Notice of Privacy Practices: Patient Acknowledgment and Agreement

By signing below I hereby acknowledge that I have read, and fully understand Northside Family Medicine's Notice of Privacy Practices for Protected Health Information (HIPAA Agreement) and may ask for a copy if desired. Furthermore, we agree that at the discretion of Northside Family Medicine, Northside Family Medicine may release any information necessary to any member of my household or immediate family (sons, daughters, parents, spouses) unless I notify Northside Family Medicine otherwise.

________________________________ ______________________
Name of Patient (please print) Date of Birth

________________________________ ______________________
Patient Signature Date

PLEASE DO NOT RELEASE MY INFORMATION TO THE FOLLOWING PEOPLE____________________________
____

Assignment of Benefits

1) I understand that I am responsible for charges not covered or reimbursed by my insurance company(s). I agree that in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
2) I authorize my insurance carrier(s) to release information regarding my coverage to Northside Family Medicine. I also authorize agents of any hospital, treatment center, or previous physicians to furnish Northside Family Medicine copies of any records of my medical history, services, or treatments.
3) My right to payment for all procedures, supplies, and any other services including major medical benefits that are provided to me by Northside Family Medicine are hereby assigned to Northside Family Medicine. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services performed by Northside Family Medicine. In the event that my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Northside Family Medicine.
4) I understand I have a right to request and receive a Notice of Privacy Practices from Northside Family Medicine.
5) I hereby authorize Northside Family Medicine to inquire into my credit history if needed to obtain payment from me or confirm information that I have provided. It will only be done if I am not paying my bills as agreed upon above and will not be released to any outside agencies that are not directly involved in obtaining payment from me for services performed at Northside Family Medicine.

By signing below I have read the above statements and accept the terms and have been provided a copy of this statement if I have requested it.

________________________________ ______________________
Patient or Responsible Party Signature Date

Online Communications Informed Consent: Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand the Online Communications Informed Consent form. I understand the risks associated with online communications between my physician and me. In addition, I agree to the instructions and restrictions outlined herein and that they may change without warning. I have had a chance to ask any questions that I had and to receive answers. Please notify us if you want a copy of our Online Communications Informed Consent. AND WE WILL ASSUME YOU WANT TO JUST USE YOUR REGULAR EMAIL ACCOUNT TO RECEIVE AND SEND INFORMATION TO US (OPTION #1) UNLESS YOU NOTIFY US YOU ONLY WANT SECURE CORRESPONDENCE AND OPTION#2. FURTHERMORE, WHEN THE SECURE OPTION BECOMES EASIER TO USE WE MAY SEND ALL CORRESPONDENCE TO YOU VIA SECURE EMAIL.

______________________ __________ ______________________
Signature Date your email address

Patient Guidelines: Patient Acknowledgment and Agreement

By signing below, I hereby acknowledge that I have read, and fully understand Northside Family Medicine's Patient Guidelines and agree to abide by the standards set therein. In addition to the instructions outlined therein, I agree to any other instructions that my physician may impose. I have had a chance to ask any questions that I had and to receive answers and have been provided a copy of the guidelines if requested.

________________________________ ______________________
Patient or Guardian Signature Date

Patient Information

Today's date_____________________________

Last Name_________________________ First_______________________ Middle_____________________

Soc. Sec#______-______-_______ DOB____/_____/_____ Sex: M or F

Marital Status M S D W Sep How did you find our office?___________________________________

Address_____________________________________ Apt#_______ Home Phone______________________

City______________________________ State______ Zip ______________ Cell Phone__________________

Mailing Address (if different)____

Email address (Only include if you signed the Online communications informed consent)_______________________

Occupation_____________________________

Employer Name and Address___________________________________ Work Phone___________________

Responsible Party for Billing Purposes____

Parent or Legal Guardian Information

(to be filled out only if patient is a minor)

Last Name_________________________ First_______________________ Middle_____________________

Soc. Sec#______-______-_______ DOB____/_____/_____ Sex: M or F

Marital Status M S D W Sep Relationship to patient:___________________________________

Address_____________________________________ Apt#_______ Day Phone______________________

City______________________________ State______ Zip ____________Night/CellPhone__________________

Employer___________________________ Occupation_____________________________

Employer Address___________________________________ Work Phone___________________

Guarantor Information

If the insurance does not go through the patient, please give the information on who the insurance goes through: or check here if same as above ________.

Last Name__________________ First______________________ Middle_______________________

Soc. Sec#______-______-_______ DOB____/_____/_____ Employer______________________

Address________________________________ Apt#_______ Day Phone______________________

City______________________________ State______ Zip ____________Night/CellPhone__________________

Employer___________________________ Occupation_____________________________

Employer Address___________________________________ Work Phone___________________

If for any reason insurance does not cover all or part of the visit, the patient, guarantor, or legal guardian, if a minor, is responsible for the balance.

Emergency Contact Persons

Primary Contact

Name:___________________________________

Phone Number___________________________

Alt. Phone Number________________________

Relationship_____________________________

Secondary Contract

Name:_____________________________________

Phone Number_____________________________

Alt. Phone Number_________________________

Relationship______________________________

If someone other than patient or patient's guardian is to receive any type of statement for payment to our office please provide the information below (as much as you have available)

Last Name___________________ First_______________________ Middle________________________

Soc. Sec#______-______-_______ DOB____/_____/_____ Employer_______________________

Address__________________________________ Apt#_______ Day Phone_______________________

City______________________________ State______ Zip ____________Night/Cell Phone_________________

Employer____________________________ Occupation______________________________

Employer Address____________________________________ Work Phone___________________

Relationship to Patient___________________________________

Insurance Cards

Primary Card

Secondary Card

Date: _______________

Please Write Name Here _______________________________ Signature __________________________________

REVIEW OF SYSTEMS Please answer the following questions by circling Yes or No- IF YOU HAVE TIME FILL OUT THE SOCIAL HISTORY AND HEALTH MAINTENANCE AREAS-

Any fevers or weight loss?	YES	NO
Any eye problems?	YES	NO
Any ear,nose, throat or mouth problems?	YES	NO
Any chest pain or irregular heart issues or swelling?	YES	NO
Any shortness of breath, coughing or wheezing?	YES	NO
Any nausea,vomiting, abdomen pain, or stool issues?	YES	NO
Any problems with urination in any way?	YES	NO
Any problems with your vagina or penis?	YES	NO
Any aches or muscle pains anywhere?	YES	NO
Any skin lesions, rashes or other problems?	YES	NO
Any breast problems?	YES	NO
Any weakness, numbness, dizziness, or tremors?	YES	NO
Any suicidal thoughts, sadness, depression, or anxiety?	YES	NO
Any bleeding problems anywhere?	YES	NO
Any runny nose, frequent sneezes or itchy eyes?	YES	NO

Any other concerns or questions you would like to discuss today?____________________________________

Any Medications you need refilled today?____

SOCIAL HISTORY

Tobacco Use?	YES	NO
Seat belt use?	YES	NO
Any Illicit Drug use?	YES	NO

How often do you drink alcohol? ____________

HEALTH MAINTENANCE

Last Physical __________________

Last Cholesterol ________________

Last Prostate Check _____________

Last Mammogram_______________

Last Colonoscopy_______________

Last Bone Density ______________

Last test for blood in stool ________

Last Pap Smear_________________

Do you have a living will?________