

Internal Medicine & Geriatrics of Houston, LLC
201 Stillwater Circle, Bonaire, Georgia 31005
Tel 478.3289690 Fax 478.3289692
FABIAN R. FRANCO, M.D.
CHRISTOPHER R. BUCHANAN, M.D.

Patient Information

Legal Name- Last: _____ First: _____ MI: _____
Preferred Name- _____
Sex: (circle one) Male Female Trans M to F Trans F to M
DOB: ____/____/____ Social Security Number: _____
Address: _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work phone: _____
Spouse name: _____ Spouse phone: _____
Email Address: _____ .com

Insurance Information

Primary Ins. _____ Policy # _____
Group # _____ Name of sponsor: _____ Sponsor DOB: ____/____/____
Secondary Ins. _____ Policy # _____
Group # _____ Name of sponsor: _____ Sponsor DOB: ____/____/____
Tertiary Ins. _____ Policy # _____
Group # _____ Name of sponsor: _____ Sponsor DOB: ____/____/____

Emergency Contact

Name: _____ Phone: _____ Relation: _____
Address: _____

Race, Ethnicity & Language Form

Please circle all that apply:
-American Indian -Native Hawaiian or other Pacific Islander
-Black or African American -White -Asian
-Other _____ Decline to answer
Are you Hispanic/Latino? Yes No Decline to answer
What is your preferred language? _____

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Health Information

Patient's Name: _____ DOB: _____
Preferred Pharmacy & Location: _____

Allergies:

Medical History: (example: Diabetes, hypertension, chicken pox)

Surgeries:

Dates:

_____	_____
_____	_____
_____	_____
_____	_____

Family History & Family Member: (example: sibling, mother, paternal grandmother)

Colon Cancer _____
Prostate Cancer _____
Breast Cancer _____
Heart Disease _____
High Cholesterol _____
Diabetes _____
Depression _____
Suicide _____
Schizophrenia _____

Social History:

Cigarette smoker-	Current	Former	Never
Other tobacco products-	Current	Former	Never
Illicit drug user-	Current	Former	Never

Do you drink alcohol? _____
Type, frequency, amount? _____

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Consent to Payment

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Internal Medicine and Geriatrics of Houston LLC all insurance benefits, if any, payable to me for services rendered.

I request that payment of authorized _____ (ins. Company) benefits to be made on my behalf to Internal Medicine and Geriatrics of Houston, LLC for services furnished to me (or my dependent) by Internal Medicine and Geriatrics of Houston, LLC. I authorize any holder of medical information about me to release to _____ (ins. Company) and its agents, all information necessary to pay the claim.

Insurance Company Name

Policy Number

Patient's Date of Birth

Patient's full name as it appears on the insurance card

Signature of patient (and printed if different from name on insurance card)

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Medical Information Release Form
HIPAA Release Form

Name: _____ Date of Birth: ____/____/____

Release of Information

- I authorize the release of information, including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:
- Spouse _____
 - Children _____
 - Other _____
- Information is not to be released to anyone.

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call:

- My home phone _____
- My work phone _____
- My cell phone _____
- Someone else's phone _____

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- Other _____

The best time to reach me is: (day) _____ between _____

Signed: _____ Date: _____

Witness: _____ Date: _____

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Patient Portal Authorization Form

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email, you will be assigned a username and password. After you register with the Patient Portal, you will be allowed to do the following:

- Update your contact information
- Request your own appointments
- Communication of laboratory results from staff to patient
- Request prescription refills
- View your medical summary, medication list, treatment history, and visitation dates
- Receive reminders through your email
- View current and past statements

The following will **NOT** be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnoses will be made by your provider during your office visit.
- Request for narcotics/controlled medications.
- Request for medication refill not currently being prescribed by a Medical Provider.

Online communications should never be used for life-threatening, emergency communications, or urgent requests. If you have an emergency, then call 911 or go to your nearest emergency room.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that utilizes encryption to prevent unauthorized individuals from accessing communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to log in to the portal site. Because the connection channel between your computer and the website uses Secure Sockets Layer technology, you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

- 1) The security message must reach the correct email address, and
- 2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appear at login. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth on the login screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Print name: _____ DOB: _____

Patient Signature: _____ Date: _____

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Rx History & E-Prescribing

CONTENT

E-Prescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. The U.S. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an E-Prescribe program. These include:

- Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.
- Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide IMGH LLC with access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I understand that my prescription history may include prescriptions dating back several years. I acknowledge that IMGH LLC may use health information exchange systems to electronically transmit, receive, and/or access my prescription history. I understand that this Prescription History Consent will be valid and remain in effect if I attend or receive services from IMGH LLC, revoked by me in writing.

By signing this consent form, you agree that Internal Medicine & Geriatrics of Houston LLC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Patient Name (Print)

Patient Date of Birth

Signature of Patient or Legal Representative

Date and Time

Print Patient Representative Name

Relationship to Patient

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD
INFORMATION

Patient Name: _____ Date of Birth: _____
Phone: H) _____ Phone: W) _____
Address: _____ City/State/Zip: _____

Type of information to disclose:

- Office notes
- Labs
- All records
- Specific dates or information requested: _____

Requesting records from (facility/Dr's office): _____
Phone number: _____ Fax number: _____

AUTHORIZATION: I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Re-disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following conditions: _____

This information may be disclosed and used by the following individuals or organizations:

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I have read the above Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient / Parent / Guardian or Authorized Representative Date

Printed name of Authorized Representative Relationship / Capacity to patient

Address and telephone number of authorized representatives

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Notice of Privacy Practices Acknowledgement

By signing this form, you will consent to our use and disclosure of your protected health information (PHI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in treatment directly or indirectly
- To obtain payment for services provided to you through third-party payers
- To conduct normal healthcare operations such as quality assessments, etc...

I have received/been offered a copy of the above-named office's Notice of Privacy Practices (NOPP) containing a detailed description of the uses and disclosures of my PHI.

We reserve the right to change our privacy policy practices as described in our NOPP. If we change our privacy practices, we will issue a revised NOPP, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

I understand that I have the right to revoke consent at any time by giving us written notice of my revocation submitted to our office. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had the full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities, and healthcare options.

Printed name

Patient or Guardian signature

Date

OFFICE USE ONLY _____ Patient refused to sign

Signature of Office Manager

Date

