New Patient Registration Form

Family Medicine at Sterling Ridge

Patient Information

Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Cell Phone #	Other Phone #	E-mail	
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Driver's License #
Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name (If Applicable)		
Employer Name	Employer Address		
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #

How did you hear about the practice and/or the provider you are seeing today?

- ❑ Family Member _____
- ❑ Established Patient _____
- ❑ Hospital _____
- ❑ ER _____
- ❑ Insurance Listing
- ❑ Physician Referral _____
- ❑ Web Search
- ❑ Location/Drive By

Responsible Party

Complete this section only if the patient is a minor

Responsible Party Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Driver's License #

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City / State / Zip		City / State / Zip	
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City / State / Zip		City / State / Zip	

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Version: 03/15/15

Health Information Sharing & Emergency Contact(s)

Family Medicine at Sterling Ridge

I authorize Family Medicine at Sterling Ridge to share my medical information with the following individual(s)

Name (please print)	Phone

In an emergency I authorize Family Medicine at Sterling Ridge to contact

Name (please print)	Phone

Pharmacy Information

Name: _____

Address: _____

_____

Phone Number: _____

Name: _____

Address: _____

_____

Phone Number: _____

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Consent to Treat & Financial Responsibility

Family Medicine at Sterling Ridge

Consent to Treat

I hereby authorize employees and agents of Family Medicine at Sterling Ridge (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Parent or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to Family Medicine at Sterling Ridge (hereinafter "FMSR") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to FMSR. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of FMSR, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Version: 03/15/15

Family Medicine at Sterling Ridge

Raja Abusharr, MD
Family Medicine at Sterling Ridge
10110 Woodlands Parkway Ste 100
The Woodlands, TX 77382-2902
Phone: (281) 419-6565 | Fax: (281) 419-0808
www.familymedicinesterlingridge.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made

Full Name: _____

Date of Birth: _____ Other Name(s) Used: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____

Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

Information regarding person or entity who can receive and use this information:

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

Email (*Optional*): _____

Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

Include: (*Indicate by Initialing*)

_____ Drug, Alcohol or Substance Abuse Records
_____ Mental Health Records (Except Psychotherapy Notes)
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)

□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other *(Specify)*: _____

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The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:

Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative:

_____ **Date:** _____

If Legal Representative, Relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____

Date: _____