Memorial Clinical Associates, P.A.
16001 Park Ten Place, Suite 300 Houston, TX 77084 Office: (713) 407- 3000
PATEINT INFORMATOIN FORM PAGE 1

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER

STREET ADDRESS Circle whether PERMANENT or TEMPORARY	CITY	STATE	ZIP	HOME PHONE - INCLUDE AREA CODE ( )

PATIENT'S OCCUPATION	Circle whether **LEFT RIGHT HANDED**	NAME OF EMPLOYER (OR SCHOOL)	MARITAL STATUS D - S - M - W - SEP

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	EMPLOYER PHONE - INCLUDE AREA CODE ( )

SPOUSE'S NAME	SPOUSE'S ADDRESS (If different from patient)	SPOUSE PHONE - INCLUDE AREA CODE ( )

SPOUSE'S EMPLOYERS NAME, ADDRESS, CITY, STATE, ZIP	SPOUSE'S SOCIAL SECURITY NUMBER	SPOUSE EMPLOYER.PHONE ( )

PERSON TO CALL IN CASE OF EMERGENCY	RELATIONSHIP TO PATIENT	HOME PHONE ( )	BUSINESS PHONE ( )

YOUR EMAIL ADDRESS (NO CONFIDENTIAL PATIENT INFORMATION WILL GO THROUGH EMAIL)	

ALL STUDENTS AND/OR MINORS (UNDER 18) MUST FILL IN SECTION BELOW

MOTHER'S NAME ☐ CHECK IF RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE, ZIP	HOME PHONE ( )

MOTHER'S EMPLOYER'S NAME, ADDRESS, CITY, STATE, ZIP	MOTHER'S SOCIAL SEC.	MOTHER'S EMPLOYER PHONE ( )

FATHER'S NAME ☐ CHECK IF RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE, ZIP	HOME PHONE ( )

FATHER'S EMPLOYER'S NAME, ADDRESS, CITY, STATE, ZIP	FATHER'S SOCIAL SEC.	FATHER'S EMPLOYER PHONE ( )

ALL PATIENTS MUST COMPLETE INFORMATION BELOW

DESCRIBE ILLNESS OR INJURY: (If injury, describe how occurred.)	TYPE OF ACCIDENT AUTO FALL WORK OTHER	IF FALL - WHERE DID YOU FALL?	DATE OF ACCIDENT/ONSET

Patient **TREATED** at or **REFERRED** by any of the following for current problem? (Circle all that apply)	**HOSPITAL (IN-PATIENT)**	**EMERG ROOM**	**"WALK-IN" FACILITY**	**PRIMARY CARE DR.**	**OTHER**

NAME OF YOUR FAMILY/REFERRING DOCTOR	YOUR DOCTORS ADDRESS	YOUR DOCTORS TELEPHONE # ( )

YOUR INSURANCE INFORMATION - ALL PATIENTS MUST COMPLETE

DRAW **ONE** CIRCLE AROUND PRIMARY INSURANCE CARRIER	**MEDICARE**	**HMO**	**PPO**	**TEXAN PLUS**	**NONE**	DEPENDENT CHILD COVERED BY: Circle which): 1 or 2 parents

PRIMARY CARRIER (NAME, SEND CLAIMS TO ADDRESS)

PRIMARY INSURANCE ID#:	GROUP NUMBER:

NAME OF POLICY HOLDER:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER	PATIENT'S RELATIONSHIP TO INSURED: (Circle which) SELF SPOUSE CHILD OTHER

ADDRESS OF POLICY HOLDER	CITY	STATE	TELEPHONE (INCLUDING AREA CODE) ( )

SECONDARY CARRIER (NAME, SEND CLAIMS TO ADDRESS)

SECONDARY INSURANCE ID#:	GROUP NUMBER:	POLICY HOLDER NAME:	DATE OF BIRTH	SOCIAL SECURITY

PARENTS/GUARDIANS: I HEARBY GIVE PERMISSION TO THE PHYSICIANS OF Memorial Clinical Associates, P.A., TO EXAMINE AND TREAT MY MINOR CHILD. SIGNED:	**NAME (PRINTED):**
TODAY'S METHOD OF PAYMENT (Required; please circle which) **CASH - CHECK - CREDIT CARD**	**DRIVER'S LICENSE NUMBER**

PREVIOUS PATIENT YES NO	IF YOU HAVE BEEN A PREVIOUS PATIENT, WHICH DOCTORS HAVE YOU SEEN? Hitchins Franco Jefferies Hughart Levins Pohil Gidvani Schultz Tenaro Hodge Marquez	HOW DID YOU HEAR OF OUR PRACTICE?

FORM UPDATED: 4-1-2018

PMC Reorder #1002

Memorial Clinical Associates, P.A.
16001 Park Ten Place, Suite 300 Houston, TX 77084
Office: (713) 407 3000 Fax (713) 461-3476

FINANCIAL RESPONSIBILITY

Thank you for choosing a **MEMORIAL CLINICAL ASSOCIATES, P.A.** physician as your health care provider. We are committed to your satisfaction. Please assist us in meeting your expectations by reviewing the Financial Policy below. The following are the financial policies and guidelines for Memorial Clinical Associates. Please read carefully before signing and do not hesitate to ask any questions you may have.

FORMS:
You will be asked to complete a registration form, which will include your home address, telephone number, social security number as well as the address and telephone number of your insurance company, if applicable. Insurance Company information can generally be obtained from a card provided to the company's insured member, and we make a copy of the card for our records. We also request a copy of your driver's license or other picture identification to include in your record to insure accuracy of your medical records.

FORMS OF PAYMENT:
For your convenience, we accept cash and checks, as well as many credit cards. We must have a copy of your driver's license to accept checks.

OFFICE VISITS:
All office charges are payable at the time the service is rendered. For your convenience, we will provide you with a receipt, documenting the charges for your visit, which you may use to file for reimbursement with your insurance carrier and/or secondary insurance.

Memorial Clinical Associates, P.A. participates in many managed care plans and will be happy to submit insurance claims to your primary insurance company.

As a courtesy, however, the patient will be responsible for filing to their secondary insurance. **Any co-payment, co-insurance percentage, deductibles for which you are responsible or co-payments that cannot be billed to patient, must be paid at the time of service.** It is your responsibility, before the physician you will be seeing renders services, to make sure your insurance covers the services provided.

Please be prepared to show your insurance card and driver license on your initial visit. We are required by insurance companies to verify insurance at each visit therefore please be prepared to show your insurance card at each visit (**if a patient ever has any insurance change, it is the patient's responsibility to provide the new information and insurance card). If this information is not provided BEFORE the visit, the patient will be responsible for the charges incurred for any dates of service prior to the new information being given.**

Some insurance companies do not cover all services performed in our office (i.e. Preventive care, routine exams, immunizations, etc…) The patient is therefore responsible for charges denied by their insurance as "not a covered benefit". If you have met your deductible please bring proof of meeting your deductible. Please let us know when you call to make an appointment of any changes in your insurance coverage or plan. It will be your responsibility to make payment for any service not covered by your insurance company. If benefits and eligibility cannot be verified prior to service, you will be required to pay for service in full. Any charges denied by your insurance carrier would be your responsibility.

FINANCIAL RESPONSIBILITY FOR MINORS
Unless prior arrangements have been made, charges for a minor child seen in the office will be the responsibility of the adult accompanying the minor child.

HOSPITAL FEES
If you are responsible for your doctors fees while in the hospital, payment arrangements may be made by calling our Business Office at (713) 407-3045 or FAX us at (713) 407-3040. In the event you have insurance for hospitalization, all fees for hospital services will be filed with your insurance company upon discharge from the hospital. Any deductible or co-payment will be due when invoiced by **Memorial Clinical Associates, P.A.**

QUESTIONS
If you have any questions concerning charges, filing insurance claims, or billing please call our Business Office at (713) 407-3045 or FAX your questions to (713) 407-3040.

I authorize **Memorial Clinical Associates, P.A.** to file my medical claims to my insurance, and release medical information necessary to process any claim. I authorize payment of medical benefits **to Memorial Clinical Associates, P.A.** I assume responsibility for payment of my account.

I have read and understand the above policies of **Memorial Clinical Associates**, **P.A.** and by signing below I agree to the above stated terms.

I, the Guarantor, have read and agree to the terms regarding payments and payment responsibility.

Signature: ______________________________ **Date:** ______________

Print Name: ______________________________ **Chart Number:** ______________

(To be completed by office)

Witness Name(Print): ______________________________

INSURANCE FINANCIAL RESPONSIBILITY

I understand that my primary will be filed, and if no payment is made within 45 days, I will be responsible for the balance.

____
Signature

I hereby authorize the clinic, as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made **to Memorial Clinical Associates, P.A**., and authorize the clinic to submit claims on my behalf for any bills or services furnished to me. I understand that by filing claims for me as the patient, **Memorial Clinical Associates, P.A.** is performing a service, not a claim requirement by law.

I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier.

If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

______________ ______________________________
Date Signature

First Date of Service______________

Patient Name ______________________________

Home Phone ( ) ______________ Work Phone ( ) ______________

Nearest Relative (outside of home) ______________ Phone ( ) ______________

This document represents an agreement between **MEMORIAL CLINICAL ASSOCIATES, P.A.** and the undersigned. If you have insurance, we will file your claim as a service to you. In the event your insurance does not pay the expected amount, you will be responsible for any remaining balance on your account, in addition to the amount required at the time of service.

____
Patient's or Responsible Party's Signature

____
Witness Signature

Memorial Clinical Associates, P.A.
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PATIENT CONTACT PERMISSION FORM Page 4

This information will allow us to contact you in regards to all medical results, inquiries and office/medical related issues.

Please list telephone numbers that we may use to contact you:

1. ____ (□ Home - □ Work - □ Cell - □ Other: ____________)
2. ____ (□ Home - □ Work - □ Cell - □ Other: ____________)
3. ____ (□ Home - □ Work - □ Cell - □ Other: ____________)

In the event Memorial Clinical Associates are unable to reach you concerning your issues related to this office and/or your treatment, may we leave a message on:

1. Home Answering Machine? YES __________ NO__________
2. Work Voice Mail? YES __________ NO__________
3. Cellular Voice Mail? YES __________ NO__________

If you have provided a work telephone number for us to contact you, and you are unavailable, may we leave a message with your receptionist/operator to have you return the office's call? YES __________ NO__________

Please list the names of any person(s) to whom you give us permission to discuss anything concerning your medical status (i.e.: relative, spouse, friend.)

IF THE NAME IS NOT LISTED, WE WILL NOT DISCUSS OR RELEASE ANY INFORMATION

Name______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

Patient Name: ____ Date: ________________

Signature: ____ Relationship (if not patient): ________________

THIS DOCUMENT WILL EXPIRE 1 YEAR FROM SIGNATURE DATE

Memorial Clinical Associates, P.A.

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT Page 5
(LAST PAGE – PATIENT COPY)

I understand that part of the provision of healthcare services, *Memorial Clinical Associates*, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization deserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.), and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that *Memorial Clinical Associates* and I must:
    a. agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and
    b. agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________	______________________________
(PATIENT'S NAME PRINTED)	DATE
______________________________	______________________________
PATIENT'S SIGNATURE (OR GUARDIAN, IF MINOR)	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
______________________________	______________________________
WITNESS (OPTIONAL)	DATE

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Patient Authorization for Publication of Patient Survey Information – Page 6

1. I, ______________________________ ("Patient") authorize Memorial Clinical Associates, P.A. ("Provider") to disclose any information I include in any Provider patient satisfaction surveys, including my initials and my medical diagnosis, if I include these items as part of the survey.

   Account #: ____________________ Date of Birth: ____________________________

2. The Information is to be disclosed to visitors to Provider's website + URL (http://www.memorialdocs.com).

   The purpose of the disclosure is for the publication, on Provider's website + URL (http://www.memorialdocs.com), by Provider, of Patient comments that Patient has included in any patient satisfaction surveys, including the Patient's initials and medical diagnosis.

3. Dates of Treatment: From: __________________________ To: ________________________

4. If included as part of the commentary I provide in the patient satisfaction survey, I give specific authorization to disclose the following information:

   - ☐ HIV test results
   - ☐ Documentation of AIDS diagnosis
   - ☐ Drug and alcohol abuse treatment records
   - ☐ Psychiatric/Mental Health treatment records

5. I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the Provider in writing.

6. The Provider may not condition the provision of treatment or payment for my care on my signing this authorization. The information to be released by this authorization may be re-released by the person or organization that receives it and my no longer be protected by Federal or Texas privacy regulations.

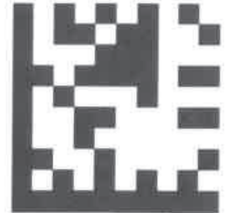
7. Unless revoked earlier, this authorization expires in one year unless I specify another time: ____________________

8. I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the information as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

______________________________	______________________________
Signature of Patient (or Patient Representative)	Date
______________________________	______________________________
Printed Name of Patient or Patient Representative	Authority of Representative to Act for Patient (Relationship to Patient)

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2) ADULT CONSENT FORM



(Please print clearly)

Last Name

First Name **Middle Name**

Date of Birth __/__/____ **Gender:** ☐ **Male** ☐ **Female**

Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7). The ImmTrac2 Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry, ImmTrac2. Once in ImmTrac2, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative):

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

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PAIN DESCRIPTION FORM Page 8

Name: ____ Date:_______________________

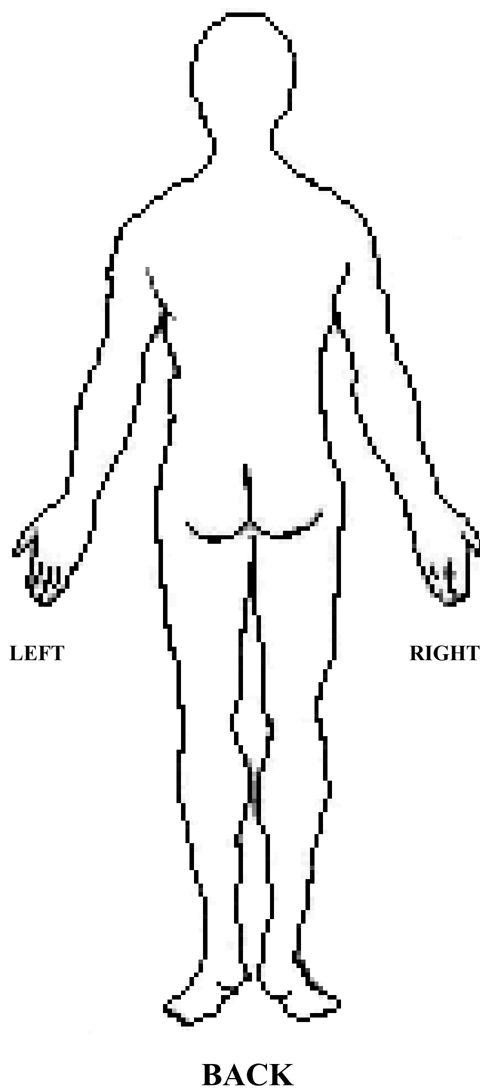
Using the symbols shown below, mark the area on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw your face.

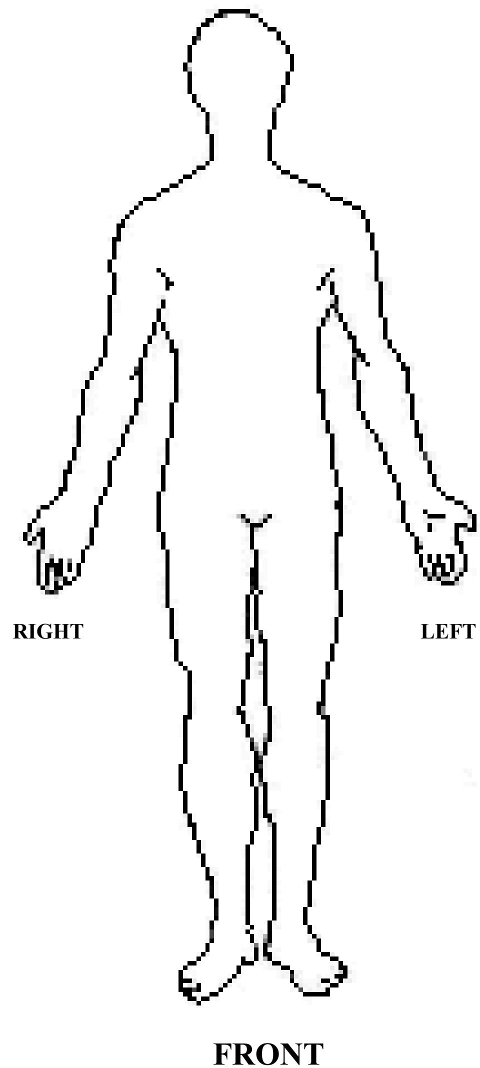
Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
^ ^ ^	= = =	O O O	X X X	/ / /	+ + +

If you are experiencing symptoms other than what is listed, please describe your symptoms:

____

____





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PATIENT HEALTH QUESTIONNAIRE Page 9 (10 & 11)

Patient Name: ______________________________ Chart#: ____________________

Date of Birth: ____________ *Age:* ____________ *Sex:* ________ *Marital Status:* ____________________

PLEASE MARK X NEXT TO THE CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

- ☐ AIDS
- ☐ ALCOHOLISM
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ APPENDICITIS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLEEDING DISORDER
- ☐ BREAST LUMP
- ☐ BRONCHITIS
- ☐ BULLIMIA
- ☐ CANCER
- ☐ CATARACTS
- ☐ CHEMICAL DEPENDENCY
- ☐ CHICKEN POX: WHEN_____
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ GLAUCOMA
- ☐ GOITER
- ☐ GONORRHEA/CHLAMYDIA
- ☐ PACEMAKER
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HERPES
- ☐ HIGH CHOLESTEROL
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV POSITIVE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MEASLES
- ☐ MIGRAINE HEADACHES
- ☐ MISCARRIAGES
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PROSTATE PROBLEM
- ☐ PSYCHIATRIC CARE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ STROKE
- ☐ SUICIDE ATTEMPT
- ☐ THYROID PROBLEM
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ TYPHOID FEVER
- ☐ ULCERS
- ☐ VAGINAL INFECTIONS
- ☐ VENERIAL DISEASE
- ☐ MULTIPLE SCLEROSIS
- ☐ OTHER ____________________

HAVE YOU EVER HAD SURGERY? IF SO, LIST OPERATIONS AND DATES:

____

____

DO YOU HAVE ALLERGIES TO MEDICATIONS? IF SO, PLEASE LIST:

____

____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING AND HOW OFTEN?

____

____

FAMILY HISTORY: AGE HEALTH PROBLEMS CAUSE OF DEATH (If applicable)

FATHER: ____

MOTHER: ____

HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING?

Condition		
TUBERCULOSIS	☐ YES OR ☐ NO	RELATIVE: ____________
HEART DISEASE	☐ YES OR ☐ NO	RELATIVE: ____________
HIGH BLOOD PRESSURE	☐ YES OR ☐ NO	RELATIVE: ____________
ALCOHOLISM	☐ YES OR ☐ NO	RELATIVE: ____________
KIDNEY DISEASE	☐ YES OR ☐ NO	RELATIVE: ____________
DIABETES	☐ YES OR ☐ NO	RELATIVE: ____________
STROKE	☐ YES OR ☐ NO	RELATIVE: ____________
EPILEPSY	☐ YES OR ☐ NO	RELATIVE: ____________
MENTAL ILLNESS	☐ YES OR ☐ NO	RELATIVE: ____________
ALLERGIES	☐ YES OR ☐ NO	RELATIVE: ____________
CANCER	☐ YES OR ☐ NO	RELATIVE: ____________

REVIEWED/DATE:

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PATIENT HEALTH QUESTIONNAIRE Page 10

Today's Date: ____________________

GENERAL

HAVE YOU EVER SMOKED CIGARETTES? ☐ YES OR ☐ NO, WHAT TYPE AND HOW LONG? ____________________

DO YOU DRINK ALCOHOL? ☐ YES OR ☐ NO, WHAT TYPE AND HOW OFTEN? ____________________

DO YOU USE DRUGS (MARIJUANA, COCAINE, ETC.)? ____________________

WEIGHT LOSS OR GAIN? ____________ WEAKNESS: __________ FATIGUE: __________ FEVER: __________

WHEN WAS YOUR LAST PHYSICAL EXAMINATION? ____________________

HOW MUCH CAFEINE (COFFEE, TEA, COLA) DO YOU DRINK PER DAY? ____________________

HAVE YOU EVER HAD YOUR CHOLESTEROL CHECKED? __________ WHEN/WHAT LEVEL: ____________________

HAVE YOU EVER HAD YOUR STOOL CHECKED FOR BLOOD? __________ WAS IT POSITIVE? ____________________

SKIN

RASH: ☐ LUMP: ☐ SORES: ☐ ITCH OR DRY: ☐ HAIR OR NAIL CHANGES: ☐

HEAD

HEADACHES: ☐ HOW OFTEN? ____________________

EYES

BLURRY VISION: ☐ PAIN: ☐ REDNESS: ☐

EARS

RINGING: ☐ DIZZINESS: ☐ PAIN: ☐

NOSE AND SINUSES

BLEEDING: ☐ PAIN: ☐ SORE OR ULCER: ☐ HOARSENESS: ☐

NECK

LUMP OR SWELLING: ☐ PAIN: ☐

BREAST (FEMALE)

SELF EXAM MONTHLY: ☐ LUMP OR NODULE: ☐ NIPPLE DISCHARGE: ☐

RESPIRATORY

COUGH: ☐ SPUTUM: ☐ COUGH UP BLOOD: ☐ WHEEZING: ☐ PAIN: ☐ SHORTNESS OF BREATH: ☐

CARDIAC

DISCOMFORT: ☐ PRESSURE: ☐ PAIN: ☐ SHORTNESS OF BREATH: ☐

GASTROINTESTINAL

SWALLOWING DIFFICULTIES: ☐ INDIGESTION: ☐ BOWEL HABIT CHANGES: ☐ DIARRHEA: ☐ CONSTIPATION: ☐
ABDOMINAL PAIN: ☐ BLOATING: ☐ STOOL INCONTINENCE: ☐ NAUSEA/VOMITING: ☐

MUSCULOSKELETAL

JOINT OR MUSCLE PAIN: ☐ JOINT STIFFNESS: ☐ BACK PAIN: ☐

NEUROLOGY

FAINTING: ☐ BLACKOUTS: ☐ SEIZURES: ☐ WEAKNESS: ☐ PARALYSIS: ☐ NUMBNESS: ☐ TINGLING: ☐
TREMORS: ☐ INVOLUNTARY MOVEMENT: ☐

HEMATOLOGIC

EASY BLEEDING OR BRUSING: ☐ TRANSFUSION IN PAST: ☐

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ENDOCRINE
HEAT INTOLERANCE: ☐ COLD INTOLERANCE: ☐ EXCESSIVE SWEATING: ☐ EXCESSIVE THIRST: ☐
EXCESSIVE HUNGER: ☐ FREQUENT URINATION: ☐

URINARY
PAIN: ☐ INCREASED FREQUENCY: ☐ URINATE AT NIGHT: ☐ URGENCY: ☐ PAIN WITH THE URINATION: ☐
BLEEDING: ☐ URINE INCONTINENCE: ☐

PSYCHIATRIC
NERVOUSNESS: ☐ TENSION: ☐ MEMORY PROBLEMS: ☐ SLEEP DISTURBANCES: ☐ APPETITE PROBLEMS: ☐

VASCULAR
LEG SWELLING: ☐ LEG PAIN OR CRAMPS: ☐

FEMALE PATIENTS ONLY
AT WHAT AGE DID YOU BEGIN YOUR MENSTRUAL CYCLE? _________ ARE THEY REGULAR? ☐ YES OR ☐ NO

WHEN WAS YOUR LAST PERIOD? _____ FREQUENT MENSES: ▯ YES OR ▯ NO POSTMENOPAUSAL? ☐ YES OR ☐ NO

DO YOU USE BIRTH CONTROL? ☐ YES OR ☐ NO WHICH KIND? ________________ HEAVY MENSES? ☐ YES or ☐ NO

NONMENSTURAL BLEEDING: ☐ BLEEDING W/INTERCOURSE: ☐ HYSTERECTOMY: ☐

WHEN WAS YOUR LAST PAP SMEAR? __________HAS IT EVER BEEN ABNORMAL? ☐ YES or ☐ NO WHEN: _______________

HAVE YOU EVER BEEN PREGNANT? ☐ YES OR ☐ NO HOW MANY TIMES? _______

HOW MANY LIVE BIRTHS HAVE YOU DELIVERED? ________

HOW MANY ABORTIONS OR MISCARRIAGES? ___________

HAVE YOU EVER HAD A CAESAREAN SECTION? ☐ YES OR ☐ NO (IF SO, HOW MANY?) _____________

MALE PATIENTS ONLY
DO YOU HAVE PROSTATE TROUBLE? ☐ YES OR ☐ NO

HAVE YOU EVER HAD A PROSTATE EXAM? ☐ YES OR ☐ NO

DO YOU EXAMINE YOUR TESTICLES FOR TUMORS? ☐ YES OR ☐ NO

HAVE YOU EVER BEEN TOLD YOU HAVE A HERNIA? ☐ YES OR ☐ NO

PENILE DISCHARGE: ☐ PENILE SORE OR ULCER: ☐ PAIN: ☐ HESITANCY: ☐ DRIBBLING: ☐ DECREASE FORCE OF STREAM: ☐

MEMORIAL CLINICAL ASSOCIATES, P.A.
NOTICE OF PRIVACY PRACTICES

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.

EFFECTIVE 09/26/13

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Memorial Clinical Associates, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described

more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

H. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

I. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. With your authorization, we may also send such reminders via email, text message, or our patient portal.

J. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

K. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

L. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

M. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

N. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue

transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

O. **Research.** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

P. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

Q. **Workers' Compensation.** We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

R. **Public Health Risks.** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

S. **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

T. **Legal Matters.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which

we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

U. **Law Enforcement, National Security and Intelligence Activities.** In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

V. **Coroners, Medical Examiners and Funeral Home Directors.** We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

W. **Inmates.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

X. **Marketing of Related Health Services.** We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

Y. **Fundraising.** We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Z. **Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. **Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization.

Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. <u>Right to an Accounting of Disclosures</u>. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. <u>Right to Request Restrictions</u>. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the

medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Memorial Clinical Associates
Attn: HIPAA Officer
16001 Park Ten Place, Suite 300
Houston, TX 77084
713-407-3000

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

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Patient Name: ____________________________________
(Please Print Name)

Patient Date of Birth: ______________________________

SIGNATURES:

Patient/Legal Representative: ______________________________________ Date:________________

If Legal Representative, relationship to Patient: ____

Witness (optional) : ____Date:_______________