PRIVIA MEDICAL GROUP

1325 Pennsylvania Avenue, Suite 400 | Fort Worth, TX 76104
(817) 250-5900 | Fax (817) 250-5901

PHYSICIAN: **JASON W. ALLEN, M.D.** (BEING SEEN TODAY)

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (MM DD YY DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ___ (ST) _____ (ZIP) (___) _____ (HOME PHONE)

Alt/Cell Phone: (___) _____ Day Phone: (___) _____ Email: _____

Race _____ Language _____ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: or School _____

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ___ (ST) _____ (ZIP)

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ (NAME) _____ (RELATIONSHIP) (___) _____ (EMERGENCY CONTACT #)

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ___ Other _____ (SPECIFY) Resp. Party SS #: _____

Name: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (MM DD YY DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ___ (ST) _____ (ZIP) (___) _____ (HOME PHONE)

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: or School _____

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ___ (ST) _____ (ZIP)

Occupation: _____ (___) _____ (WORK PHONE) (___) (EXT)

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ (DATE OF BIRTH) Spouse's Work Phone: (___) _____ (___) (EXT) Occupation: _____

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (STREET or P.O. BOX) (___) _____ (PHONE)

Co-Pay Amount: (if applicable) _____ _____ (CITY) ___ (ST) _____ (ZIP)

Primary Care Physician: _____

Policy Holder: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) _____ (SS #)

Patient Relationship to Insured Party: Self ___ Spouse___ Child___ Other _____ (SPECIFY)

Employer's Name: _____ _____ (INSURED'S ID) _____ (GROUP NAME AND/OR NUMBER)

Address: _____ (STREET) _____ (CITY) ___ (ST) _____ (ZIP)

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self ___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSURED'S ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident _____ Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgment that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

- If you have health insurance coverage and personally pay, out-of-pocket, in full for medical services provided, you may request that we not submit any information regarding these services to your insurance carrier.
- To request this restriction, notify the front desk of the physician's office. You will be provided with a separate form documenting this request. Please give or send the request to the Practice Team Liaison in this office.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address info1mation.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health info1mation also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided info1mation if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIP AA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIP AA. In any event, the lower of the fee permitted by HIP AA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set.
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIP AA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

Secretary of the U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(877) 696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Jason A. Copling, Privacy Officer
Texas Health Care
2821 Lackland Road, Suite 300
Fort Worth, TX 76116
(817) 740-8400
jcopling@priviahealth.com

This notice is effective on the following date: June 28, 2017.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ○ OK to leave a message with detailed information
  - ○ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ○ OK to leave message with detailed information
  - ○ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birth date

FORT WORTH
COLON & RECTAL
SURGERY ASSOCIATES
Texas Health Care, P.L.L.C.

Patient History - For Dr. Allen's Patients Only

Patient Name: _____ **Date:** _____

Date of Birth: ____/____/____ **Age:** _____ **Height:** _____ **Weight:** _____ **Sex: M F**

Chief Complaint: _____

How long have you had this complaint? _____

Current Conditions: Circle the appropriate answers for each question

Are you having any rectal bleeding?	Yes	No
If yes, is the bleeding bright red or dark red?	Bright red	Dark red
If yes, is the blood mixed with the stool or not mixed with the stool?	Mixed	Not mixed
Do you have any blood on the toilet paper?	Yes	No
Do you have blood in the toilet water?	Yes	No
Do you feel your rectum is falling out of your anus?	Yes	No
If yes, does the rectum go back in spontaneously?	Yes	No
If yes, do you ever have to push the rectum back in manually?	Yes	No
If yes, have you ever been unable to push the rectum back in?	Yes	No
Do you have severe pain around the anus?	Yes	No
Do you feel a ripping at the anus with bowel movements?	Yes	No
Do you have itching/burning at the anus?	Yes	No
Did you ever have anal warts?	Yes	No
Do you have drainage from the anus?	Yes	No
Are you incontinent to solid stool?	Yes	No
Are you incontinent to liquid stool?	Yes	No
Are you incontinent to gas?	Yes	No
In mother, did you have birthing trauma that required stitches?	Yes	No
Do you have abdominal pain or cramps?	Yes	No
If yes, what is the location? _____		
Has anyone in your family had colon cancer at ages less than 50?	Yes	No
Has anyone in your family had colon polyps?	Yes	No
Has anyone in your family had more than 10 colon polyps?	Yes	No
Do you need antibiotics prior to dental procedures?	Yes	No

Patient History-For Dr. Allen's Patients Only

Patient Name: _____ **Date:** _____

Past Medical History (place an X in the box next to your associated medical conditions):

	Diabetes		High cholesterol		Crohn's disease
	Asthma		High blood pressure		Ulcerative Colitis
	Emphysema		Irritable bowel		Colon polyps
	Arthritis		Stomach ulcer		Colon cancer
	Migraines		Kidney stones		Breast cancer
	Anxiety		Enlarged prostate		Uterine cancer
	Depression		Abnormal heart rhythm		HIV
	Hepatitis		Heart valve damage		Prostate cancer
	Diverticulosis		Heart murmur		Glaucoma
	Fibromyalgia		Heart attack		Stroke
	Liver disease		Anemia		Blood clots
	Rheumatic Fever		Chronic back pain		Kidney disease
	Other				

Previous Surgeries (include dates): _____

_____

_____

_____

Medications (please include name, dose, and when taken):

_____ _____

_____ _____

_____ _____

Any Allergies? (please list the medication or substance *and* your reaction):

_____

_____

Are you allergic to latex? Yes No Are you allergic to peanuts? Yes No

Social History:

Do you smoke? Yes No

Have you ever smoked? Yes No

How many years? _____

How many packs per day? _____

Do you take aspirin daily? Yes No

Do you drink alcohol? Yes No

Daily? Yes No

Do you use caffeine? Yes No

Type/quantity/frequency _____

Do you take blood thinners? (i.e. Coumadin, Plavix, Xarelto, Pradaxa, Eliquis) Yes No

Family History (please specify which family member had any of the following conditions):

Colon polyps _____

Ulcerative colitis _____

Familial polyposis _____

Diabetes _____

Heart disease _____

Stroke _____

Colon cancer _____

Crohn's disease _____

Breast cancer _____

Uterine cancer _____

Other cancer _____

Other _____

Patient Name: _____ **Date:** _____

Review of Systems:

Eyes:

Have your eyes turned yellow:	Yes	No
Do you have glaucoma?	Yes	No

Head, ears, nose, throat and neck:

Do you have loose teeth?	Yes	No
Any chronic sinus problems	Yes	No
Any frequent nose bleeds?	Yes	No
Do you have sleep apnea?	Yes	No

Cardiac:

Do your legs ever swell up?	Yes	No
Do you have chest pain?	Yes	No
Does your heart ever flutter?	Yes	No
Do you ever get light-headed?	Yes	No

Lungs:

Do you get short of breath?	Yes	No
Do you have a chronic cough?	Yes	No

Gastrointestinal:

Have you been nauseated recently?	Yes	No
Have you been vomiting recently?	Yes	No
Are you constipated?	Yes	No
Have you been having diarrhea recently?	Yes	No

Genitourinary:

Do you urinate often during the night?	Yes	No
Do you get urinary infections?	Yes	No
Do you have blood in the urine?	Yes	No
Any pain/burning when you urinate?	Yes	No

Neurologic:

Do you have headaches?	Yes	No
Any recent slurring of your speech?	Yes	No
Are you sensitive to light?	Yes	No
Have you ever been temporarily blind?	Yes	No

Integuments:

Any skin ulcers?	Yes	No
Dry skin?	Yes	No
Any breast pain or masses?	Yes	No
Any unusual rashes?	Yes	No

Psychiatric:

Feeling down?	Yes	No
Hearing voices?	Yes	No
Trouble concentrating?	Yes	No

Endocrine:

Gaining weight?	Yes	No
Losing weight (not intentional)?	Yes	No

Hematologic:

Bleeding problems?	Yes	No
Prior blood clots?	Yes	No
Sickle cell disease?	Yes	No

Musculoskeletal:

Difficulty walking?	Yes	No
Do your joints hurt?	Yes	No

Have you had any of the following tests? (If yes, give the approximate date):

Flexible sigmoidoscopy Yes No Date:_____ If yes, by whom?_____

Colonoscopy Yes No Date(s):_____ If yes, by whom/where?_____

If yes, were polyps found? Yes No How many colonoscopies have you had?_____

Barium enema Yes No Date:_____

CT scan of the abdomen Yes No Date:_____

Which pharmacy do you use? _____

Address:_____ Phone number:_____

PRIVIA MEDICAL GROUP

Patient Name: _____ **Date of Birth:** _____

Patient Health Questionnaire (PHQ-9)

Use ✓ to indicate your answer

Over the last 2 weeks, how often have you been bothered by any of the following problems?	***Not at all***	***Several days***	***More than half the days***	***Nearly every day***
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or over eating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in someway				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?				

Future Fall Risk and Plan of Care: If you are 65 years of age or older, it is recommended that you complete a fall risk assessment.

Have you had a fall(s) in the last year? Yes No N/A

If you answered yes, how many? _____ **Did the fall(s) result in an injury?** Yes No N/A

Please visit the American Geriatrics's website for addition information on **Fall Risk Assessments:** http://www.americangeriatrics.org

PRIVIA
MEDICAL GROUP

Patient Name: _____ **Date of Birth:** _____

BMI Screening: When your Height and Weight are entered into our Electronic Health Record, your Body Mass Index (BMI) is calculated automatically. If you BMI is considered above or below normal, we are required to give you information pertaining to a healthy lifestyle of diet and/or exercise. We recommend you visit the Center for Disease Control's Website for more information: http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Pneumonia Vaccination Status: If you are 65 years of age or older, it is recommended that you get a Pneumococcal vaccination. Have you had a Pneumonia Vaccination? Yes No N/A Approximate date of vaccination? _____

**If no, please talk with your Primary Care Physician about getting one. For more information on the Pneumococcal vaccine please visit the Center for Disease Control's website at http://www.cdc.gov/VACCINes/vpd-vac/pneumo/default.htm

Influenza (Flu) Vaccination Status: It is recommended that you get an influenza vaccination annually. Have you had a Flu Vaccination? Yes Not yet Decline Approximate date of your last vaccination? _____

If no, please talk with your Primary Care Physician or pharmacy about getting one. For more information on the Influenza (Flu) vaccine please visit the Center for Disease Control's website at https ://www.cdc.gov/vaccines/vpd/flu/public/index.html

Breast Cancer Screening: If you are a female 40-69 years of age, it is recommended that you get regular screenings for breast cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had your screening tests. Have you had a mammogram? Yes No N/A Approximate date of your last mammogram?_____ What were the results? Normal Abnormal

If no, please talk to your Primary Care Physician or Gynecologist about ordering a mammogram. For more information on mammograms please visit the American Cancer Society's website at www.cancer.org

Colorectal Cancer Screening: If you are 50-75 years of age, it is recommended that you get regular screenings for colorectal cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had your screening test(s). Have you had a Colonoscopy or Cologuard home test? Yes No N/A Approximate date of your last colonoscopy? _____ What were the results? Normal Abnormal

If no, please talk to your Primary Care Physician about ordering a colonoscopy. For more information on colonoscopies please visit the American Cancer Society's website at www.cancer.org

Tobacco Use: If you are 18 years old or older: Have you *EVER* used any type of tobacco product (including smokeless products)? Please circle: **Never** (If **NEVER**, you are finished) **Current** **Former**

If **CURRENT** or **FORMER**, please answer the following questions to the best of your abilities:

1. Type of tobacco used: _____
2. How much per day: _____
3. Approximate age started: _____
4. Have you ever tried to stop?_____ If yes, approximate age: _____
5. What method did you use to try to stop (if applicable): _____
6. Approximate age stopped successfully (if applicable): _____

Please visit the Center for Disease Control's website for additional information on Tobacco cessation. http://www.cdc.gov/tobacco