

**PATIENT INFORMATION**

Patient Name _____			Social Security # _____	
Last	First	MI	Date of Birth _____	
Address _____			Home Phone _____	
City _____			Work Phone _____	
Zip _____		County _____		Cell Phone _____
How did you hear about our practice? _____			May we contact you at these numbers? YES _____ NO _____	
Employer _____			Marital Status    single    married	
Address _____			widowed    divorced	
Emergency Contact				
Name _____			Phone(s) _____	
Relationship to patient _____				

**FINANCIAL RESPONSIBILITY**

Name _____		Social Security # _____	
		Date of Birth _____	
Relationship to Patient _____		Home Phone _____	
Address _____		Work Phone _____	
		Cell Phone _____	
Employer _____			
Address _____			

**METHOD OF PAYMENT**

<b>INSURANCE</b>	<b>MEDICARE</b>	<b>MEDICAID</b>	<b>SELF-PAY</b>	<b>TRICARE</b>
Please circle one of the above.				
In order to record accurate information, we will need to make copies of your insurance cards.				

**CONSENT**

I give my consent to be treated by a Nurse Practitioner, who I understand is not a physician. This consent is granted until I withdraw this consent in writing.		
Signature _____	Date _____	Witness _____

VICTORIA NP CLINIC, PLLC  
606 E. Nueces Victoria, TX 77901  
361-575-4100 PH 361-575-4111 FX

PATIENT AUTHORIZATION FORM

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, PRIOR TO BEING SEEN, UNLESS  
PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

FINANCIAL AGREEMENT

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is provided.

A.) **You are responsible** for co-pays, deductibles, non-covered services, co-insurance and items considered 'not medically necessary' by your insurance company.

B.) For unpaid claims over 45 days, it is **your responsibility** to follow up with your insurance company and the balance due is considered due and payable.

2. It is **your responsibility** to notify our front desk staff of any insurance, phone or address changes.

3. **You will be responsible** for any incidents that occur if we are not notified.

PATIENT AUTHORIZATION

1. I authorize Victoria NP Clinic, PLLC to submit insurance claims using my signature on file below.

2. I authorize the release of any medical information necessary to process this assignment on the claim.

3. I authorize payment of medical benefits to be paid directly to Victoria NP Clinic, PLLC for services described on the claim form.

\_\_\_\_\_  
Patient Signature (or authorized representative)

\_\_\_\_\_  
Date

VICTORIA NP CLINIC, PLLC  
606 E. Nueces Victoria, TX 77901  
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Medical Information Consent for Release

I authorize Victoria NP Clinic, PLLC to release any medical or billing information necessary, for treatment, payment or healthcare operations to the following family and friends: (list names and relationships and contact information).

NAME	RELATIONSHIP	TELEPHONE

I give my permission for reminders and messages to be left on my answering machine or with someone at my telephone number.

\_\_\_\_\_  
YES                      NO

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Witness

# HIPAA Notice of Privacy Practices

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VICTORIA NP CLINIC, PLLC  
606 E. Nueces Victoria, TX 77901  
361-575-4100 PH 361-575-4111 FX

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may also be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research Criminal Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the provider's practice has taken action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your provider amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**PATIENT HISTORY**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Do you have an Advance Directive (Living Will)? Yes No Located Where? \_\_\_\_\_

**Past Medical History...Have you ever had:**

YES	NO	Heart Attack, Angina (Pain)	YES	NO	Frequent Headaches
YES	NO	Stroke	YES	NO	Frequent Earaches
YES	NO	Diabetes	YES	NO	Urinary Tract Infections
YES	NO	High Blood Pressure	YES	NO	Irregular, Heavy or Missed Periods
YES	NO	Arthritis	YES	NO	Seizures
YES	NO	Asthma	YES	NO	Anemia
YES	NO	Emphysema, Bronchitis, or Pneumonia	YES	NO	Sexually Transmitted Disease
			YES	NO	HIV or AIDS
YES	NO	Ulcers	YES	NO	Depression / Anxiety
YES	NO	Tuberculosis	YES	NO	Concussion or Head Injury
YES	NO	Cancer	YES	NO	Thyroid Problems
YES	NO	Hepatitis	YES	NO	Other
YES	NO	Broken Bones			

**List operations/hospitalizations you have had:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**When was your last:**

Exam \_\_\_\_\_ Colonoscopy \_\_\_\_\_  
 Chest X-Ray \_\_\_\_\_ EKG \_\_\_\_\_  
 HIV test \_\_\_\_\_ Bone density \_\_\_\_\_  
 TB test \_\_\_\_\_ Tetanus shot \_\_\_\_\_  
 Pneumonia shot \_\_\_\_\_ Flu shot \_\_\_\_\_  
 Hepatitis shots \_\_\_\_\_

**Men:**

Prostate Blood Test \_\_\_\_\_ Exam \_\_\_\_\_

**Women:**

Breast Exam \_\_\_\_\_ Mammogram \_\_\_\_\_  
 Pap Smear \_\_\_\_\_ Any Abnormal? \_\_\_\_\_  
 Last normal menstrual period \_\_\_\_\_  
 Total # pregnancies \_\_\_\_\_ # Live Births \_\_\_\_\_

**Patients Under 10:**

Birth Wt \_\_\_\_\_  
 (Circle one below:)  
 Premie-Overdue-On Time  
 Complications of  
 Pregnancy? \_\_\_\_\_

**List ALL medications you take:** (prescriptions, birth control pills, over the counter, herbal and home remedies)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List allergies to medications and foods you have: What reactions do you have?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History:**

Tobacco use: None \_\_\_\_\_ Packs per day \_\_\_\_\_ Age started \_\_\_\_\_ Chew/Dip \_\_\_\_\_  
 Alcohol use (amt): None \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Less often \_\_\_\_\_ Type of alcohol \_\_\_\_\_  
 Recreational drug use: None \_\_\_\_\_ Type used \_\_\_\_\_ Last used \_\_\_\_\_

PATIENT HISTORY

What grade/year of school have you completed? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Hobbies/Fun? \_\_\_\_\_

Do you have family or a close friend to help you when needed? Yes / No

**Family Medical History:** Please list age and any illness your relatives have. If deceased, please indicate with a (D).

Relative	Age	Medical problems or Cause of Death (high blood pressure, cancer, mental illness, diabetes, heart, stroke, etc.)
Mother		
Father		
Mother's Mother		
Mother's Father		
Father's Mother		
Father's Father		
Brother		
Brother		
Brother		
Brother		
Sister		
Sister		
Sister		
Sister		
Daughter		
Daughter		
Daughter		
Daughter		
Son		
Son		
Son		
Son		

This information is provided to the best of my knowledge and ability.

Signed: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Victoria NP Clinic, PLLC  
606 E Nueces, Victoria, Tx  
77901-5087

361-575-4100 phone  
361-575-4111 fax

**CONSENT TO PHOTOGRAPH**

I \_\_\_\_\_ consent to the use of photographs for use by Victoria NP Clinic PLLC for patient identification purposes. Pictures may also be obtained of any skin disorders or wounds for the purpose of medical documentation and evaluation of progress of such disorders or wound(s). I give this consent voluntarily.

Patient signature: \_\_\_\_\_

Date of signature: \_\_\_\_\_

Witness signature: \_\_\_\_\_

Refusal signature: \_\_\_\_\_