Lakeside
FAMILY HEALTH CARE

**Elizabeth Vu, DO**

# Patient Consent and Release Forms

## CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY

The patient agrees to general medical treatment by Lakeside Family Health Care and understands and consents to the review and use of his/her medical records by our office. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to, that the patient is responsible for all fees, including remainder of deductibles, regardless of insurance coverage. It is customary to pay for services when rendered, unless other arrangements have been made in advance.

## INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Lakeside Family Health Care to furnish information concerning my medical condition and treatment thereof to my insurance carriers. I also assign insurance benefits to be paid on my behalf to Lakeside Family Health Care by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by Lakeside Family Health Care. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked by me, in writing.

**AUTOMATED CALLS**: I consent to receive automated phone calls regarding appointments, including patient portal communication. ___ **YES** ___ **NO**

**MEDICATION HISTORY:** I consent that my medication history may be downloaded from Sure Scripts to properly manage my care. ___ **YES** ___ **NO**

**VACCINE HISTORY:** I consent that my vaccines may be downloaded from IMMTRAC through the Texas Department of Health Services (DSHS). ___ **YES** ___ **NO**

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**Signature** **Date of Birth** **Date**

**Lakeside Family Health Care**
**6701 Heritage Pkwy, Suite 140, Rockwall, TX 75087**
**Phone: 972-460-3500 Fax 972-460-3501**

## NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may use and disclose, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Information Portability and Accountability Act of 1996 ( HIPPA)

## OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with this important information. For a complete guide of the privacy practices of our office regarding your health information rights, please review the notebook in the waiting room. If you would like a copy to retain for yourself please request this from our front desk staff.

I acknowledge that I have been presented with the Notice of Privacy Practices as well as the Office Protocol and understand my responsibilities.

**Signature** **Date of Birth**

**Signature of Patient or Legal Representative** **Date**

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## AUTHORIZATION FOR MEDICAL RECORDS

I hereby authorize: _____

Phone: _____ Fax: _____

to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____

**Print Patient Name** **Date of Birth** **Social Security Number**

**Description of information to be released:**

_____

_____

Purpose of the use and/or disclosure: **CONTINUATION/CO-ORDINATION OF CARE**

The health information described herein shall be released to:

**Lakeside Family Health Care**
**6701 Heritage Pkwy, Suite 140**
**Rockwall, TX 75087**

**Phone: 972-460-3500 Fax: 972-460-3501**

I further understand that I may revoke this authorization at any time by notifying you in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient Date

Lakeside
FAMILY HEALTH CARE

**Elizabeth Vu, DO**

# Patient Registration Form

Name: _____
(Last) (First) (Middle)

Name you prefer to be called: _____

Date of Birth_____/_____/_____ Social Security Number_____ Sex: Select

Marital Status _____ Dominant Hand _____ Language Preferred _____

E-mail Address: _____

Phone: Work_____ Home_____ Cell_____

Mailing Address_____

City, State, Zip (+4) _____

Emergency Contact Name_____ Phone Number_____

Emergency Contact/Relationship to Patient_____

Whom shall we thank for referring you to our office? _____

**INSURED PARTY INFORMATION (if different from patient information)**
Insured Party Name: _____

Date of Birth_____/_____/_____ Social Security Number_____ Sex: Select

**PREFERRED PHARMACY:**
Pharmacy Name: _____Phone Number _____

Address _____

**Lakeside Family Health Care**
**6701 Heritage Pkwy, Suite 140, Rockwall, TX 75087**
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## DISCLOSURE AUTHORIZATION

As stipulated by the HIPAA privacy rule, patients have the right to control how and to whom their protected medical information is given. Please instruct below how you would like the staff at Lakeside Family Health Care to contact you.

**I wish to be contacted in the following manner:**

☐ OK to leave message with detailed information at home
☐ OK to leave message with call back number only at home

☐ OK to leave message with detailed information at work
☐ OK to leave message with call back number only at work

☐ OK to mail to my home address

☐ OK to communicate messages & results through the portal

**WHOM TO CONTACT**

In order to further protect your privacy, we will only disclose and/or discuss your healthcare information to members of your family, or others close to you, if you authorize us to do so.

Therefore, if you permit Lakeside Family Health Care to disclose information related to your medical condition(s) please list their information below:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

☐ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____

Printed Patient Name Date of Birth

_____

Signature of Patient or Legal Representative Date

**Lakeside Family Health Care**
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# Lakeside Family Health Care

Medical Questionnaire

Name _____ Date _____

**Past Medical History:**

_____

**Past Surgical History:** _____

**Hospitalization Other Than Surgery:** _____

**Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)**

| Drug Name | Dose | Drug Name | Dose | Drug Name | Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Allergies to Medications, X-Ray Dyes, or Other Substances** ☐ **No** ☐ **Yes**
(If yes, please list name of medicine and type of reaction)

| | | |
|---|---|---|
| | | |
| | | |
| | | |

**Family History:** Has any member of your family (including parents, grandparents and siblings) ever had the following?

| Illness | Which family member? | Age when diagnosed |
|---|---|---|
| Cancer (describe type) | | |
| Hypertension (high blood pressure) | | |
| Heart Disease | | |
| Diabetes | | |
| Strokes | | |
| Mental disease (anxiety, depression, etc.) | | |
| Drug or alcohol addiction | | |
| Glaucoma | | |
| Bleeding diseases | | |
| Other | | |

**Immunization history — Have you had?**

Hepatitis B Vaccine ☐ No ☐ Yes When?_____
Hepatitis A Vaccine ☐ No ☐ Yes When?_____

Pneumovax immunization? ☐ No ☐ Yes When?_____
Tetanus immunization? ☐ No ☐ Yes When?_____

**Review of Systems:** Check (✓) symptoms you currently have or have had in the past year.

Date of last PSA

_____

❒ Date of last menstrual period _____
❒ Date of last Pap Smear _____
❒ Date of last mammogram _____
❒ Date of last bone density _____
❒ Date of last colonoscopy _____ Pregnancies____ Birth____ Miscarriage____

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**Prevention**

| | | | |
|---|---|---|---|
| Do you wear seat belts? | ☐ Yes | ☐ No | If no, why not? _____ |
| Do you wear a bike helmet? | ☐ Yes | ☐ No | ☐ N/A |
| Do you exercise regularly? | ☐ Yes | ☐ No | If yes, type, duration and number of times per week? _____ |
| Do you smoke? | ☐ Yes | ☐ No | If yes, how many packs per day? _____ |
| Do you drink alcoholic beverages? | ☐ Yes | ☐ No | If yes, how much per week? _____ |
| Do you drink coffee? | ☐ Yes | ☐ No | If yes, how many cups per day? _____ |
| Do you drink tea? | ☐ Yes | ☐ No | If yes, how many cups per day? _____ |
| If there is a gun in your home, do you keep it unloaded and out of children's reach? | ☐ Yes | ☐ No | ☐ N/A |
| Do you use drugs? (marijuana, cocaine, crack, etc.) | ☐ Yes | ☐ No | If yes, explain: _____ |
| Have you ever engaged in any activity which has put you at risk of getting AIDS? | ☐ Yes | ☐ No | If yes, explain: _____ |
| Do you wish to be tested for AIDS? | ☐ Yes | ☐ No | |
| Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? | ☐ Yes | ☐ No | If yes, explain: _____ |
| Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? | ☐ Yes | ☐ No | |
| Do you ever feel afraid of your partner? | ☐ Yes | ☐ No | ☐ N/A |
| Do you have a "living will"? | ☐ Yes | ☐ No | |
| Do you have a donor card? | ☐ Yes | ☐ No | |

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**Signatures**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ Date

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient