FAMILY CLINICS OF SAN ANTONIO

11730 West Avenue
San Antonio, Texas 78216
Telephone: (210) 340-8501
Fax: (210) 340-0129

2115 Pleasanton Rd.
San Antonio, Texas 78221
Telephone: (210) 922-3627
Fax: (210) 922-1184

NEW PATIENT REGISTRATION

PLEASE PRINT

ARE YOU PREGNANT? YES _____ NO _____

Patient Information

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ AGE _____ DATE OF BIRTH _____

M _____ F _____ SOCIAL SECURITY NUMBER _____

OCCUPATION _____ EMPLOYER _____

WORK PHONE _____ WORK ADDRESS _____

Responsible Party

NAME _____ EMPLOYER _____ PHONE NUMBER _____

Person to notify in case of an emergency _____
(Other than someone in your household)

HOME PHONE _____ WORK PHONE _____

IS THIS A WORK RELATED INJURY? _____ YES _____ NO. IF YES, EMPLOYER, NAME, ADDRESS, AND PHONE NUMBER MUST BE LISTED HERE:

EMPLOYER _____

ADDRESS _____

PHONE NUMBER _____ CONTACT PERSON _____

HAVE YOU BEEN TO THIS CLINIC BEFORE? _____ YES _____ NO

HOW DID YOU FIND OUT ABOUT US? _____

_____

_____

Payment is expected at the time of service. A receipt will be given to you in order to help you file to your insurance. If you have any questions, please feel free to speak with us now. Thank you.

WE ACCEPT CASH, CHECK, MASTERCARD AND VISA. PLEASE CIRCLE METHOD OF PAYMENT. IF MEDICAID PLEASE CIRCLE.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR FAMILY CLINICS OF SAN ANTONIO/BULVERDE

Dear Patient,

This notice describes how information about you may be used and disclosed. Please review it carefully. At Family Clinics of San Antonio we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect and how and when we use or disclose that information. This notice was effective April 4, 2003 and applies to all protected health information as defined by federal regulations.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing, medical conditions and providing treatment. For example results of a laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted to staff members.

WE WILL USE YOUR INFORMATION FOR PAYMENT

Your health plan may request and receive information on dates of service the services provided and the medical condition being treated in order to pay for the service rendered to you.

COMMUNICATION WITH FAMILY

Due to the nature of our field we will use our best judgement when disclosing health information to a family member, other relatives or anyone person that is involved in your care or that you have authorized to release this information to.

____ Yes I authorize Family Clinics of San Antonio/Bulverde to disclose my information. (Name:s) of person:s you trust to obtain your medical information and or have access to your medical records use the space below).

____ No, I do not authorize release of my medical information.

_____ _____

Signature Date

Family Clinics of San Antonio

2115 Pleasanton Rd.
San Antonio, Texas 78221

11730 West Avenue
San Antonio, Texas 78216

Personal Injury and Unrelated Medical Services Policy

When a patient is represented by an attorney, our providers are only authorized to evaluate and treat injuries directly related to the accident covered by the attorneys' "Letter of Protection". The Letter of Protection does **NOT** cover any medical care or services related to health condition(s) that are not directly and/or casually related to your case.

If any other health condition(s) is identified and you elect to receive medical care or services for any such unrelated health condition(s), it is our policy to bill these services separately from the personal injury case. Payment arrangements can be made by providing our staff with current health insurance information for billing purposes and/or cash to satisfy the cost of care and services provided. Any remaining balance due for related and/or unrelated care and services will continue being the patients' responsibility. We consider the personal injury and unrelated medical care and services as separate encounters whether or not performed on the same day.

I acknowledge having read and fully understand this policy. Also, all my questions relating to this policy have been answered to my satisfaction.

_____ _____

Patient Signature Date

_____

Patient Name Print

Family Clinics of San Antonio

Dr. Hugo Rojas

Patient Responsibility Agreement for Controlled Substance Prescriptions

By signing below I agree to the following conditions during my treatment at Family Clinics of San Antonio. I understand that breaking this contract may result in my treatment being terminated.

- I understand that benzodiazepines and opioids can interact with other substances especially sedatives; therefore, I will inform my provider of any other medication or drugs I am taking both legal and illegal.
- I understand that these benzodiazepines and opioids are drugs of dependence. The risks of dependence, tolerance, and side effects such as cognitive impairment due to this medication have been explained to me.
- I understand that no replacement or early prescriptions will be provided to me. Looking after my medications and prescriptions is my responsibility.
- I agree to take my medications as prescribed.
- I agree to submit to urinalysis screening as needed as determined by my triage nurse and provider. Refusal to submit a sample upon request will terminate your narcotic prescriptions.
- **I agree to bring the bottles of all the medications prescribed to me to each visit. Medications will be counted and number of refills will be checked.**
- I will NOT request or accept controlled substance medications from any other physician or individuals while I am receiving such medications from this office. I will not give, share or sell my medications to any other person.
- I will participate in all other types of treatment that I am asked to participate in.
- I will take my medication as instructed and not change the way I take it without talking to the doctor or other member of the treatment team.
- I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated immediately, without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. I am responsible for any withdrawal syndrome that may occur due to my misuse of the narcotic medications and/or treatment of my care. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

PATIENT: _____ **DOB:** _____

PATIENT SIG: _____ **MA SIG:** _____

DATE: _____ **PROVIDER SIG:** _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____) _____ **ALT. PHONE** (_____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name FAMILY CLINIC OF SAN ANTONIO
Address 11730 WEST AVE
City SAN ANTONIO State TX Zip Code 78216
Phone (210) 340-8501 Fax (210) 340-0129

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional) Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures 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, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

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 (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

Family Clinics of San Antonio

Initial Evaluation Questionnaire
Evaluacion y Preguntas

Patient Name: _____ Date: _____

(Nombre de Paciente) (Fecha)

Date of Accident: _____ DOB: _____

(Dia de Acidente) (Feche de Nacimiento)

Chief Complaint(s) (Queja Principal):

_____

Were you thr driver or passenger (if passenger, where in the vehicle were you sitting)? (Manejara o era pasajero endonde estaba ud sentada)

_____

Please describe how the accident happened: (Por favor describa los hechos del accidente:

_____

Did the airbags deploy? (Airbags desplegado) Y / N

Did you lose consciusness? (Perdio reconisimiento) Y / N

Did you go to ER? (Fue a la Emergencia) Y / N

What was the name of the hospital? (El nombre de hospital) _____

Have you been seen by any other healthcare providers? (A consultado a otro medico) Y / N

Have you had any Xrays, MRI's or other imaging performed? (Has tenido rayas X, Resonancia Magnetica y Imagenes Fueron realizados) Y / N

Results (Resultados): _____

Were any medications prescribed to you? (A recivido medicamientos) Y / N _____

_____

What is your pain level (Cual es su nivel de dolor)? _____/10 and (y) at its worst (en su peor momento) _____/10.

Please circle all to describe your pain (Encierre todas ias que describanel dolor que siente)

Dull (de aliviar) Ache (dolor) Sharp (agudo) Stabbing (dolor punzante) Burning (ardiente)

Is it Constant or Comes & Goes (Es constante o viene y se va)

Does your pain radiate to other area(s) (su dolor se extiende a otras partes de su cuerpo) Y / N

Where (donde): _____

Do you experience any numbness and/or tingling? (tiene entumesimiento y/o hormigueo) Y / N

Where (donde): _____

Is it Constant or Comes & Goes (Es constante o viene y se va)

Have you experienced headaches since your accident (ha tenido dolor de cabeza) Y / N

Have your headaches improved or resolved (sus dolores de cabeza han mejorados o resueltos) Y / N

Where are your headaches located? (Donde estan localizados tus dolores de cabeza) _____

What is the frequency and duration of your headaches? (que es la frecuencia y duración de sus dolores de cabeza) _____

_____

Have you experience sleep difficulties since the accident? (ha tenido dificultades a dormir desde el acidente) Y / N

Please explain (por favor explique): _____

Are you experiencing any difficulties with physical activities since your accident? (sitting, walking, standing, bending, kneeling, squatting, climbing stairs, overhead reaching, lifting or other (Está teniendo alguna dificultad con las actividades fisicas despues del accidente (sentarse, caminar, estar de pie, agacharse, arrodillarse, ponerse en cuclillas, subir escaleras, alcanzar por encima de la cabeza, levantar objetos u otros)

_____

Have you attended any therapy or other treatments for your injuries from this accident? (Ha asistido a alguna terapia u otro tratamiento para sus lesiones debido a este accidente) Y / N

If Yes, what treatments (si es si, qué tratamientos) _____

Any relief? (sé alivio) Y / N _____

Patient Signature (Firma del Paciente): _____ Date (Fecha): _____