



REGISTRATION INFORMATION

PATIENT DETAILS

Name _____ Date _____
 Last First Middle
 Address _____
 Street City State Zip
 Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security # _____ Age _____ Birth date _____ Sex: Male Female
 Driver License # _____ Marital Status: Single Married Widowed Separated Divorced
 Employer _____ Occupation _____
 Employer Address _____ Phone _____

SPOUSE / GUARANTOR DETAILS

Name _____ Birth date _____
 Last First Middle
 Address _____
 Street City State Zip
 Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security # _____
 Employer _____ Occupation _____
 Employer Address _____ Phone _____
 Who is responsible for this account _____ Relationship to patient _____

INSURANCE DETAILS

Do you have medical Insurance? Yes No
 If Yes, Name of Primary Insurance _____
 Policy # _____ Group # _____ Co-pay _____
 Name of Secondary Insurance _____
 Policy # _____ Group # _____ Co-pay _____
 Medicare # _____ Medicaid # _____
 In case of Emergency, who should be notified _____
 Relationship _____ Phone _____
 Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Jacinto Medical Group,
 Name of Insurance Company
 all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

 (Signature of Insured/Guardian)

 DATE

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jacinto Medical Group for any services furnished me by that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA - 1588 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or the supplier agrees to accept the charge determination to the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

 BENEFICIARY SIGNATURE

 DATE



Patient Consent and Acknowledgment Form for Use and Disclosure of Protected Health Information

I hereby give my consent for Jacinto Medical Group, P.A. (JMG) , Jacinto Medical Corporation (JMC), and /or Baytown Urgent Care, Ltd.(BUC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided to me by JMG, JMC, and/or BUC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. JMG, JMC, and/or BUC reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Cathy Rouse, Office Manager at 2800 Garth Road, Baytown, Texas or by calling (281) 425-3800** for further information.

With this consent, JMG, JMC, and/or BUC may call my home or other alternative location and leave a message on voice mail or in person in reference to my items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, JMG and/or JMC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, JMG, JMC, and/or BUC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that JMG and/or JMC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices and consenting to allow JMG, JMC, and/or BUC to use and disclose my PHI to carry out TPO.

Furthermore, I understand that JMG, JMC, and/or BUC have an electronic medical records system, which entails all of my private healthcare information. Within this electronic system, there is a function to include a digital photograph on each patient's chart. This photograph is solely used as to identify the patient upon reviewing the patient's chart. I hereby consent to JMG, JMC, and/or BUC and his or her assistants as necessary to photograph myself as the patient on record and to download onto my electronic medical chart.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If you do not sign this consent, or later revoke it, JMG and/or JMC may decline to provide treatment to me. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Signed by: _____
Signature of Patient or Legal Guardian Date Relationship to Patient

Printed Patient's Name Print Name of Legal Guardian, if applicable

Signature of JMG/JMC Authorized Representative Date

Consent to Treat

I hereby authorize and direct JMG, JMC, and/or BUC and his or her assistants as necessary to perform quality care, to perform the following procedures/treatment upon me:

Medical Care Visits Procedure/Treatment: _____

The nature and purpose of this procedure, alternative methods of treatment, and potential risks and complications listed below have been fully explained to me, including the following: _____ procedure/ treatment(s) upon me.

I acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the outcome of this procedure and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Print Name _____ **Date of Birth** _____

Signature _____ **Date** _____

Witness _____ **Date** _____

If the patient is a minor or has a legally designated representative:

Print Patient Name _____ **Date** _____

Representative Signature _____



Patient Financial Policy

Purpose:

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions, regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard you complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or you health insurance carrier, full payment is due at the time of service. For your convenience, we accept cash, check, MasterCard, Visa, American Express, and Discover.

Your Insurance:

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service.
If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
In the event that you health care plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receive of a statement from our business office.
We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody of payment.

I have read and understand the financial policy of the practice, and I to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient

Signature of Patient or Responsible Party

Date

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Jacinto Medical Group, P.A., Jacinto Medical Corporation, and/or Baytown Urgent Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Jacinto Medical Group, Jacinto Medical Corporation, and/or Baytown Urgent Care, Ltd. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Jacinto Medical Group, Jacinto Medical Corporation, and/or Baytown Urgent Care on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorization.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

Witness Signature

Date



**AVOIDING BREACHES OF CONFIDENTIALITY
THE ANSWERING MACHINE
OR
SPOUSE/IMMEDIATE FAMILY MEMBER**

If you have a telephone answering machine or voice mail system, staff may have the opportunity to leave a message for you. These messages may contain confidential information regarding your condition or the fact that you are a patient. People other than you may hear these messages.

____ Yes, the doctor's office may leave a message on my answering machine/voice mail.

____ No, no messages are to be left.

There may be times when your spouse or and immediate family member will call to request your test results, or ask questions regarding your health.

____ Yes, the doctor's office may discuss my medical conditions with the names listed below.

____ No, do not discuss my medical condition.

Please Print Name

Signature

Date



NEW PATIENT INFORMATION SHEET

OFFICE VISIT POLICY

If you are a new patient, we welcome you to Jacinto Medical Group. Our goal is to give you the most efficient and proper care. For existing patients, we thank you for your loyalty and hope we have and will continue to provide you with the best care. We ask that you arrive to every appointment at least 10minutes ahead of time. This will allow us to get you check in and verify your insurance, if need be. We do verify insurance information for all new patients and every 6 months thereafter. Please be prepared to show your insurance card at the time of each visit.

If you are calling in to schedule an appointment, please be prepared to confirm your current address, phone #, and date of birth. They will also confirm your current insurance information. .

WALK-IN CLINIC

For your convenience, if you are in need of medical attention due to an acute problem. We do have a Physician Assistant (PA) on staff that would provide the necessary care under the supervisor of JMG physicians on site. The clinic is opened 8:00AM - 11:30AM and 2:00PM - 4:30PM. This is on a walk-in basis, so please remember, you could wait an hour or so, but we strive for quick, yet personal attention.

REFILL POLICY

If a refill is needed, please allow us 24 hours notice to obtain approval from your physician. Please have the pharmacy send the refill request Electronically via Surescripts or Fax us at 281-425-3992. Routine medication refills will be filled from 8:30AM - 3:00PM weekdays only.

PATIENT MEDICAL QUESTIONS

If you have any questions regarding your medical care, please call our office during office hours (8:00-5:00) at 281-425-3800. You will then be transferred to the appropriate nurse's phone. If voice mail picks up, leave a message and the nurse will return your call in a timely matter. If it is an emergency, please state the problem, and we will have one of our staff members deliver the message to the nurse directly. If you have an emergency after hours, weekends, or holidays, you can contact the answering service at 713-935-2339. They will then page our on call physician for your call to be returned.

PATIENT ASSISTANCE PROGRAMS

We do offer a patient assistance program in our office for the patients that qualify for financial aide in obtaining their medications. We do this through www.needymeds.com. You may also go to www.needymeds.com for all the proper forms needed. If you are on this program and need refills, please call 3 weeks prior to your medication running out.

APPOINTMENT CONFIRMATION

We now have an electronic call system that will verify your scheduled appointment. Please listen to the message and press the appropriate button to confirm your appointment.

CANCELLATIONS

If you are unable to your appointment, please give us 24-hour notice so that we may fill that appointment time.

Patient Signature

Date



Patient Name: _____ Date of Birth: _____

Gender: _____ Referring Physician: _____ Family Physician: _____

Allergies (Medications & food): _____

Surgical History (Please fill in the answer bubble for any past surgeries)

- | | | |
|--|--|---|
| <input type="radio"/> Appendectomy (<i>Appendix removal</i>) | <input type="radio"/> Total Hysterectomy (<i>Uterus & Ovaries</i>) | <input type="radio"/> Partial Hysterectomy (<i>Only Uterus</i>) |
| <input type="radio"/> Nephrectomy (<i>Kidney removal</i>) | <input type="radio"/> Hernia Repair (<i>Groin or umbilical</i>) | <input type="radio"/> Hiatal Hernia (<i>Stomach</i>) |
| <input type="radio"/> Colon Surgery | <input type="radio"/> Cholecystectomy (<i>Gall Bladder removal</i>) | <input type="radio"/> Lung Biopsy/Surgery |
| <input type="radio"/> Prostate Surgery | <input type="radio"/> Thyroidectomy (<i>Thyroid removal</i>) | <input type="radio"/> Bladder Suspension |
| <input type="radio"/> Heart valve replacement | <input type="radio"/> Stent placement in the heart (<i>PTCA</i>) | <input type="radio"/> Heart Bypass surgery (<i>CABG</i>) |
| <input type="radio"/> Pacemaker placement | <input type="radio"/> Hip Replacement (<i>Rt or Lt or both</i>) | <input type="radio"/> Knee Replacement (<i>Rt / Lt or both</i>) |
| <input type="radio"/> Carotid Artery Surgery | <input type="radio"/> Breast biopsy/lump removal | <input type="radio"/> Mastectomy (<i>Breast removal</i>) |
| <input type="radio"/> Tubal Ligation | <input type="radio"/> C-Section | <input type="radio"/> Oophorectomy (<i>Ovary removal</i>) |
| <input type="radio"/> Knee Surgery (<i>Rt or Lt or both</i>) | <input type="radio"/> Foot Surgery (<i>Rt or Lt or both</i>) | <input type="radio"/> Neck surgery |
| <input type="radio"/> Back Surgery | <input type="radio"/> Carpal Tunnel Surgery | <input type="radio"/> Cataract Surgery |
| <input type="radio"/> Tonsillectomy (<i>Tonsil removal</i>) | <input type="radio"/> Adenoidectomy (<i>Adenoid Removal</i>) | <input type="radio"/> Other Orthopedic (<i>Joint</i>) Surgery |
| <input type="radio"/> Gastric Bypass Surgery | <input type="radio"/> Gastric Banding | <input type="radio"/> Gastric stapling |
| <input type="radio"/> Hemorrhoidectomy (<i>Hemorrhoid removal</i>) | <input type="radio"/> Polyp removal | <input type="radio"/> Vasectomy |
| | | <input type="radio"/> Other: _____ |

Past Medical History (Please fill in the answer bubble for the medical issues that apply to you)

Cardiovascular (Heart Problems)

- | | | |
|---|---|--|
| <input type="radio"/> Coronary Artery Disease (<i>Plaque in the arteries</i>) | <input type="radio"/> Arrhythmias (<i>Irregular Heart Rate</i>) | <input type="radio"/> Heart Valve disease |
| <input type="radio"/> Hyperlipidemia (<i>High Cholesterol</i>) | <input type="radio"/> Hypertension (<i>High Blood Pressure</i>) | <input type="radio"/> DVT (<i>Clot in the legs/arms</i>) |
| <input type="radio"/> Peripheral Vascular Disease (<i>Poor circulation in the legs</i>) | <input type="radio"/> Abdominal Aortic Aneurysm | <input type="radio"/> Myocardial Infraction (<i>Heart Attack</i>) |
| <input type="radio"/> Cerebrovascular Accident CVA (<i>Stroke</i>) | <input type="radio"/> Transient Ischemic Attack TIA (<i>Mini strokes</i>) | <input type="radio"/> Heart Failure CHF |
| <input type="radio"/> Hypotension (<i>Low Blood pressure</i>) | <input type="radio"/> Rheumatic Heart Disease | <input type="radio"/> Cardiomyopathy (<i>Heart muscle disease</i>) |
| | | <input type="radio"/> Atrial Fibrillation |

Pulmonary (Lung Problems)

- | | | |
|---|---|--|
| <input type="radio"/> Asthma | <input type="radio"/> Chronic Obstructive Pulmonary Disease COPD | <input type="radio"/> Bronchitis |
| <input type="radio"/> Sleep Apnea | <input type="radio"/> Pulmonary Embolism (<i>Clot in lungs</i>) | <input type="radio"/> Pulmonary Fibrosis |
| <input type="radio"/> Allergic Rhinitis | <input type="radio"/> Sarcoidosis | |

Gastroenterology (Stomach & intestine Problems)

- | | | |
|--|--|--|
| <input type="radio"/> Ulcers | <input type="radio"/> GERD (<i>Heartburn/reflux</i>) | <input type="radio"/> Hiatal Hernia |
| <input type="radio"/> Irritable Bowel Syndrome | <input type="radio"/> Diverticulitis/ Diverticulosis | <input type="radio"/> Gallstones |
| <input type="radio"/> Pancreatitis | <input type="radio"/> Hepatitis B | <input type="radio"/> Hepatitis C |
| <input type="radio"/> Alcoholic Hepatitis | <input type="radio"/> History of colon polyps | <input type="radio"/> Femoral Hernias (<i>Groin hernias</i>) |
| <input type="radio"/> Fatty Liver | <input type="radio"/> Constipation | <input type="radio"/> Hemorrhoids |
| <input type="radio"/> Ulcerative Colitis | <input type="radio"/> Chron's disease | <input type="radio"/> Hepatitis A |



OCCUPATIONAL MEDICINE

CITY OF BAYTOWN WELLNESS CLINIC

2800 Garth Road, Baytown, TX 77521 * Tel:(281) 425-3868 *Fax:(281) 425-3896

Liver Cirrhosis

Endocrinology (hormone problems)

Diabetes type 2 (*High Blood Sugar*)

Hypothyroidism (*Low Thyroid Hormone*)

Hyperparathyroidism (*High parathyroid Hormone*)

Impaired Fasting Glucose (*Pre-Diabetes*)

Hypoglycemia (*Low Blood Sugar*)

Insulin Resistance

Obesity

Polycystic Ovarian Syndrome

Diabetes type 1

Hyperthyroidism (*High functioning thyroid*)

Cushing Syndrome

Gestational Diabetes (*Diabetes during pregnancy*)

Hematology (*Blood Disorders*)

Iron Deficiency Anemia

Sickle Cell Anemia

Leukemia

Thalassemia Major/ Minor

Bleeding Disorders

Currently on Blood thinners

Neurology (*Brain & Nerve problems*)

Headache

Migraines

Seizures

Tremors

Alzheimer's Disease

Parkinson's Disease

Meningitis

Bell's Palsy

Memory Loss

Carpal Tunnel Syndrome

Lumbar Radiculopathy (*Low back pain going down the legs*)

Cervical Radiculopathy (*Neck pain going down to arms*)

Peripheral Neuropathy (*Nerve pain*)

Spinal Stenosis (*Narrowing of space in the spinal cord*)

Disc disease

Fibromyalgia

Sciatica

Shingles

Herniated Disc

Obstructive Sleep Apnea

Multiple Sclerosis

Psychiatry/ Rheumatology/Other

Depression

Anxiety Disorder

Mental Retardation

Alcohol Abuse

Drug Abuse

Tobacco Abuse

Bipolar Disorder

ADHD – Hyperactive / Inattentive

Systemic Lupus Erythematosus

Osteoarthritis

Gout

Rheumatoid Arthritis

Glaucoma

Attention Deficit Disorder

Sleep changes

Insomnia

Joint Problems

Cataracts

Osteoporosis / Osteopenia

Hip Fracture

Eating Disorders

Urology/Nephrology/Gynecology (*Bladder/Kidney/Prostate/Breast/Female Organs Problems*)

Incontinence

Renal Failure / dialysis

Polycystic Kidneys

Kidney stones

STI Sexually transmitted Infection

Sexual problems

Fibroids (*Benign uterine tumors*)

Dysmenorrhea (*Irregular Painful periods*)

Breast lumps

Genital Herpes

Endometriosis

Abnormal pap smears in the past

Menopause

Urinary tract infections

Benign Prostatic Hypertrophy (*Large Prostate*)

Erectile Dysfunction

Menorrhagia (*Heavy periods*)

Miscarriage

Prostate Cancer

Brain Cancer

Bone Cancer

Testicular Cancer

Thyroid Cancer

Lung Cancer

Colon Cancer

Rectal Cancer

Ovarian Cancer

Uterine Cancer

Breast Cancer

Skin Cancer

Head & Neck Cancer

Pancreas Cancer

Cervical Cancer

Advance Directives

Radiation

Chemotherapy

Other: _____



OCCUPATIONAL MEDICINE

CITY OF BAYTOWN WELLNESS CLINIC

2800 Garth Road, Baytown, TX 77521 * Tel:(281) 425-3868 *Fax:(281) 425-3896

Illicit Drug Use: Currently using Former user Never used illicit drugs

Please fill the information below **if** you are a current or former user. What types of drugs do/did you use?

Heroin cocaine crack marijuana meth

Piercings & Tattoos: Do you have any piercings or tattoos? Yes No
(other than ears)

Marital Status: Single married Divorced Separated Widowed

Children? How many children do you have? 1 2 3 4 5 6 7 8 9 None

Exercise Yes No If **NO** skip to the next question

How long? 10-15 mins 20-30 mins 30-45 mins 45 mins or more

How often? Less than 2 times a week 3-4 times/week 5-6 times/week 7 days a week

Education: Grade School High School/GED Vocational/Tech
 Junior College Undergraduate College Graduate Degree

Employment Status Full time employment Retired Unemployed Not employed outside home
 Part-time employment Full time student Part-time Student

Occupational Exposure: Asbestos Flourine/Flourides/Benzene Coal Dust
 Radiation Sulfur dioxide cyanides Organic solvents
 Pesticides/Insecticides Tuberculosis Physical Work Shift work

Health Maintenance (Please list the last time you had the following testing/immunizations done)

Bone Density Test (screening for osteoporosis) (month/year) _____

Mammogram (screening for breast cancer) (month/year) _____

Pap smear & Pelvic exam: (screening for cervical and ovarian cancer) (month/year) _____

Colonoscopy (Screening for colon cancer) (month/year) _____

Rectal Exam (Screening for prostate/colon cancer) (month/year) _____

TDaP (Immunization for Tetanus,diphtheria, pretussis) (year) _____

Pneumococcal vaccine (Immunization for pneumonia) (year) _____

Zoster Vaccine (Immunization for Shingles) (year) _____