VICTORIA NP CLINIC, PLLC

4206 N Ben Jordan Victoria, TX 77901
Office: 361-575-4100
Fax:361-575-4111

PATIENT INFORMATION

Patient Name:_____
Last *First* *MI*

Address:_____
Street

_____
City *County* *ZIP*

Employer: _____

Address: _____
Street

_____
City *State* *ZIP*

Emergency Contact: _____

_____
Contact Number *Relation to Pt*

SSN #: _____

Date of Birth: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

May we contact you? ☐ Yes ☐ No

Preferred Contact Method
☐ Home ☐ Work ☐ Cell

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

How did you hear about Victoria NP Clinic?
☐ Patient ☐ Friend ☐ Advertisment
Other_____

FINANCIAL RESPONSIBLITY

☐ Check if patient is guarantor

Guarantor Name: _____

Relation to Patient: _____

Address: _____

_____

SSN #: _____

Date of Birth: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

METHOD OF PAYMENT

☐ INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ TRICARE ☐ SELF-PAY

We will copy your insurance card(s) for record accuracy. If changes occur, please provide information and card(s) at your next appointment.

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

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PATIENT AUTHORIZATION FORM

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, PRIOR TO BEING SEEN, UNLESS PREVIOUS ARRANGMENTS 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 the 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

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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, 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

_____
Date

_____
Patient's Name Printed

_____
Witness

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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected heath 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 providers' 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 health care students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to health care 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, Organ Donation, Research Criminal Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement 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 a 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 may 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 right 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 **January 1, 2018.**

We are required by law to maintain the privacy of, and provide individual 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 phone number above.

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

Print Name: _____

Signature: _____

Witness: _____

Date: _____

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PATIENT HISTORY

Name: _____ Social Security #: _____
Do you have an Advance Directive (Living Will) YES/ NO Located where: _____

Past Medical History: Check Applicable

☐	Heart Attack, Angina (pain)
☐	Stroke
☐	Diabetes
☐	High Blood Pressure
☐	Arthritis
☐	Asthma
☐	Emphysema, Bronchitis or Pneumonia
☐	Ulcers
☐	Tuberculosis
☐	Cancer
☐	Hepatitis
☐	Broken Bones

☐	Frequent Headaches
☐	Frequent Earaches
☐	Urinary Tract Infections
☐	Irregular, Heavy or Missed Periods
☐	Seizures
☐	Anemia
☐	Sexually Transmitted Disease
☐	HIV/AIDS
☐	Depression/ Anxiety
☐	Concussion/ Head Injury
☐	Thyroid Problems
☐	Other

List All 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 shot _____

Men:
Prostate Blood Test_____ Exam _____

Women:
Breast Exam _____ Mammogram_____
Pap Smear _____ Any abnormal?_____
Last normal menstrual period_____
Total #of pregnancies ____ # live births____

Patients under 10:
Birth wt _____
Circle on below:
Premie-over due-on time
Complications of Pregnancy?_____
_____

List All Medications you take (prescriptions, birth control pills, over the counter, herbal and home remedies):_____
_____
_____
_____

List All Allergies to medications and food 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 _____

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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 knowledge and ability.

Signed: _____ DOB: _____

Relationship to Patient: _____

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Kerri Pillar, RN, FNP **L. Chris Stines, RN, FNP**

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: _____