HANSON INTERNAL MEDICINE, P.A.

PATIENT REGISTRATION

Patient Name:____________________________________ Date of Birth:____/______/______ Sex: M/F

Last First MI

(Circle one) Married Single Divorced Widow

Social Security Number: ________-______-_________

Address:____

(Street) (City/State/Zip)

Home Phone: (_____)____________-__________ Work/Mobile Phone(_____)___________-_______________

E-mail Address:____________________________

Would you be interested in having communications sent to you via your e-mail address? (examples:appointment reminders, administrative updates and health bulletins) Yes No

Employer Name:________________________________Employer Phone Number: (____)_______-_______

Employer Address:____

(Street) (City/State/Zip)

Referred By:_____ Friend/Relative ______ Emergency Room _____ Yellow Pages _____ Shopper______Other______

Referring Physician:___________________________________Physician Phone_______________________________

Person responsible for bill (Complete only if different from patient)

Subscriber's Name:_____________________________ Social Security Number________-_________-_________

(Name of person that holds the insurance)

Relationship to Patient:(please check):( )self ( ) spouse or ( ) parent Date of Birth: _____/___/______

Address:____Phone Number:(___)_________

Employer Name:_______________________________ Employer Phone Number: (___)_________

Employer Address:____

(Street) (City/State/Zip)

Who to call for an emergency:

Name:__________________________________ Address:__________________________________

Home Phone: (___)__________ Work Phone: (___)__________ Relationship:__________________

FIRST INSURANCE INFORMATION

Plan Name:____I.D. Number:_________________________

Address:____Group Number:_______________________

Insurance Company Phone#___________________________Effective Date:_________________________

Policy Holder:__________________________________ Sex: M/F

Policy Holder's Social Security Number:__________-____________-_____________

Policy Holder's Date of Birth: _______/_______/_________

SECOND INSURANCE INFORMATION

Plan Name:____I.D. Number:_________________________

Address:____Group Number:_______________________

Insurance Company Phone#___________________________Effective Date:_________________________

Policy Holder:__________________________________ Sex: M/F

Policy Holder's Social Security Number:__________-____________-_____________

Policy Holder's Date of Birth: _______/_______/_________

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? IF YES, PLEASE NOTIFY THE RECEPTIONIST Y______ N___________

Medical History

Prepared for:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any protected health information (PHI) necessary. PHI is usually released or shared as needed to help with treatment decisions, payment, or health care operations. Groups that may request PHI include:
A. Any third party payor covering the medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree of necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies; and
F. Other parties as otherwise required by law.

In each case, Hanson Internal Medicine, P.A. shall take reasonable steps to ensure that only the minimum necessary information is given.

I permit a copy of this authorization to be used in place of the original.

DATE: ______________________________ SIGNATURE: ____________________________________

I hereby authorize Hanson internal Medicine, P.A. to apply for benefits on my behalf for covered services rendered. I request that payment for my insurance company be made to Hanson Internal Medicine, P.A.

I certify the information I have provided with regard to my insurance is correct. I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

DATE: ______________________________ SIGNATURE: ____________________________________

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

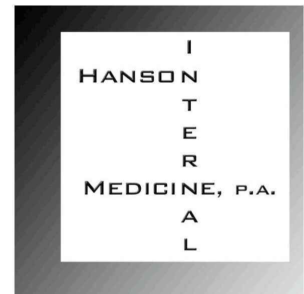
DATE: ______________________________ SIGNATURE: ____________________________________

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing this section I am indicating Hanson Internal Medicine, P.A. has provided a copy or offered me a copy of their notice of privacy practices (pages 9-10). I have been provided with the ability to ask questions or comment on the practice’s notice

DATE: ______________________________ SIGNATURE: ____________________________________

NOTICE OF PRIVACY PRACTICES (MEDICAL)



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.

Prepared For:

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used to disclose by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information. All identifying features are removed before use in this manner.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by your written request.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the practice.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected heath information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of September 25th 2006 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

Thank You,
Hanson Internal Medicine, P.A.

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Friends and Relatives that may be Informed of my Medical Care

Prepared for:

Physician: Gregory W. Hanson, M.D.

Please share medical information on a need-to-know basis with my family and friends as indicated below

Name Relationship

Address

Inform / Do not inform

Phone

Name Relationship

Address

Inform / Do not inform

Phone

Name Relationship

Address

Inform / Do not inform

Phone

Name Relationship

Address

Inform / Do not inform

Phone

Hanson Internal Medicine, P.A.
6100 Harris Parkway, Suite 240
Fort Worth, TX 76132
Office 817.433.5160
Fax 817.433.5161

HANSON INTERNAL MEDICINE, P.A.

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

We believe all patients should be actively engaged in their health. Besides prevention and day-to-day management of medical issues, all patients should have an understanding of the following concepts:

Living will (also known as A Directive to Physicians and Family or Surrgoates): a document, signed by a patient in the presence of witnesses, that clearly identifies a person's wishes in regards to LIFE PROLONGING PROCEDURES. A Directive to Physicians and Family or Surrogates is a form that allows you to instruct physicians to administer, withdraw or withhold life-sustaining treatment when it has been determined by your physician that you have an irreversible or terminal condition and you are not able to communicate. Life-sustaining treatment is a treatment or procedure that includes life-sustaining medications and artificial life supports, such as mechanical breathing machines, kidney dialysis and artificial nutrition and hydration, that is not expected to cure your condition or make you better, and is only prolonging the moment of death. Living wills tend to be very straightforward. Another example of a living will is the Five Wishes. We would like all members to consider completing the Five Wishes and sharing it with their families.

**Circle one: - I HAVE / HAVE NOT prepared a living will.

Medical Power of Attorney (formerly known as Durable Power of Attorney for Health Care): A Medical Power of Attorney is a form that allows you to appoint someone (your "agent") to make health care decisions for you if you are no longer able to make decisions for yourself. These decisions can include (1) agreeing to or refusing medical treatment; (2) deciding not to continue medical treatment; or (3) making decisions to stop or not start life-sustaining treatment.

**Circle one: - I HAVE / HAVE NOT designated a health care surrogate.

These topics are discussed more in the Federal PATIENT SELF DETERMINATION ACT. You are encouraged to read more about this on-line, or ask us questions if needed.

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Signature of Patient or Representative Date