FAMILY PRACTICE RURAL HEALTH CLINIC
HAMILTON HEALTHCARE SYSTEM
PATIENT INFORMATION FORM

For office Use Only
Entered by: _____
Date: _____

_____
Patient's Name

In order to serve you more properly, we need the following information. **All information is strictly confidential**. **Please print clearly**.

Patient's Name: _____
Last First MI Maiden

Mailing Address: _____
Street/POB City State Zip

Telephone #: (___)_____ (___)_____ (___)_____
Home Work Cell

Sex: _____ Race: _____**Birthday**: _____ **Marital Status**:_____ **TX Drivers Lic #**:_____

Social Security #: _____ ___ **Retired**? __ Yes __No **Employer**: _____

Employer's Address: _____ (___)_____
Street/POB City State Zip Telephone #

Emergency Contact: _____ Phone: _____ Relationship: _____

Guarantor or Responsible
Party's Name:_____ Date of Birth: _____
Last First MI

Mailing Address: _____
Street/POB City State Zip

Relationship to Patient: _____ **Social Security #**: _____

Telephone #: (___)_____ ___ (___)_____ ___ (___)_____
Home Work Cell

TX Drivers Lic #:_____ ___ **Retired**? __ Yes __No **Employer**: _____

Employer's Address: _____ _____ (___)_____
Street/POB City State Zip Telephone #

Assignment of Benefits

I authorize payment of medical benefits to Family Practice Rural Health Clinic/or Hamilton Healthcare System.
This Authorization shall remain valid until revoked, in writing, by patient or guarantor. Please note that Family Practice Rural Health Clinic and Hamilton Healthcare System reserve the right not to accept assignment of benefits when such assignment does not conflict with benefit contracts or federal policies.

_____ _____
Patient or Responsible Party Date

STATEMENT OF PERMIT FOR PAYMENT OF MEDICAL BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENTS

Lifetime Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me be or in Family Practice Rural Health Clinic, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

_____ _____
Patient/Responsible Party/Subscriber Date

HAMILTON HEALTHCARE SYSTEM
NEW ADULT PATIENT HEALTH HISTORY

Name:_____ DOB:_____

Address:_____

Age:_____Sex:_____ Marital Status:_____

Education Level:_____

Occupation:_____

Work/Cellular Phone:_____/_____

Emergency Contact Person:_____

Emergency Phone Number:_____

Date:_____

Physician:_____

_____

_____

PAST MEDICAL HISTORY: ***Please check*** any of the following conditions/problems/diseases that you either now have or have been diagnosed with in the past.

_____Abuse (Physical/Mental/Sexual/Verbal/etc.)
_____Abnormal PAP
_____Alcoholism/Drugs
_____Anemia
_____Anxiety/Nerves
_____Arthritis
_____Asthma/Allergies
_____Bleeding disease
_____Other
_____Blood Clots
_____Cancer/Tumor
_____Cholesterol (high)
_____Gout
_____Headaches/Migraine
_____Heart Disease
_____Hepatitis (Any)
_____High Blood Pressure
_____Kidney or Bladder problems
_____Lung Disease
_____Osteoporosis
_____Serious accident/injury
_____Sexual disease/VD
_____Stroke
_____Thyroid Disease
_____Tuberculosis
_____Ulcers/Stomach disease

CURRENT MEDICATIONS: List all medicines that you take routinely or that have been prescribed for you by a doctor (include vitamins, over-the-counter medications, eye drops, herbal medications, etc.)

MEDICATION	DOSE	HOW OFTEN	MEDICATION	DOSE	HOW OFTEN

ALLERGIES: None Antibiotics Food Inhalants Insects Latex Meds Pollens Skin Transfusions
XRay Contrast Specify:_____

FAMILY HISTORY Blood Relatives	Age if Living	Age at Death	**Major Illnesses &/or Cause of Death** Choose from PAST MEDICAL HISTORY section above
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Brothers #___			
Sisters #___			
Children #___			

List any other diseases that your blood relatives have: _____

_____

_____

HAMILTON HEALTHCARE SYSTEM
NEW ADULT PATIENT HEALTH HISTORY

PAST SURGICAL HISTORY: List the year you had any of the following:

_____Appendectomy _____Gallbladder _____Hernia _____Tonsillectomy

_____Blood Transfusion _____Heart /Cath _____Hysterectomy _____Tubal/Vasectomy

Others:_____

HOSPITALIZATIONS/MAJOR TRAUMA-(delivery hospitalizations not necessary)

Date (start with most recent) Reason List any Major Tests or Procedures done

_____

_____

_____

_____

_____

_____

_____

HABITS Do you use (or have you used) any of the following:

Tobacco: ___Never ___Now ___Quit (year):_____ **Type used:**____cigarettes ___pipe ___smokeless
Amount used per day:_____

Alcohol: ___Never ___Now ___Quit (year)_____ Type used: _____beer ___wine ____liquor
Amount used per day: ____12 oz. beers ___6 ozs. wine ___2 oz. shots

Drug Use: ___Never ___Now ___Quit (year)_____ Type: ___Pot ___Cocaine ___IV ___Pain pills
____other_____

Caffeine: # per day___ Coffee (cups)_____ Tea (glasses)_____ Soda (12 oz. cans)_____

Exercise: ___None per week _____#of times/week=_____ doing what?_____

NUTRITIONAL ASSESSMENT

Do you follow a special diet or have any dietary restrictions? _____NO _____YES

HEALTH CARE MAINTENANCE:

Last Cholesterol Screen: Year_____ Value_____

Pneumonia Shot? _____Never Year_____ Last Tetanus Shot? Year_____

Have you been involved in: ____Military? ____International Travel?

COPING / STRESS TOLERANCE ASSESSMENT:

Describe how you manage stress: ___Exercise ___Gardening ___Hobbies ___Read ___Sports ___TV
___Other_____

Who lives with you? ___Alone ___Spouse ___Children ___Parent(s) ___Other_____

Current Stressors: ___Family ___Friends ___Job ___Marriage ___Money ___Other?_____

In the past year have you had a major loss or change in your life? ____Yes ____NO.

VALUES/BELIEFS ASSESSMENT:

Check if you have any of the following documents: ____Donor Card ____Living Will ____Durable Power of Attorney for Health Care?

Do you have any religious or cultural practices we should be aware of? ____YES ____NO.

DESCRIBE:_____

_____

_____

_____

Patient Signature/Date Completed Physician Signature/Date Reviewed

OFFICE USE **Assistance required completing the form** **Non-English speaking patient**

Patient Preference Regarding Communication with Hamilton Healthcare System Rural Health Clinics

The electronic medical record system that is utilized at Hamilton Healthcare System Rural Health Clinics allows us to customize the way we contact you for appointment reminders, lab results, and other health related information. Please note that appointment reminders are sent through an automated system. Please listen to the full message and follow the prompts given.

***Any messages left on voicemail or sent via text message will be HIPAA compliant. We will not provide Protected Health Information over voicemail or via text message.**

Date:_____

Patient Name:_____ Date of Birth:_____

How to Contact

Please tell us your preferred method of communication by checking the appropriate box and provide your contact information below.

☐ I prefer a Phone Call.

- Please call this number:_____
- This is my (select one): ☐ Home Phone ☐ Work phone ☐ Cell phone

☐ I prefer a Text Message.

- Please text this number:_____

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of communication, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Thank you for choosing Hamilton Healthcare System!

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Name of Responsible Party Relationship to Patient

For Clinic Use Only:

Entered by:_____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I have read and/or received a copy of Hamilton Healthcare System's Notice of Privacy Practices.

Patient or Responsible Party Signature:_____ Date:_____

Relationship to Patient (Self, Spouse, Parent or Legal Guardian): _____

Witness Signature:_____ Date:_____

Failure to Obtain Signed Acknowledgment

Hamilton Healthcare System presented this Acknowledgment to _____.

The patient refused to provide a signature when requested.

Witness Signature: _____ Date:_____

CONDITION OF ADMISSIONS

AUTHORIZATION FOR TREATMENT AND/OR SURGERY

The patient and others whose signatures are attached below do hereby consent to any and all medical surgical treatments, including anesthetics and operations, which may be deemed advisable by his or her physicians and surgeons serving on the staff of Hamilton Healthcare System, the intention hereof being to grant authority to administer and to perform all and singular any examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care be deemed advisable or necessary. We also agree that the patient when admitted is to remain in the Hamilton Healthcare System until his or her physicians recommend the patient's discharge, and then the physicians decide that the patient no longer needs hospital care, we consent to and authorize the patient's transfer to his or her home or place of abode. In witness of our consent and agreement of the matters stated in the two preceding sentences, we have subscribed our signature below.

ASSIGNMENT OF BENEFITS -- HOSPITAL

I/We hereby transfer, assign and convey all my/our rights, title and interest in and all benefits due me/us, if any, by reason of services described in the statements rendered, and as provided for in any contract of policy of insurance under which I/we may be an insured of beneficiary and I direct said insurance company(s) to pay directly to Hamilton Healthcare System, at Hamilton, Hamilton County, Texas, all of such benefits. I/we also assign my/our causers of action against any and all third parties who may be responsible or liable for the injuries requiring admission to or treatment by Hamilton Healthcare System any remaining balance after insurance payment or denial of coverage under this assignment of benefits.

AUTHORIZATION TO RELEASE INFORMATION

I authorize that any medical, mental health, HIV testing and status, and/or substance abuse information be released. I understand and agree that no liability of any nature shall attach to the releasing organization or person, to any physician or surgeon in release of this information, or to any employee of any of them acting upon this request.

ASSIGNMENT OF BENEFITS -- PHYSICIANS

I agree to be primarily responsible for payment of physician(s) charges. I also assign to my physician(s) my right to all applicable insurance benefits and my causes(s) of action against any third party liable for the condition or injuries requiring physician services. I grant the physician(s) a lien against all settlement proceeds or recovery by judgment from any such third party – up to but not to exceed the amount of the physician's charges and reasonable attorney's fees.

MEDICARE ASSIGNMENT AND AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration, Health Care Financing Administration or their intermediaries any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PATIENT VALUABLES

All parties are advised that valuables should not be kept in their respective Hamilton Healthcare System room. Proper and safe facilities for any valuables are offered by Hamilton Healthcare System. Hamilton Healthcare System is not responsible for valuables not properly registered. Hamilton Healthcare System cannot be held responsible for personal belongings and it is strongly urged that you not keep any personal items of significant value in your room.

AUTHORIZATION / PRECERTIFICATION

If my group of private insurance policy requires prior certification, authorization, second opinions, or any other type of utilization review function, I understand that I am responsible for compliance with these and all other terms of my policy.

PATIENT FINANCIAL RESPONSIBLITY

Hamilton Healthcare System's election to pursue one or more forms of collection shall not constitute a waiver of its right to pursue other collection measures it deems necessary or advisable. All such remedies shall be cumulative in nature. Venue for collection shall be Hamilton County, Texas. This agreement shall not require payment by any person in contravention of any state or federal statute, rule or regulation.

SCOTT & WHITE RADIOLOGY CONSENT FOR THE ELECTRONIC TRANSFER OF INFORMATION FOR CONSULTATION PURPOSES

I authorize Hamilton General Hospital to electronically transmit patient information to Scott & White for the purposes of radiological consultation and associated professional fee billing. I acknowledge that the potential exists for the confidentiality of my patient information to be compromised during the transmission. Further, I acknowledge that Scott & White had implemented internal policies and procedures that solely protect the confidentiality of my patient information through DES encryption as mandated by HCFA and security settings that prevent random unpermitted access. Scott & White Memorial Hospital – Authorization to release information and assignment of insurance benefits: I hereby assign to Scott & White Clinic, an association, and Scott & White Memorial Hospital and Scott, Sherwood and Brindley Foundation, a corporation, such insurance benefits to which entitled providers, and their agents and employees, to any insurance company, agent or employee of said company for the purpose of acting on, or with respect to any insurance claim.

Signature of Patient or Legally Authorized Representative _____ Date _____

ADVANCE DIRECTIVES

Do you have an Advance Directive? ☐Yes ☐ No ☐ Booklet Given If yes, please give a copy to your RN

HAMILTON HEALTHCARE SYSTEM

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.

Your Information. Your Rights. Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses & Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

See back for more information on these rights and choices uses how to exercise them and for more information on these uses and disclosures.

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Disclosures & Uses

How do we typically use or share your health information? *We typically use or share your health information in the following ways.*

Treat you
- We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization
- We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services
- We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site: www.hamiltonhospital.org

Thank you for visiting Hamilton Healthcare System today. Your opinion counts.

Help us improve the care we deliver by completing an email survey about your visit. Our survey partner, Press Ganey, will hold your information in strict confidence. It will only be used to help us improve our quality of care.

- Your information will never be sold to a third party.
- Your email will not be used for promotional marketing.
- Information is confidential, in compliance with HIPAA patient privacy regulations.

Physician Seeing Today: _____

Patient Name: _____

Date of Birth: _____ (mm/dd/yyyy)

Email Address: _____

Check here if you do not have email. ☐

From everyone at Hamilton Healthcare System, thank you for trusting us with your care.

HAMILTON HEALTHCARE SYSTEM

PRESS GANEY®