CLEAR LAKE
FAMILY PHYSICIANS
1045 Gemini St. Suite 200-B
Houston, TX 77058
(281)486-7900 Fax: (281)286-8110

Patient Demographic Information

Prefix______________ Patient Full Name ____ Suffix______________
Gender______________ Social Security # _______________________ Marital Status____________________
D.O.B. ______________Race (optional)_________________ Ethnic Group (optional)_______________________
Preferred Language (optional)________________________ Primary Care Provider_________________________
Mailing Address ____
City ____ State _________________ Zip ______________
Phone # _______________________ Cell Phone _______________________ Work Phone _______________________
Email Address ____
(We do not sell, or advertise your email address to any other firm – This is for out Patient Portal purposes)

Insurance Information
Primary Insurance Company __________________________________ ID# _______________________
Group# _______________ Primary Insured's Name____
DOB___________ Primary Insured's SSN _________________ Relationship to policy holder_________________

Secondary Insurance Company __________________________________ ID# _______________________
Group# _______________ Primary Insured's Name ____
DOB _____________ Primary Insured's SSN _________________ Relationship to policy holder_______________

Emergency Contact __________________________________ Relationship____________________________________
Phone # _______________________ Cell Phone _______________________ Work Phone _______________________

Pharmacy ___________________________ Pharmacy phone _______________________ Fax ____________________
Address ____

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Please read and sign the following Assignment of Benefits.

I hereby authorize assignment of benefits directly to Clear Lake Family Physicians for all my insurance claims related to services provided to me. I agree to pay all charges that exceed my insurance coverage and/or charges not covered by my insurance carrier.
I understand that copayments, deductibles, and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance carrier. I permit a copy of this authorization to be used in place of the original.

Signature____ Date ____________________

Clear Lake Family Physicians

Patient Authorization for the Use & Disclosure of Protected Health Information

I hereby give my consent to Clear Lake Family Physicians (CLFP) to use and disclose protected healthcare information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I also hereby give my consent for treatment by the physicians of CLFP.

I have the right to review the Notice of Privacy Practices prior to signing this consent and any time thereafter.

With this consent CLFP may do the following: *(Please select yes or no from each statement below)*

- May call my home and leave message on voicemail: Yes ◯ No ◯
- May call my place of employment and leave message on voicemail: Yes ◯ No ◯
- May call my cell phone and leave message on voicemail: Yes ◯ No ◯

Give authorization for review of my medical records to all appropriate clinic personnel regarding clinical trials. (For complete description, please see receptionist for a copy of our Notice of Privacy Practices/HIPAA).

Please list the individuals with whom we may communicate regarding your treatment at CLFP, (i.e. family members, caregivers, etc.). Please list alternative phone numbers for family members if necessary.

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

By signing this form, I am consenting CLFP's use and disclosure of my PHI to carry out TPO. I understand that this form will remain in effect until revoked. I may revoke or change my consent at any time.

______________________________ Patient Name (please print)

______________________________ Responsible Party (please print)

______________________________ Patient (or responsible party) Signature

______________________________ Date

Clear Lake Family Physicians

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.

If you have any questions about this notice, please contact the Privacy Officer for Clear Lake Family Physicians,

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At Clear Lake Family Physicians (CLFP), we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit CLFP, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of CLFP, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Clear Lake Family Physicians is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

CLFP, reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to us or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of How the CLFP, May Use or Disclose Your Health Information:

For Treatment: CLFP may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: CLFP may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointments: CLFP may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification or Communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: Clear Lake Family Physicians may use and disclose information about you as required by law. For example, Clear Lake Family Physicians may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice's Privacy Officer.

Clear Lake Family Physicians
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Phone (281) 486-7900 Fax (409) 286-8110

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer in writing, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights - U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Acknowledgment of Receipt of this Notice

Clear Lake Family Physicians is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:
Clear Lake Family Physicians

____________________________ ____________________________

Patient Name (please print) Responsible Party (please print)

____________________________ ____________________________

Patient (or responsible party) Signature Date

In accordance with the HIPPA guidelines this practice is authorized to discuss my medical information with the following individuals.

Name	Relationship	Telephone

Clear Lake Family Physicians
1045 Gemini St. Suite 200-B Houston, TX 77058
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Financial Policy/Consent for Payment

I understand that my insurance company may or may not pay for services rendered to me by Clear Lake Family Physicians (CLFP). I also understand that I am responsible for copayments, co-insurance amounts, and any in/out of network deductibles that I may owe. I am also responsible for any referrals and preauthorization's required by my insurance carrier(s).

I agree to be 100% responsible for payment if my insurance denies reimbursement for my claims. An authorization, pre-certification, or verification of eligibility is not a guarantee of payment.

All payments will be made to CLFP by cash, check, or a major credit card.

Payment Arrangements and Expectations

Clear Lake Family Physicians requires payment due at the time services are rendered. In the event you need to make special payment arrangements, our policy is to collect payment in-full within three (3) months. If your account becomes delinquent and we are unable to collect your debt, we may transfer your account to an outside collection agency. Should your account be transferred to a collection agency, you will be responsible for any associated collection fees and you may also be discharged from treatment and care from CLFP.

No-Show, Cancelation, and Administrative Fees

There may be a $35.00 fee assessed to your account if you fail to call and cancel your appointment within 24 hours of your scheduled appointment time. There will also be a $35.00 fee assessed to your account if you fail to show up for your appointment.

Our office may also charge the following Administrative Fees:

- Returned checks: $30.00
- Completion of forms: $25.00 minimum
- Medical Records on CD: $25.00 minimum
- Medical Records Printed: $25.00, first 20 pages $0.50 per page thereafter.

The financial and insurance information provided by me to CLFP is true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney fees and cost of collection, in the event of account default. I also authorize CLFP to furnish or obtain any/all information to/from insurance carriers, Social Security Administration (Medicare), the referring physicians, or other agencies to which CLFP refers and designated family members or caregivers concerning my illness and treatments. I authorize my insurance company to send claim payments directly to CLFP. I further understand that this signed policy will remain in effect until revoked.

______________________________ ______________________________
Patient Name (please print) Responsible Party (please print)

______________________________ ______________________________
Patient (or responsible party) Signature Date

Health History

Clear Lake Family Physicians

Patient Name ____ Today's Date _________

Age ___________ Birthdate ____________ Date of last physical examination __________________

What is your reason for visit?____

Patient Comments

____
____
____
____
____
____
____
____
____
____

Allergies

____
____
____
____
____
____

Pharmacy Name:

____

Pharmacy Phone:

____

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Health History

Have you ever had a blood transfusion? ❐ Yes ❐ No If yes, please give approximate dates ___________________

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (√) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Illicit Drugs	
	Alcohol	
	Other	
	Exercise	

Occupational

Check (√) if your work exposes you to the following:

	Stress		Heavy Lifting
	Hazardous Substances		Other

Occupation: ________________________________

Certification

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

________________________________ Signature ________________ Date

________________________________ Reviewed By ________________ Date

NAME: ____________________________　　**ALLERGIES:**

____

List all your medicines including prescription, over-the-counter, vitamins and supplements.

____

Name of My Medicine	How Much Do I Take	When Do I Take It	What Do I Use It For	Physician
XXXXXX Example	*1 tablet 400mg*	*3 Times a day After meals*	*Arthritis*	

The information you need should all be available on the label of your prescription bottle.

Keep this in your purse/wallet and show it to your doctors, pharmacist, or nurse.