treatment alternatives that we believe may be of interest to you.