MEDICAL CLINIC OF BELLAIRE, P.A.
DR. ESTHER GUY

Patient Information

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ SS#: _____

Marital Status*: (circle one)* Single Married Widowed Divorced Separated Sex *(circle one) M* F

Emergency Contact: _____ Relationship to Patient: _____

Phone: _____ How did you hear about us? _____

Preferred Pharmacy: _____ Address: _____

Pharmacy Phone: _____ Fax: _____

Patient /Spouse Employer Information

Patient Employer: _____ Spouse's Employer: _____

Phone: _____ Phone: _____

Patient Occupation: _____ Spouse's Occupation: _____

Insured Person/Policyholder (if not patient)

Policy Holder Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Insurance Co.: _____ Phone: _____

Policy ID: _____ Group #: _____

AUTHORIZATION FOR TREAMENT:
I authorize Dr. Esther Guy to perform medical procedures as she deems necessary for the treatment of my condition.
AUTHORIZATION FOR ASSIGNMENT:
I hereby authorize payment directly to Medical Clinic of Bellaire, PA. Any changes to this authorization must be received in writing.
I agree to release any/all my medical information, including test results and financial information to process this and any future claims to my insurer/payor of health benefits.

Patient/Responsible Party: X_____ Date: _____

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Annual Examination Patient Questionnaire

(Please fill out completely to the best of your knowledge.)

Past Medical History (list all medical conditions such as Hypertension, Diabetes, High Cholesterol, Etc.)

Past Surgical History (list all surgeries, year performed, complications, if any)

Medications (list all prescriptions, over the counter vitamins, minerals, and herbal supplements with their doses)

Drug Allergies and Sensitivities

Name of Physicians you see and their Specialty

_____

_____

_____

_____

_____

_____

Health Screening/Testing (please note most recent exam and findings)

Mammogram: _____

Pap Smear: _____

Flexible Sigmoidoscopy/Colonoscopy: _____

Prostate Screening/PSA: _____

Bone Density Testing: _____

Family History (please list their ages, any diagnoses/chronic conditions, causes and age of death, if applicable.)

Father: _____

Mother: _____

Children: _____

Brother: _____

Sister: _____

Social History

Job Description and Occupational Exposures: _____

Nicotine Use (type, amount, and length of use): _____

Alcohol (type and amount of consumption): _____

Marital Status: _____

Exercise Habits/Frequency: _____

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Review of Systems

(Please note if any apply to you and describe the symptoms.)

General
[ ]Weight Gain or Loss
[ ]Changes in Appetite
[ ]Weakness
[ ]Fatigue
[ ]Fevers
[ ]Night Sweats

Endocrine (Hormonal)
[ ]Frequent Urination
[ ]Excessive Thirst
[ ]Thyroid Disease
[ ]Heat or Cold Intolerance
[ ]Hot Flashes

Respiratory
[ ]Cough
[ ]Phlegm or Sputum
[ ]Wheezing or Asthma
[ ]Bloody Cough
[ ]Snoring

Skin/Breast
[ ]Rashes
[ ]Moles
[ ]Itching
[ ]Lump
[ ]Breast Masses
[ ]Breast Pain or Discharge

Eyes
[ ]Wear Glasses/Contacts
[ ]Vision Loss or Difficulties
[ ]Eye Pain
[ ]Double Vision

Musculoskeletal
[ ]Joint Pain
[ ]Cramps
[ ]Arthritis
[ ]Swelling
[ ]Neck Pain
[ ]Back Pain

Neurological
[ ]Headache
[ ]Fainting
[ ]Numbness
[ ]Tremors
[ ]Dizziness
[ ] Bleeding
[ ]Changes in Bowel Habits

Ears/Nose/Throat
[ ]Hearing Loss
[ ]Ringing in ears (tinnitus)
[ ]Vertigo or Dizziness
[ ]Sinus Problems or Allergy
[ ]Hoarseness or Change in Voice

Gastrointestinal
[ ]Heartburn
[ ]Abdominal Pain
[ ]Nausea
[ ]Vomiting
[ ]Diarrhea
[ ]Constipation

Hematologic (Blood)
[ ]Anemia
[ ]Easy Bruising
[ ]Easy Bleeding
[ ]Enlarged Lymph Nodes
[ ]Varicose or Swollen Veins

Mouth/Gums
[ ]Mouth Pain
[ ]Dental Problems
[ ]Dentures

Psychiatric
[ ]Anxiety or Panic
[ ]Depression
[ ]Sleep Disorders
[ ]Memory Loss

Cardiovascular
[ ]Chest Pain
[ ]Palpitations
[ ]Shortness of Breath
[ ]Difficulty Breathing while Sleeping
[ ]Heart Murmur
[ ]Hypertension
[ ]Leg Pain with Walking
[ ]Swelling in Legs
Date of last Menstrual Cycle: _____

Urinary/Genital
[ ]Urinary Frequency
[ ]Nighttime Urinary Frequency
[ ]Incontinence
[ ]Blood In Urine
[ ]Painful Urination
Men: [ ]Erectile Disfunction
[ ]Prostate Enlargement
Women: [ ]Abnormal Menstruation

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Release of Medical Records

Today's Date: _____

To:*(Physician's Name)* _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I _____ *(Date of Birth)* _____ hereby request that any/all of my medical records be released to my Primary Care Physician:

Dr. Esther Guy

5959 West Loop South Suite 510 Bellaire, TX 77401

Phone:(713)526-5606 Fax:(713)526-0058

Records to include the past 3-5 years only.

_____ Labs _____X-ray/Radiology/EKG _____Progress Notes _____Procedure Notes

Other:_____

_____

_____

Patient Signature: X_____ Date: _____

Print Name: _____

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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.

Medical Clinic of Bellaire is required to maintain the privacy of health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

Medical Clinic of Bellaire reserves the right to amend or change its practices, policies, or procedures regarding PHI at any time, and to make such changes effective for all PHI in our possession, including any PHI that may have been created or received prior to such changes. In the event of such a change MCB will post a new revision of the notice in our office and make a copy available to you upon request.

Medical Clinic of Bellaire is required to always make sure that our office operates in a manner that is consistent with the provisions of the most current revision of this notice. If at any time you believe MCB has acted in a manner inconsistent with our most current notice of privacy practices, or you feel your rights to privacy have been violated in any way, you are entitled to file a complaint with this office or with the secretary of Department of Health and Human Services. To file a complaint with this office or for further information with regard this notice. Medical Clinic of Bellaire's privacy practices, please contact the office personnel at 713-526-5606. MCB will not retaliate in any way against any individual who files a complaint with this office or with the Secretary of the Department of Health and Humans Services.

1- Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

2- Use or Disclosure of PHI for Treatment, Payment and Operations

MCB may use or disclose your PHI without your authorization for your treatment, to receive payment for any service rendered, and I for the normal operations of this office. For example:

Treatment – We may use or disclose your PHI in coordinating treatment among our staff or with other providers, such as specialists.

Payment- We may use or disclose your PHI to your insurance company as required to obtain payment for services that have been rendered.

Operations- We may disclose your PHI for quality assurance purposes, as part of employment performance evaluations, or to help train new employees.

Other uses of Disclosure of PHI Permitted Without your Authorization

Medical Clinic of Bellaire may also use or disclose your PHI without written authorization in the following situations:

- To you: MCB may disclose your PHI to you
- Incidental to an otherwise Permitted user of Disclosure: accidental disclosures of your PHI that occur in the course of making an otherwise permitted disclosures are permitted as long as MCB has taken appropriate safeguards to try to protect the confidentially of your PHI.
- Appointment reminders: MCB may use or disclose your PHI to contact you to provide appointment reminders, information about treatment alternates that may apply to you, and other health related services or benefits that may be of interest to you.
- Disclose to others involved in your care: PHI may be used or disclosed to family members or others designated by you as being involved in your care. This may include notifying such individuals who are waiting for you while you are being treated in our facility, or leaving telephone messages concerning your condition, your treatment, or your account, on answering machines or with family members. Such disclosures will be limited to the minimum information necessary or to the extent of the person's involvement in your care. You have the right to object to such disclosures. Please notify the office Personnel if you wish to object.
- Disaster Relief/Response: MCB may disclose your PHI to a public or private entity that is authorized by law in its charter to assist with disaster relief efforts (for example, Red Cross)

- Required by the Secretary of Health and Human Services: PHI may be used or disclosed to demonstrate our compliance with the Health Insurance Portability Act, if so, directed by the secretary.
- Required by Law: PHI may be used or disclosed to the extent required by law such as for the purposes of abuse or neglect, in response to a judicial or administrative proceeding, or as may be required for law enforcement purposes. Such disclosures will be limited to the minimum information required by the law.
- For Public Health Activities: PHI may be used or disclosed for public health activities such as presenting or controlling disease injury or disability: reporting child abuse or neglect: or reports to employees about work related injuries or workplace surveillance.
- To Report Victims of Abuse, Neglect or Domestic Violence. PHI may be used or disclosed to agencies authorized by law to receive reports about abuse, neglect, or domestic violence.
- For Health Oversight Activities: PHI may be used or disclosed to a health oversight agency for activities authorized by law including licensure activities, investigations, etc.
- Judicial or Administrative Proceedings: PHI may be used or disclosed in response to an order of the court or administrative tribunal subpoena, discovery request or other lawful process.
- For Law Enforcement: In certain circumstances, PHI may be used or disclosed to law enforcement officials for law enforcement purposes.
- To Coroner and Funeral Directors: PHI about decedents may be used or disclosed to a coroner, medica; examiner or funeral directors to allow them to carry out their duties as authorized by law.
- For Organ and Tissue Donation: PHI may be used or disclosed to organizations authorized in the procurement, banking or transposition of cadaveric organs and tissue.
- For Research: PHI may be used or disclosed for research studies that have been approved by an institution review board as having established the necessary protocols to protect the privacy of PHI.
- For Specialized Government Functions: PHI may be used or disclosed in situations involving armed forced personnel, national or intelligence activities, as necessary for the protection of the President or the authorized person or the public.
- For Worker's Compensation Programs: PHI may be used or disclosed as required to comply with worker's compensation and other similar programs.
- To Business Associates: MCB may disclosed your PHI to a business associate of ours (a third party) whom we have a contract with to perform a function on our behalf (such as billing or collections), if our contract required that our business Associate safeguard our PHI and keep it confidential.

Uses or Disclosures of PHI that requires your written authorization

Any other use or disclosure of your PHI, not previously identified, will only be made upon receipt of your written authorization. Such authorizations will be requested by MCB as needed. Your receipt of care may not be conditioned upon approval of an authorization unless the sole reason for health care is provide PHI to a third party (Physical examination for insurance eligibility), or treatment is part of research study requiring your authorization.

You are entitled to revoke any authorization at any time, provided the revocation is in writing and expect to extent that MCB has already acted in reliance on your authorization, or if the authorization was a condition of obtaining insurance coverage. To revoke an Authorizations, please submit your written request to the office personnel.

Your rights with Respect to Your Personal Health Information

Right to request Restrictions: You have the right to request reasonable restrictions on the use or disclosure of your PHI including uses and disclosures for treatment, payment and operation. MCB is not obligated to honor your requests; however, we will attempt to make reasonable accommodations. To request a restriction, please see the Office Personnel for the paper form.

Right to Confidential Communications: You have the right to confidential communications by alternative means or at alternative locations. For example, you may request we not contact you by phone, or not at your work location. MCB will accommodate reasonable requests.

Right to Inspect and Copy your protected Health Information: With certain exceptions, you have the right to inspect or copy PHI that exists in a designated record as that information is in the possession of MCB. To inspect or copy your PHI, please contact office personnel for the proper form.

Right to Amend your Protection Health Information: You have the right to request an amendment be made to your PHI that exists in a designated records set for as long as that information is in the possession of MCB. If you would like to request an amendment to your PHI, please see the office personnel for the proper form.

Right to receive an Accounting of Disclosures: you have the right to receive an accounting for disclosures of your PHI that were made, with certain exceptions, within the six years prior to the date of the request. If you would like to receive an accounting of the disclosures, please see the office personnel for the proper form.

Right to receive Copies of the Notice of Privacy Practices: You have the right to receive a paper copy of our most current Notice of Privacy Practices at any time. If you would like to receive a new copy, please ask the Office receptionist for a copy. ***Effective July 1, 2004***

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Acknowledgement of Notice of Privacy Practices

I, *(name of patient)* _____, acknowledge and agree that I have reviewed a copy of Medical Clinic of Bellaire's Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Signature of Patients Legal Representative *(if applicable)* Date

_____ _____
Print Name of Legal Representative Relationship to Patient

Office use Only:

Patient was given a copy of Medical Clinic of Bellaire's Notice of Privacy Practices but refused to sign the acknowledgment.

_____ _____
Signature of Employee Date

_____ _____
Print Name *(staff member)* Title

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Patient Authorization for Disclosure of Protected Health Information
Please print all information, sign and date authorization form at the bottom.

Patient Name: _____ Date of Birth: _____

Designated Person: I authorize Medical Clinic of Bellaire, P.A. to disclose or provide protected health information about me, to (identify person or persons who will receive the Information):

_____

_____

_____

Description of information to be disclosed: I authorize Medical Clinic of Bellaire, P.A. to disclose the following protected health information about me to the person or persons identified above (please provide a written description of the information to be disclosed):

_____

_____

_____

Expirations or termination of authorization: I understand that I have the right to terminate this authorization at any time. I must notify the Privacy Office in writing, Should I decide to terminate the authorization.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, I have the right to revoke or terminate this authorization by submitting a written request to our Privacy Office. This can be done in person or by mailing a request to:

Medical Clinic of Bellaire, P.A.
5959 West Loop South Suite 510
Bellaire, TX 77401

Redisclosure: We have no control over the person or persons you have listed to receive your protected health information. Therefore, your protected health information disclosure under this authorization will no longer be protected by the requirements of the Privacy rule and no longer be the responsibility of our clinic once released.

_____ _____
Patient Name (please print) Date

_____
Patient Signature