WELCOME

New Patient Packet
Genesis Medical Group

PATIENT INFORMATION

Patient's Name _____
Last Name

_____
First Name Middle Initial

Address:_____

City: _____

State: _____ ZIP: _____

Sex: ☐Male ☐Female Birthdate: ____/____/____

SS# _____

Employer _____

Occupation _____

Preferred Language _____

Home Phone Number (_____) _____

Cell Phone Number (_____) _____

Who are you living with?

_____

Marital Status

☐Married ☐Widowed ☐Single
☐Divorced ☐Domestic Partner ☐Separated

Spouse's Name _____

Spouse's Phone Number (_____) _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone Number (_____) _____

Cell Phone Number (_____) _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance

and assign directly to

_____
Name of Doctor

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

For any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary or Personal Representative

_____
Printed Name of Beneficiary or Personal Representative

_____ _____
Date Relationship to Patient

PATIENT HISTORY QUESTIONNAIRE

Primary Care Physician _____

Referring Provider (Who sent you to our practice?) _____

Reason for Visit _____

Pharmacy Information

_____ (_____) _____

Pharmacy Name Pharmacy Phone Number

_____,_____,_____

Address City State Zip Code

Food & Medication Allergies

Allergies	**Reaction**	**Severity**
Example: Penicillin	*Breathing Difficulties*	__ Severe __Moderate __ Mild
		__ Severe __Moderate __ Mild
		__ Severe __Moderate __ Mild
		__ Severe __Moderate __ Mild
		__ Severe __Moderate __ Mild

Current Medications

Medication (Name of Drug)	**Medication Strength**	**Daily Dose**	**Date Started**	**Prescribing Doctor**
Example: Levaquin	*500 mg*	*2 per day*	*01 / 01 / 2021*	*Dr. Sample Smith*
			____/____/_____	
			____/____/_____	
			____/____/_____	
			____/____/_____	
			____/____/_____	
			____/____/_____	
			____/____/_____	
			____/____/_____	

Previous Surgeries / Hospitalizations (Check All That Apply & Year If Known)

☐ Appendectomy
☐ Bone Marrow Biopsy
☐ Bone Marrow Transplant
☐ CABG
☐ Cataract Extraction
☐ Cholecystectomy
☐ Colectomy
☐ Brachytherapy
☐ Breast Biopsy
☐ Colostomy
☐ Craniotomy
☐ Cystectomy
☐ Gastric Volvulus
☐ Hemicolectomy
☐ Hip Surgery
☐ Knee Surgery
☐ Lumpectomy
☐ Lymph Node Biopsy
☐ Lymph Node Dissection
☐ Needle Aspiration
☐ Nephrectomy
☐ Omentectomy
☐ Pneumonectomy
☐ Radical Neck Dissection
☐ Other _____

Male:
☐ Orchiectomy
☐ Prostate Biopsy
☐ Prostatectomy
☐ Radical Prostatectomy
☐ TURP

Female:
☐ D & C
☐ Hysterectomy
☐ Mastectomy
☐ Oophorectomy
☐ Ovarian Cystectomy
☐ TAH
☐ TAH / DSO
☐ TVH

Recent Diagnostic Tests

Specific Type of Study	CAT Scans / X-Ray Date(s)	PET Scans/Bone Scan Date(s)	Ultrasound Date(s)	MRI Date(s)	Medical Facility

Other Hospitals/Urgent Care Facilities Visited: _____

_____

Address/State: _____

Diagnosed Medical Illnesses (Check All That Apply)

☐ AIDS/HIV
☐ Allergies
☐ Anemia
☐ Angina
☐ Arthritis or Gout
☐ Asthma
☐ Irregular Heartbeat
☐ Blood Clots
☐ Cancer
☐ Stroke
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ GERD
☐ Other _____
☐ Hepatitis B
☐ Hepatitis C
☐ High Cholesterol
☐ High Blood Pressure
☐ Irritable Bowel Syndrome
☐ Liver Disease
☐ Kidney Disease
☐ Migraine Headaches
☐ Obesity
☐ Osteoarthritis
☐ Peptic Ulcer Disease
☐ Rental Disease
☐ Seizure Disorder
☐ Thyroid Disease

Health History

	Don't Know	No	Yes	Year	Kind of Cancer or Type of Disease / Condition / Physician's Name
Prior Cancers (Before Current Illness)					
Prior Radiation Treatment					
Prior Chemotherapy					

Reproductive History (Females)

Age at First Period: _____ Age at Menopause: _____ Age of First Pregnancy: _____

Number of Children: _____ Number of Pregnancies: _____ Hormone Use: ☐Yes ☐ No

Pain Information

Have you been experiencing pain? ☐Yes ☐ No Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

How is your pain relieved? _____

Where is your pain located? _____

Symptoms (Circle All That Apply)

Constitutional Symptoms:
Fatigue
Fever
Chills
Weight Loss
Weight Gain
Night Sweats
Generalized Weakness
Poor Appetite
Sleep Disturbances
Hot Flashes
Other: _____

HEENT:
Blurred Vision
Double Vision
Sensitivity to Light
Dry Eyes
Excessive Tearing
Hearing Loss
Ringing in Ears
Mouth Sores
Dry Mouth
Altered Taste
Sinus Tenderness
Nosebleeds
Hoarseness
Other: _____

Respiratory:
Difficulty Breathing
Shortness of Breath
Wheezing
Dry Cough
Productive Cough
Coughing Up Blood
Other: _____

Cardiovascular:
Chest Pain
Palpitations
Swelling
Other: _____

Gastrointestinal:
Nausea
Vomiting
Difficulty Swallowing
Heartburn
Abdominal Pain
Diarrhea
Constipation
Melena/Black Tarry Stools
Blood in Stool/Hematochezia
Other: _____

Genitourinary:
Blood in Urine
Pain with Urination
Urgency to Urinate
Incontinence
Urination at Night
Hesitancy
Frequent Urination
Other: _____

Musculoskeletal:
Bone Pain
Muscle Pain
Back Pain
Joint Pain
Joint Swelling
Limited Range of Motion
Other: _____

Integumentary:
Rash
Itching
Skin Lesions
Other: _____

Neurological:
Headaches
Focal Weakness
Paralysis
Neuropathy/Numbness
Seizures
Speech Impairment
Tremor
Altered Consciousness
Dizziness
Other: _____

Hematologic:
Excessive Bleeding
Spontaneous Bleeding
Excessive Bruising
Spontaneous Bruising
Other: _____

Mental Health:
Anxiety
Depression
Insomnia
Panic Disorder
Other: _____

Cancer Screening (Please Provide Dates for Each or Enter None)

Female:	Last Mammogram:_____	Last Colonoscopy: _____
	Last Pap Smear: _____	Last Bone Density Scan: _____

Male:	Last Colonoscopy:_____	Last PSA Screening:_____
	Last Prostate Exam: _____	

Family History

Do any of your family members have cancer or blood disorders? If so, who and what type?

Family Member	Living Status	Medical Problem / Present Health / Cause of Death
Mother	☐Living ☐Deceased	
Father	☐Living ☐Deceased	
Children	☐Living ☐Deceased	
Brother(s)	☐Living ☐Deceased	
Sister(s)	☐Living ☐Deceased	
Grandmother (M)	☐Living ☐Deceased	
Grandfather (M)	☐Living ☐Deceased	
Grandmother (P)	☐Living ☐Deceased	
Grandfather (P)	☐Living ☐Deceased	
Aunt(s)	☐Living ☐Deceased	
Uncle(s)	☐Living ☐Deceased	
Cousin(s)	☐Living ☐Deceased	
Other: _____	☐Living ☐Deceased	

Tobacco Use

Circle types of tobacco used if applicable: Cigarette/Cigar Chewing Tobacco Vape

☐ Current Everyday Smoker	☐ Current Some Day Smoker	☐ Smoker, Current Status Unknown
☐ Former Smoker	☐ Never Smoker	☐ Smoking Status Unknown

Units/day:_____ Years Used: _____ Pack/Years: _____

Ever tried to quit? ☐ Yes ☐ No Quit: _____ Longest Tobacco Free: _____

Passive Smoke Exposure? ☐ Yes ☐ No Recreational Drug Use: ☐ Yes, Type: _____ ☐ No

Alcohol Use

☐ Yes ☐ No ☐ Formerly (Year Quit: _____)

Type: _____ Frequency: _____ Amount: _____ Last Drink: _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

HIPAA Notice of Privacy Practices

Genesis Medical Group
2255 East Mossyoaks Rd, Suite 500, Spring, TX 77386
281-975-1000

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 condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, 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 physician'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. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician 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 sent to your 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 physician'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 physician. We may also call you by name in the waiting room when your physician 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 requirement, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates. 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 physician or the physician's practice has taken an action in reliance on the 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 purpose of treatments, payments 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 the notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction(s) requested and to whom you want the restrictions(s) to apply.

Your physician is not required to agree to a restriction that you nay request. If your physician 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 physician 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 became 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.

Your signature below is acknowledgment that you have received this Notice of our Privacy Practices and been provided the opportunity to review it:

Print Name: _____ Birth Date: _____

Signature: _____ Date:_____

Genesis Medical Group℠

PATIENT AUTHORIZATION
TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner (Check All That Apply):

☐ **Phone**
- ○ Leave a message with detailed information.
- ○ Only leave a message with callback details.

☐ **Written Correspondence**
- ○ Mail to my home address on file.

PATIENT ONLINE PORTAL

Genesis Medical Group has a convenient, free, easy-to-use Patient Portal you can access online. The Patient Portal is an online tool you can use to easily view and update some of your health/clinical information. The Patient Portal should not be used for emergency questions, concerns, or anything that needs a same day response; for all those inquiries, please contact the office you are seen at. **This portal is separate from the one used by Genesis Medical Group Primary Care Physicians.**

Please check one selection:

☐ **I would like** to be enrolled with Genesis Medical Group's Patient Portal

My email address is _____ (please print)

☐ **I would NOT like** to enroll for the Genesis Medical Group's Patient Portal because…

- ☐ I do not have an email address.
- ☐ I am declining enrollment and do not want to provide my email address.

AUTHORIZED DESIGNEES

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. Understand that the identity of designees must be verified before release of PHI. **These designees may include spouse, family, or friends.**

Authorized Designees:

Name: _____ Relationship:_____ Telephone: _____

Name: _____ Relationship:_____ Telephone: _____

Name: _____ Relationship:_____ Telephone: _____

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke authorization in writing.

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.

_____ _____ _____

Patient/Responsible Party Name Patient/Responsible Party Signature Date

☐ **REVOKE/CANCEL AUTHORIZATION** _____ _____

Patient/Legal Representative Signature Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Genesis Medical Group to: ____ Release to: ____Receive from:

Person or organization	Address
Phone	Fax

Information / Copies from the medical records on:

Patient	Date of Birth	Social Security Number

Dates(s) of Service

Information to be released:

☐ Emergency Room	☐ Radiology Reports	☐ Lab Work	☐ Radiology Films
☐ History and Physical	☐ Drug/Alcohol Program	☐ Pathology Report	☐ Billing Records
☐ Consultations	☐ Psychiatric Information	☐ HIV test results	☐ Cath Lab Films
☐ Operative Reports	☐ Discharge Summary	☐ AIDS Information	

☐ OTHER: _____

This information is being released for the following purpose:

☐ Continued Care	☐ Attorney / Litigation	☐ Insurance	☐ Disability Services

☐ OTHER: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that the action has been taken in reliance on it and that in any event this authorization shall expire (365) days from the date of my signature, unless specified in writing here:

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider, the released information may no longer be protected by federal and/ or state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Signature of Patient or Legally authorized Representative	Date
Relationship to Patient	Date
Print Name of Legally Authorized Representative	Date
Witness- Printed Name/Signature	Date

Genesis Medical Group℠

GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

_____**MEDICAL CONSENT**: I consent to all medical care, treatment, laboratory, imagine, and other medical procedures performed or prescribed by a physician of Genesis Medical Group and his/her designees as directed in his/her judgment.

_____ **PHARMACY CONSENT:** We are now providing a low cost drug options for our patients on specific treatments. This program benefits are available at no cost to you or or your insurance and also include access to additional resources. To be eligible for this program, we simply require your permission to enroll you, which you can grant by initialing.

_____**RIGHT TO REFUSE TREATMENT:** I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

_____**ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices.

_____**ADVANCE DIRECTIVES:** I understand that I have an opportunity to make known my wishes, in writing, regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for healthcare.

_____**RELEASE OF MEDICAL INFORMATION:** I authorize Genesis Medical Group to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to my care/treatment with Genesis Medical Group. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

_____**FINANCIAL AGREEMENT**: I certify that the insurance information that I have provided is accurate, complete, and current and that no other coverage or insurance exists. I understand I am financially responsible to Genesis Medical Group for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. Genesis Medical Group will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles, and co-insurance. I am responsible to pay all copays, deductibles, and patient responsibility at the time of service unless other arrangements have been made in advance.

_____**ASSIGNMENT OF INSURANCE BENEFITS**: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance and any other health / medical plan, to issue payment check(s) directly to Genesis medical Group for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

_____**MEDICARE CERTIFICATION**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Legal Representative to sign this document. I also acknowledge that Genesis Medical Group reserves the right to dismiss me as a patient from Genesis Medical Group.

_____ _____

Patient/Responsible Party Signature Date

Genesis Medical Group℠

ADVANCE DIRECTIVES CONFIRMATION FORM

Under Texas law, you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas, any person age 18 years or older who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

☐ ***YES,*** *I have Advance Healthcare Directives (select all advance directive(s) that you have)*

- ○ Texas Durable Medical Power of Attorney
- ○ Living Will (officially known as the Directive to Physicians and Family or Surrogates)
- ○ Out of Hospital Do Not Resuscitate (DNR)

☐ ***NO,*** *I do not have Advance Healthcare Directives. I understand that I can request more information about advance directives.*

- ○ I have received the information sheet about advance directives.
- ○ I would like additional information about the three advance directives recognized in Texas.

_____	_____	_____
Patient Signature	Patient's Printed Name	Date

For Genesis Medical Group Use Only
Complete this section, if this form is not signed and dated by the patient.

____ Patient Refused to Sign
____ Patient Unable to Sign

_____	_____
Employee Name	Date

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐