CHRISTUS

New Patient Questionnaire

Patient Name: _____ Date of visit _____
Reason for visit: _____ Side: Right/Left/Both
Who is your primary care physician? _____
Who referred you to our practice? _____
If your injury is the result of an accident please answer the following?
Date of injury: _____ Where did it happen? _____
How did it happen? _____
Is this a Workers Compensation Claim? YES/NO
Was this a Motor Vehicle Accident? YES/NO
IF this is not an injury? How long has this bothered you? _____
Have you taken ANY medications for this problem? (Prescription or OTC)

_____
Have you ever had any other treatment for this problem? (Doctors, physical therapist, etc.)

_____
Please rate your pain/discomfort by circling: None = 0 1 2 3 4 5 6 7 8 9 10 = Severe
Quality of the pain (please circle): sharp dull throbbing burning other _____
What makes your condition/injury better? _____
What make your condition/injury worse? _____

ALLERGIES to Medications? Yes/No If yes, please list allergies? _____

MEDICATIONS

List all current medications. Please include dosage & reason:
(If additional space is needed, please continue on the back of the form)

SURGICAL HISTORY

List all past surgeries.

CHRISTUS

PAST MEDICAL HISTORY

Have you ever had: (circle)

Excessive Bleeding	Edema/leg swelling	Diabetes	Rheumatoid arthritis	Osteoporosis
Osteoarthritis	Heart Stent	Claudication/Calf Pain	Ulcer	Reaction to anesthesia
Heart Attack	Irregular heartbeat	Hypertension	On Blood thinners/Aspirin	Blood clot/DVT
Sleep apnea	COPD	Stroke	Asthma	Thyroid Disease
Kidney Disease	Gout	Fibromyalgia	Hepatitis	Muscle Disease
Other:	Other:	Other:	Other:	Other:

FAMILY HISTORY

Please check off any family member(s) next to the condition. Please mark if the relative is Alive=A or Deceased=D.

	Mother	Father	Brother	Sister	Daughter	Son
Cancer (what kind?)						
Diabetes						
Heart Disease						
Hypertension						
Asthma						
High Cholesterol						
Rheumatoid Arthritis						
Lupus						
Stroke						
Thyroid Disease						
Seizures						
Other:						

SOCIAL HISTORY

Please answer all questions

Marital Status: Single Married Divorced Widowed Number of children? _____
Occupation: _____ Employer: _____
Tobacco use None/Yes _____packs per day _____ years _____date quit
Alcohol use: None/Yes _____drinks per week Marijuana use: No/Yes _____per week
Fitness/Sports/Athletic activities: _____

PATIENT INFORMATION FORM

TODAY'S DATE (mm/dd/yyyy): ____/____/____

PATIENT INFORMATION

Last Name	First Name	MI

Date of Birth	Driver's License Number	Social Security #

Gender: [ ] Male [ ] Female

Marital status (Check one) [ ] Single [ ] Married [ ] Divorced [ ] Widow(er) [ ] Partner [ ] Separated [ ] Unknown

Home Street Address	City	State	Zip Code

Home #	Work #	Cell #	Email

Preferred Language:
[ ] English [ ] Spanish [ ] Vietnamese [ ] Other _____

Chose clinic because / Referred to clinic by (please check one box): [ ] Physician [ ] Insurance Plan [ ] Hospital [ ] Yellow Pages [ ] Family [ ] Friend [ ] Close to home / work [ ] Other _____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

[ ] Check here if same as above

Guarantor Name	Address

Patient's relationship to Guarantor
[ ] Self [ ] Spouse [ ] Child [ ] Other _____

INSURANCE INFORMATION

Please complete items below if Not included on insurance card(s)

Primary Insurance	ID certification #

Insurance Address

Subscriber's name	Birthdate	Policy / Group #	Co-pay $_____

Patient's relationship to policy holder
[ ] Self [ ] Spouse [ ] Child [ ] Other _____

Secondary Insurance (if applicable)	ID certification #

Insurance Address

Subscriber's name	Birthdate	Policy / Group #	Co-pay $_____

Patient's relationship to policy holder
[ ] Self [ ] Spouse [ ] Child [ ] Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home #	Work / Cell #

I hereby authorize payment directly to C.H. Wilkinson Physician Network for any surgical and/or medical benefits, if any, otherwise payable to me. I also authorize C.H. Wilkinson Physician Network to file all necessary papers for insurance and to release any and all copies of medical records requested by my insurance company for the purpose of determining benefits. I understand such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. I acknowledge full responsibility for the payment of such services and agree to pay my bill in full AT THE TIME OF SERVICES unless other arrangements are made with the financial department.

Patient / Guardian Signature	Date

Medication History Authority

Patient Name: _____

Date: _____

The above named patient gives his/her provider the legal authority to obtain his/her medication history.

Please circle: YES NO

Signature: _____

Pharmacy: _____

Pharmacy: _____

CHRISTUS Health.

STATE OF TEXAS
HOSPITAL CARE CONSENT

1. **General Consent:** I consent to Ortho San Antonio (the "Facility") giving me medical services and treatment that my doctor or other medical staff have ordered. My consent includes diagnostic testing (such as labs and x-rays), injections, immunizations, medications, and other medical treatment. I have the right to make decisions about my care. I know that I have the right to discuss treatment and procedures with the doctor beforehand. I also have the right to consent or refuse any treatment. Where appropriate, I consent to delivery of care utilizing interactive video conferencing thereby enabling a provider at a distant location to provide treatment to me and/or consult and advise my local healthcare provider in making decisions about the care provided to me. I understand that medicine is not an exact science. No one has guaranteed me results. The medical care I receive while in the Facility is under the direction of an independent provider, who is not an employee of the Facility. The Facility is not responsible for the medical care, medical judgment, and plan of care provided by non-employees. I recognize that services rendered in the hospital, including but not limited to, in the emergency department, inpatient, outpatient, SDC, etc. are admissions to the hospital for the purposes of, among other things, the Texas Property Code, Section 55.
2. **Personal Property:** I understand that I am responsible for my personal property while at the Facility. The Facility is not responsible for keeping my property safe.
3. **Financial Assistance:** If I cannot afford my Facility medical bills, I may be eligible for charity care or other adjustments. I have been offered a paper copy of the Facility's plain language summary of its Financial Assistance Policy. The full policy and more information is available at www.christushealth.org/charitycare
4. **Release of Information:** I allow the Facility to release health information for payment purposes and other reasons allowed by law. The law allows the release of my information to other providers for my care as written in the Facility's Notice of Privacy Practices. I agree that all records about my treatment are the Facility's property. I understand that medical records and billing information created or maintained by the Facility are available to Facility workers, volunteers, allied health professionals, and medical staff. These persons may use and disclose my medical information for treatment, payment, and healthcare operations.
5. **Medicare/Medicaid Benefits:** If applicable, 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 about me to release to the Social Security Administration or its intermediaries any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. If I have Medicare/Medicaid, my financial obligations may be limited by law.
6. **Communication:** I authorize the Facility (including any billing service, collection agency, agent, or contractor on the Facility's or contractor's behalf) to contact me by phone at any number that I have provided to the Facility at any time. The Facility may also contact me at any number it may obtain for me in the future, including cell phone numbers, which could result in charges to me. The Facility may use pre-recorded or artificial voicemail messages and the use of an automatic dialing device or automated telephone dialing systems. The Facility may send me voicemail messages, text messages, or e-mails. I allow the Facility to contact me using any e-mail address that I have given it or any e-mail addresses that the Facility may obtain for me in the future.
7. **Testing After Accidental Exposure and State Reporting:** If a healthcare worker accidentally touches my blood or other body fluids, state law allows the Facility to test me for certain diseases. These diseases include human immunodeficiency virus (HIV). These tests are conducted to protect healthcare workers. I will not be charged for such tests. I understand that the Facility is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the state health department or Centers for Disease Control.
8. **Photography:** I consent to the Facility videotaping, photographing, video monitoring, or taking other recordings of me or parts of my body for diagnosis, treatment, research, or patient safety purposes. These recordings might be used for medical education, quality improvement, research, or for other reasons related to treatment or operations. If the recordings or images are used, my identity will not be revealed. I will talk with my doctor if I do not want my recordings used for these purposes.
9. **Ethics:** The Facility is a Catholic health ministry dedicated to helping the sick and injured in compliance with the *Ethical and Religious Directives for Catholic Health Facilities*. The Facility may not be used for procedures that violate the directives.

CHRISTUS Health

STATE OF TEXAS
HOSPITAL CARE CONSENT

10. **Teaching and Observation:** I understand that the Facility may be a teaching facility. I consent to allow medical residents, students, and fellows who have a formal affiliation with the Facility to participate in my care as supervised by the treating physicians and permitted by Facility policy. Students, residents, and fellows from other non-affiliated programs as well as vendors may observe my care consistent with Facility policy and as approved by my treating physician.

11. **Assignment of Benefits:** In consideration of services rendered and to be rendered, the sufficiency of which is hereby acknowledged, I hereby irrevocably assign and transfer to CHRISTUS _____ Hospital (hereinafter referred to as the "Hospital") all right, title, and interest in all claims or benefits payable for hospital services rendered in the past or future, which are provided in any and all insurance policies, employee benefit plans, and/or third party actions against any other person or entity (hereinafter referred to as "Benefits") from whom my dependents or I may be entitled to recover. I further hereby irrevocably assign and transfer to the Hospital all right, title, and interest in any and all causes of action against all insurance companies, employee benefit plans, liability carriers, third party administrators, tortfeasors, and/or all other persons or entities responsible for payment (hereinafter referred to as "Responsible Parties") of Benefits and I hereby appoint the Hospital as my attorney in fact, with power of substitution, to sue or otherwise obtain payment of Benefits from the Responsible Parties. This irrevocable assignment and transfer shall be for the purpose of irrevocably granting the Hospital an independent right of recovery of Benefits against any Responsible Parties, at its option, but shall not be construed to be an obligation of the Hospital to pursue any such right of recovery. I hereby direct and irrevocably authorize all Responsible Parties to pay directly to the Hospital all Benefits and amounts due for services rendered by the Hospital without further request or written authorization from me. I further irrevocably authorize and direct that any Responsible Parties furnish copies of any insurance policies, employee benefit plans or any other document requested by the Hospital without further request or written authorization from me. I understand that in the event that the Hospital is not paid in full by proceeds of my insurance policies, this assignment does not release my obligation and liability to the Hospital for payment of the services and items provided to me by the Hospital. I agree to pay the Hospital for all charges incurred by me, or in the alternative, for all charges in excess of the sums actually paid by my insurance policies. We have the right to apply available funds in any or all of your accounts with us and our affiliates otherwise payable to you to any prior existing or future debt that you owe us. When we set-off a debt that you owe us, we reduce the funds in your account(s) by the amount of the debt. We are not required to give you any prior notice to exercise our right of set-off. The effect and consequences of this irrevocable assignment and financial responsibilities have been fully explained to me to my understanding, and I have signed this document freely and without inducement.

12. **Balance Billing Disclosure:** Professional services rendered by independent healthcare professionals are not part of the hospital bill. These services will be billed to the patient separately. Please understand that physicians or other healthcare professionals may be called upon to provide care or services to you or on your behalf, but you may not actually be seen, or be examined by, all physicians or healthcare professionals participating in your care; for example, you may not see physicians providing radiology, pathology, and EKG interpretation. In many instances, there will be a separate charge for professional services rendered by physicians to you or on your behalf, and you will receive a bill for these professional services that is separate from the bill for hospital services. These independent healthcare professionals may not participate in your health plan and you may be responsible for payment of all or part of the fees for the services provided by these physicians who have provided out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services. We encourage you to contact your health plan to determine whether the independent healthcare professionals are participating with your health plan. In order to obtain the most accurate and up-to-date information about in-network and out-of-network independent healthcare professionals, please contact the customer service number of your health plan or visit its website. Your health plan is the primary source of information on its provider network and benefits. To help you determine whether the independent healthcare professionals who provide services at this facility are participating with your health plan, this healthcare facility has provided you with a complete list of the names and contact information for each individual or group.

CHRISTUS Health

STATE OF TEXAS

HOSPITAL CARE CONSENT

13. **Patient Rights and Advance Directives:** The Facility provided me a copy of the Patient Rights and Responsibilities when I arrived to the hospital. I also understand that I can request an additional copy any time. The Patient Rights and Responsibilities includes information about advance directives, my right to refuse medical treatment, and my right to have visitors or name someone who can exercise patient visitation rights on my behalf, if I cannot. If I give the Facility an advance directive, my caregivers will follow it to the extent allowed by law. I also have the right to consent to a DNR order, I can change my mind about DNR orders at any time. I have the right to know if my doctor makes changes to orders about resuscitation.

_____ **(Initials) I have declined a copy of the Patient Rights and Responsibilities, and understand I can request a copy at any time.**

14. **Notice of Privacy Practices:** I have received a copy of the Facility's Notice of Privacy Practices at this or an earlier visit. The Facility will give me a copy of the Notice of Privacy Practices any time I ask for one.

_____ **(Initials) I acknowledge receipt of the CHRISTUS Notice of Privacy Practices**

15. **Facility Directory:** Unless I object, the Facility will include my name, location in the facility (room number), and general condition in the Facility Directory. Directory information is available to callers or visitors who ask for patients by name. Directory information and religious affiliation (if provided to Facility) are available to clergy members even if they do not ask for patients by name. If I object, I will be excluded from the Facility Directory.

(If you object, initial below.)

_____ I ***DO NOT*** want any information about me to be included in the Facility Directory. I understand that mail, flowers, telephone calls, and visitors will be refused on my behalf because hospital staff cannot acknowledge my presence in the hospital. If I make phone calls from the hospital, caller ID may show call recipients that I am calling from the hospital.

16. **Insurance Information:**

Primary Insurance:

Secondary Insurance:

Tertiary Insurance:

_____ **(Initials) I acknowledge that I have provided the Facility with complete and correct insurance information in the appropriate filing order listed above.**

ACKNOWLEDGEMENT: By signing below, I certify that I have read this document, understand its contents, and agree to the terms. I acknowledge that I am the patient or I am the patient's legally authorized representative and/or guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

_____ _____

Signature of Patient / Legally Authorized Representative — Date

_____

Patient's Name

_____ _____

Name of Legally Authorized Representative (if not Patient) — Relationship to Patient

_____ _____

Facility Representative — Date

CHRISTUS Health.

AUTHORIZATION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE

This provider participates in Health Information Exchanges (HIEs). HIEs are electronic systems that allow health care providers to share information about patients. HIEs give information (like your allergies, medicines, and test results) from other doctors or hospitals to your current provider. The information may help your provider make more informed treatment decisions. The HIE also helps you receive efficient care because your health information is more easily available to providers when they need it.

You have the right to choose if you want to participate in the HIE. Your information will be stored within the CHRISTUS HIE system, but it will not be visible to non-CHRISTUS providers unless you choose to participate. Your treatment is not conditioned on your decision. You can access medical care at CHRISTUS whether or not you participate in the HIE.

You may change your decision at any time by notifying the hospital admitting staff and completing a new authorization form.

(Initial one option below)

_____ **Yes, I authorize the release of my medical information through the Health Information Exchange.**
I allow the HIE to share my health information. I understand this may include information created both before and after the date I sign this form. I understand that my medical records are confidential. They cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed by this authorization may be subject to re-disclosure to the extent permitted by applicable laws. I understand that my health information in the HIE may include genetic information (including genetic test results), substance abuse records, mental illness records, or communicable disease status, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).
OBSTETRIC PATIENTS ONLY. I authorize the HIE to include information about any child/children born to me during this hospitalization.

OR

_____ **No, I do NOT authorize the release of my medical information through the Health Information Exchange.**
I do not want my information to be shared through the HIE. I understand that my providers may have less information about me when making decisions about my care. If I decide to participate in the HIE at other participating providers, they will not receive information from CHRISTUS unless I submit a new copy of this form and authorize the release of my CHRISTUS medical information.

TEXAS ONLY: Texas law requires all health care providers to notify patients that we must collect statistics on services performed by CHRISTUS. We submit that information to the Texas Healthcare Information Collection program. You cannot opt out of this data collection, but the data will not personally identify you. Additional information is provided to you on the *Texas Department of State Health Services Patient Notification of Data Collection* form or you may contact the State Department at 512-776-7261 or www.dshs.state.tx.us/thcic.

I certify that I have read and fully understand the information on this form. My decision regarding the release of information to the HIE will remain in effect indefinitely unless I submit a revised form.

Signature of Patient or Legal Representative	Date of Signature
Printed Name of Legal Representative (if applicable)	Relationship to Patient
Printed Name of Patient	Patient's Date of Birth

PERMANENT PART OF MEDICAL RECORD

HIE Authorization Consent

CHRISTUS.

REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____, request communication of my protected health information by CPG by alternative means or at alternative locations. I understand this request applies only to communications from CPG to the patient.

I wish to be contacted in the following manner: (check all that apply)

___ *Home Telephone_____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Written Communication
- ___ OK to mail to my home address
- ___ OK to mail to my work/office address

___ *Work Telephone _____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___*Cell Telephone_____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Other _____
_____
_____

***As a service to our patients, we provide courtesy appointment reminder calls and other important calls that may be placed using an automated or prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.**

I wish for the following individuals to be allowed information *verbally*:

Name:_____ Phone #_____ Relationship to patient: _____

Name:_____ Phone #_____ Relationship to patient: _____

Name: _____ Phone #_____ Relationship to patient: _____

NOTE: This request will remain in effect until you notify us of a change

_____
Patients Name (PRINT)

_____
Patient's Guardian/Representative (PRINT)

_____
Signature of Patient

_____
Signature of Guardian/Representative

_____
Date

_____
Relationship to Patient/Representative Authority

_____
Date of Birth

_____
Date

****

The identity of the requestor has been validated either with a picture ID, such as a driver's license or passport, or comparison of signatures documented in the medical record by: _____

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: (_____)_____

Information to be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

☐ Complete health record	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ Radiology reports/images	☐ Cardiac imaging
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill
☐ Discharge Instructions	☐ Pulmonary function results	☐ Immunization Record
☐ Release Of Information (ROI) Abstract – History &Physical (H&P), Discharge Summary, Labor & Delivery Note, Operative Report, Procedure Note, Consultation, Laboratory, Pathology, X-ray reports.		

☐ Other (specify) _____

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

☐ Other (specify) _____

Send / Release Information

☐ Paper ☐ CD ☐ Electronic Portal (E-mail notification when access is available)

***Please initial if you have requested your information to be sent to you in an unencrypted electronic format. _____.**

Release to Name: _____

Mail to Name: _____

Mail to Address: _____

E-mail Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and/or psychiatric treatment I have been afforded the opportunity to sign a specific authorization. ***Initial One:*** **Yes_____ No_____ Not Applicable _____**

I understand if my medical or billing records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.
Initial One: **Yes_____ No_____ Not Applicable _____**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Carole Cassidy, 919 Hidden Ridge, Irving, TX 75038 or carole.cassidy@christushealth.org. Unless revoked, this authorization will expire on the following date or event _____or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize CHRISTUS Physician Group to release the protected health information specified above.

Signature: _____ Date: _____

Authority of Personal Representative to Request Disclosure: _____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

Verified by: _____

Effective Date: 8/19/2015