SOUTH SHORE FAMILY HEALTH CENTER
103 DAVIS RD, SUITE C
LEAGUE CITY, TX 77573
281-538-1003

PLEASE COMPLETE ENTIRE FORM. IT IS PERTINENT THAT WE HAVE ACCURATE INFO.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: ___/___/_____
FIRST MIDDLE LAST
ADDRESS: _____
CITY STATE ZIP
SOCIAL SECURTIY #:_____-___-_____ SEX: ___M___F HOME PHONE: _____

MARITAL STATUS: _____W _____M _____S _____DIVORCED CELL PHONE: _____

ETHNICITY: _____ LANGUAGE PREFERENCE _____

EMAIL ADDRESS: (KEPT CONFIDENTIAL) _____

EMPLOYER NAME: _____ EMPLOYER PHONE #:_____

SPOUSE NAME: _____ SPOUSE DATE OF BIRTH:___/___/_____

SPOUSE PHONE: _____ SPOUSE SOCIAL SECURITY #___-___-_____

IN CASE OF AN EMERGENCY WHO SHOULD WE CONTACT? NAME: _____

RELATIONSHIP: _____ PHONE NUMBER: _____
WHOM MAY WE THANK FOR REFERRING YOU: _____

INSURANCE INFORMATION/ ACCOUNT GUARANTOR
NAME OF PERSON FINANCIALLY RESPONSIBLE FOR PAYMENT _____
DATE OF BIRTH: __/___/_____ RELATIONSHIP: _____
MAILING ADDRESS: _____
SOCIAL SECURTIY NUMBER: ____-____-_____ PHONE #:_____
PRIMARY INSURANCE: _____SECONDARY INSURANCE_____

IF PATIENT IS UNDER AGE OF 18, PLEASE COMPLETE:
MOTHERS NAME: _____DATE OF BIRTH: _____PHONE:_____
FATHERS NAME: _____DATE OF BIRTH: _____PHONE:_____
CHILD LIVES WITH: (CIRCLE ONE) MOTHER FATHER BOTH OTHER

AUTHORIZATION AND RELEASE

I HEREBY AUTHORIZE PAYMENT FOR ALL SERVICES RENDERED TO BE PAYABLE TO SOUTH SHORE FAMILY HEALTH CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID BY INSURANCE OR NOT. PERMISSION IS HEREBY GRANTED TO SSFHC, TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

_____ _____
SIGNATURE DATE

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This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your expressed written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allow us to provide you the most complete medical care possible. This form will be reviewed with you at your first office visit.

GENERAL							
NAME:			BIRTHDATE:			SS#	
Date of your last complete physical exam?				Date of last chest x-ray?			
Date of your last cholesterol screening?				Date of last dental exam?			
Date of your last eye exam?				Date of last colonoscopy?			
WOMEN:				MEN:			
Date of last mammogram?				Date of last PSA?			
Date of last pap smear?				Date of last rectal/prostate exam?			
IMMUNIZATIONS				Pneumonia		DATE:	
MMR (Measles, Mumps & Rubella)		DATE:		Hepatitis B		DATE:	
TETANUS, DIPTHERIA & PERTUSSIS(Tdap)		DATE:		Influenza		DATE:	
PERSONAL PAST MEDICAL HISTORY: (CHECK THOSE THAT APPLY)							
	Scarlet Fever		Chicken pox		Measles		Epilepsy
	Blood or Plasma Transfusion		Rheumatic fever		Mumps		HIV
	Whooping Cough		Mononucleosis		Polio		Cancer
HOSPITAL/SURGICAL HISTORY:			**ALLERGIES:**	Please list any drug, food, contact or environmental substance to which you have had an allergic or bad reaction to:			
Illness or operation		DATE:					
1)			1)				
2)			2)				
3)			3)				
MEDICATIONS: Please list any prescription or over-the-counter medications, vitamins, herbs or supplements that you are now taking. Please list dosage and times you take them.							
1)			4)			7)	
2)			5)			8)	
3)			6)			9)	
SOCIAL HISTORY:			Occupation:			Marital Status:	
Do you exercise regularly? YES NO			What type?			How often?	
Do you smoke? YES NO NEVER			Quit Date:		How many packs?	How many years?	
Do you use other forms of tobacco? YES NO What?					Do you use illicit drugs? YES NO		
Do you you drink alcohol? YES NO			How much/how often?		How much/how often?		
Do you have any risk factors for HIV infection? YES NO					Have you been exposed to Tuberculosis? YES NO		
Have you had excessive exposure to the sun because of your work or recreation? YES NO							
Are you currently experiencing unusual stress? YES NO					Explain?		
Are there any environmental risks involved in your job or home environment? YES NO Explain:							
FAMILY HISTORY:	Relationship			Relationship			Relationship
	Anemia			Epilepsy			High Cholesterol	
	Asthma			Glaucoma			Kidney Disease	
	Obesity			Leukemia			Thyroid Disease	
	Cancer			Depression			High Blood Pressure	
	Diabetes			Heart Disease			Alcohol Problems	
	Stroke			Lung Disease			Bleeding Tendency	
PRESENT AGE OR AGE OF DEATH:		Mother:					Father:	
Sibling #1			Sibling #2				Sibling #3	
WOMEN ONLY:	Age of Menstrual Period onset			Regular? YES NO			First day of last period?	
Age at menopause:		Difficulty with periods? YES NO					Explain:	
Pregnancies: # of children:		Born Alive:		Cesarean:			Premature:	
		Stillborn:		Miscarriages:			Abortions:	
Describe Complications:								

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ASSIGNMENT AGREEMENT

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO SOUTH SHORE FAMILY HEALTH CENTER OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTOR FOR CHARGES THAT ARE NOT COVERED BY THIS AUTHORIZATION.

I understand that South Shore Family Health Center accepts insurance assignments as a courtesy to their patients. I understand that estimates of payments from the insurance carrier are based on current information available to the office and that actual payment may vary, resulting in a balance due from the responsible party.

I also understand that I am entirely responsible for payment of medical care if said care is not paid within sixty (60) days by the insurance carrier.

I authorize South Shore Family Health Center or any of their agents to inquire into and report my credit worthiness and history for purposes of location or collection efforts. I understand if I have an unpaid balance and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

Finally, I agree to be responsible for providing South Shore Family Health Center with adequate insurance information, including updates, policy changes and completion of any applicable forms.

Date: _____ Signed: _____ Witness: _____

NOTE: Signature represents agreement to all information listed above. In order to know the exact benefits your insurance company will pay, we recommend a written predetermination.

SOUTH SHORE FAMILY HEALTH CENTER GUIDELINES

In order to meet your expectations, we would like to communicate some of our guidelines:

- **24-HOUR CHANGE NOTICE IS REQUESTED ON ALL APPOINTMENTS. FOR ALL MISSED OR CANCELLED APPOINTMENTS WITHOUT A 24 HOUR NOTICE, A $35.00 CHARGE WILL BE INCURRED BY PATIENT**
- YOUR PATIENT RIGHTS ENTITLES YOU TO RECEIVE A COPY OF YOUR MEDICAL RECORDS. YOU MAY BE CHARGED OUR STANDARD MEDICAL RECORDS FEE FOR ANY REQUESTS.
- PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
- **THERE IS A $50 RETURNED CHECK FEE.**
- ACCOUNT BALANCES NOT PAID MONTHLY MAY BE CHARGED A $10 LATE FEE PER MONTH, UNTIL BALANCE IS PAID.
- THERE MAY BE A CHARGE FOR TELEPHONE CALLS AT PROVIDER'S DISCRETION BASED ON NATURE AND LENGTH. YOU WILL BE INFORMED AT THAT TIME OF ANY CHARGES.
- AFTER-HOUR VISITS (AFTER 5PM) AND WEEKEND VISITS WILL BE PROVIDED AT A SURCHARGE OF $25 IN ADDITION TO CO-PAY/CO-INSURANCE CHARGES.
- TELEPHONE CALLS WILL BE RETURNED AT THE END OF THE BUSINESS DAY OR THE FOLLOWING BUSINESS DAY UNLESS THERE IS AN EMERGENCY REQUIRING IMMEDIATE ATTENTION.
- **TWO-DAY NOTIFICATION ON ALL PRESCRIPTION REFILLS IS REQUESTED.**
- PERIODICALLY, YOU WILL BE REQUESTED TO SHOW YOUR INSURANCE CARD FOR VERIFICATION. PLEASE BRING TO ALL YOUR APPOINTMENTS.
- **IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY OUR OFFICE OF ANY INSURANCE OR POLICY CHANGES BEFORE SERVICES ARE RENDERED.**

I have read and understand the above policies.

Date_____Signed_____Witness_____

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Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by **South Shore Family Health Center** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent as it is posted in our lobby for your convenience. You may also request a copy of the Notice at the Front Desk for your personal records.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice
This office reserves the right to modify the privacy practices outlined in the Notice.

Signature
I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it. I also acknowledge that I have either, read or been given access to South Shore Family Health Center's Notice of Privacy Practices.

_____
Name of Patient (Print)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

_____
Office Representative Date

Please list names of whom you authorizing us to discuss your medical information with:

1._____ 2._____ 3._____

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Dear Patient:

In an effort to provide you with flexible payment options, we have listed our payment policy.

PAYMENTS ARE REQUIRED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash

___ Payment by check (for co-pays/co-insurance only – less than $50)

___Payment by credit card/debit card (self-pay, cosmetic and weight loss services including products will incur a 3% fee if use credit/debit card payment method)

Please initial all options, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use you Visa and MasterCard to automatically cover amounts not paid by insurance.

If none of the above apply, please see the Office Manage. Thank you.

_____
Print your name here and sign below

X_____

Date: _____

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1) PER DEA AS OF 10-9-2012:

WE CAN NO LONGER REFILL CONTROLLED SUBSTANCES WITHOUT AN OFFICE VISIT. IT'S THE PATIENT'S RESPONSIBILITY TO MAKE AN APPT. BEFORE YOU RUN OUT OF YOUR MEDS.

NO EXCEPTIONS!!!!!!!!!!!!!!!!!!!!

PLEASE GIVE US UP TO 72 HOURS TO REFILL A MEDICATION. PLEASE CONTACT YOUR PHARMACY FIRST TO REQUEST A REFILL. ___**INITIAL**

2) OFFICE POLICY AS OF 4/22/15:

ABNORMAL LABS WILL NOT BE RELEASED TO THE PATIENTS PRIOR TO MAKING AN APPOINTMENT AND REVIEWING THEM WITH THE PRACTITIONER. WE WILL CALL YOU AND LET YOU KNOW IF YOU NEED TO RETURN TO CLINIC TO DISCUSS YOUR LAB RESULTS. ___**INITIAL**

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

SIGNATURE: _____ THANKS,

DATE: _____ SSFHC