Hillcrest Senior Center & Internal Medicine Clinic

2201 MacArthur Drive Suite 100
Waco, TX 76708

Please complete all forms fully and to the best of your ability.
If something does not apply to you please write *N/A* in the field.

Patient Demographics:

Name: _____
Address: _____
Apt: _____ City: _____
State: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Date of Birth: _____
Employer: _____
Social Security Number: _____
Email Address: _____

Sex: Male Female

Marital Status: Married Single Divorced Widowed

Race: White Black/African American American Indian/Alaska Native Asian Declined Other

Ethnicity: Hispanic/Latino Declined Not Hispanic/Latino

Employment Status: Employed Unemployed Student Retired

Emergency Contacts (person you are giving us permission to release your health information to):

Name: _____
Relationship to Patient: _____
Phone: _____

Name: _____
Relationship to Patient: _____
Phone: _____

Guarantor (where the bills will be sent if not self):

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

Date of Birth: _____
Social Security Number: _____
Relationship to Patient: _____
Phone: _____

Primary Insurance Information:

Insurance Company: _____
ID Number: _____
Group Number: _____
Relationship to Patient: _____

Cardholder Name: _____
Date of Birth: _____
Social Security Number: _____

Secondary Insurance Information:

Insurance Company: _____
ID Number: _____
Group Number: _____
Relationship to Patient: _____

Cardholder Name: _____
Date of Birth: _____
Social Security Number: _____

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Narcotics/Controlled Substances Prescription Notice

Our office does not routinely prescribe narcotics on a long term basis, nor do we administer narcotics by injection at the clinic. No narcotic medications are kept on site. Individuals who are seeking "pain killers" for chronic use are hereby advised to seek treatment with an appropriate pain management clinic or, if the pain is severe, with the local emergency department. Narcotic prescriptions will not be refilled after office hours or on weekends.

It is an inherently dangerous practice to receive prescriptions for narcotics and other controlled substances from several physicians at the same time. Therefore, patients who do seek narcotic prescriptions through our office agree that, unless otherwise indicated by our physicians, we are to be the sole prescribing physicians for the patient. Furthermore, patients desiring prescriptions from our clinic agree to grant us permission to contact pharmacies and other physicians in order to ensure compliance with this policy. If we determine that multiple physicians are ordering prescriptions for pain medications, we will immediately cease all orders for such treatments from our office.

Prescription Policy

- The patient will be given a choice to designate a pharmacy to be used (see signature page). All prescriptions should then be filled through this pharmacy only.
- We ask that you contact your designated pharmacy for all refill requests even if you have no refills remaining. Please allow for a 72 hour turnaround time on all prescriptions.
- We do not refill prescriptions on weekends or holidays. Be sure to submit your request before 2:00pm on Thursday for prescriptions you will be out of over the weekend.
- We will not refill prescriptions for patients not seen in the past 6 months by a provider in our office.
- We will not refill prescriptions for patients who have missed appointments until you are seen by one of our providers.
- Prescription requests submitted after 2:00pm will not be called in until the next business day.
- Medications will only be called into the designated pharmacy.
- Medications are to be taken according to directions. No early refills will be granted.
- It is the patient's responsibility to keep medications safe. Lost or damaged medication may not be refilled. If medication is stolen, you must file a police report and submit the number for verification to our office.

ACKNOWLEDGMENT OF PRESCRIPTION POLICIES

I have read and understand the policies of this office regarding prescriptions and nicotine use. I agree to the terms involved in the Prescription and Narcotic Policies and have received a copy of these policies.

_____ _____

Patient/Guarantor Signature **Today's Date**

_____

Relationship to Patient

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Baylor Scott & White HILLCREST MEDICAL CENTER WACO

CONSENT FOR MEDICAL CARE

AUTHORIZATION FOR EXAMINATION AND TREATMENT: I authorize the examination and/or treatment considered necessary, and that the treatments and procedures will be performed by the physicians and/or nurse practitioners of Hillcrest Physician Services. Authorization is hereby granted for such treatments, procedures, administration of local anesthetics, medications, or other treatments as deemed reasonable and medically necessary for care.

ASSIGNMENT OF BENEFITS

INSURANCE BENEFITS: I authorize Hillcrest Physician Services to furnish any information to my insurance company in order to process my claim, including release of medical records as necessary. I understand that my insurance coverage is a contract between myself and the insurance, and I acknowledge that co-payment, deductible, and co-insurance amounts are due at time of service, as stated in my health insurance agreement.

NOTICE OF NON-COVERAGE: I understand that in the event of non-coverage, I am responsible for payment, at time of service, to Hillcrest Physician Services for any service or item provided during treatment. Non-coverage would include uninsured patients, failure to provide proof of insurance coverage, or any services or items not covered by your insurance.

TELEPHONE CONSUMER PROTECTION ACT: I agree, in order for you to service my account or to collect monies I may owe, Hillcrest Physician Services and/or their agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or emails, using any email address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

PAPERWORK: Various paperwork, including but not limited to disability and FMLA forms, may need to be filled out by your physician. If required by your physician, a $25 charge **per set** is due when we receive the paperwork, and we require 48 hours for completion. Many forms cannot be fully completed until after surgery.

PATIENT PRIVACY AND RIGHTS

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been made aware and offered a copy of the Hillcrest Health System's Notice of Privacy Practices related to the handling of patients' private health information.
PATIENT RIGHTS: I understand that I have the right to participate in my plan of care and treatment. I have the right to refuse treatment and be informed of the consequence of such refusal.

_____ _____

Patient/Guarantor Signature **Today's Date**

_____

Relationship to Patient

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PATIENT NAME: _____ **DOB:** _____

PATIENT MEDICAL HISTORY (check all that you currently have and/or have previously had)

HEART PROBLEMS
ÿ Congestive Heart Failure
ÿ Deep Vein Thrombosis
ÿ Heart Attack
ÿ Heart Murmur
ÿ High Blood Pressure
ÿ High Cholesterol
ÿ Neuropathy
ÿ Irregular Heartbeat
ÿ Anemia/Clotting Disorder
ÿ Other: _____

NEUROLOGICAL
ÿ Alzheimer's disease
ÿ Parkinson's disease
ÿ Migraines
ÿ Seizure Disorder
ÿ Stroke
ÿ Dementia
ÿ TIA
ÿ Other: _____

PSYCHOLOGICAL
ÿ Anxiety
ÿ Depression
ÿ Schizophrenia
ÿ Bipolar

GASTROINTESTINAL
ÿ Cirrhosis
ÿ Gastric Ulcer
ÿ GERD (acid reflux)
ÿ Rectal Bleeding
ÿ Hemorrhoids
ÿ Diverticulitis
ÿ Crohn's Disease/Ulcerative Colitis
ÿ Other: _____

ENDOCRINE PROBLEMS
ÿ Diabetes Type I (Juvenile)
ÿ Diabetes Type II (Adult Onset)
ÿ Hyper/Hypothyroid Disorder
ÿ Hyper/Hypocalcaemia
ÿ Other: _____

CANCER (type, stage and location)
ÿ _____
ÿ _____

URINARY PROBLEMS
ÿ Kidney Infection
ÿ Kidney Stones
ÿ Kidney Disease/Failure
ÿ Prostate Enlargement
ÿ Other: _____

LUNG PROBLEMS
ÿ Asthma
ÿ COPD
ÿ Emphysema
ÿ Pneumonia
ÿ Pulmonary Embolism
ÿ Sleep Apnea
ÿ Allergies
ÿ Other: _____

MUSCULOSKELETAL
ÿ Osteoarthritis
ÿ Osteoporosis
ÿ Rheumatoid Arthritis

INFECTIONS
ÿ Hepatitis B
ÿ Hepatitis C
ÿ HIV +

FAMILY MEDICAL HISTORY (please list medical conditions and/or cause of death)

Mother: _____
Father: _____
Maternal Grandmother: _____
Maternal Grandfather: _____
Paternal Grandmother: _____
Paternal Grandfather: _____
Siblings: _____
Children: _____

SURGICAL HISTORY (please list all previous surgeries, year performed, and surgeon)

_____
_____
_____

SOCIAL HISTORY

Marital Status: _____
Number of children: _____
Occupation: _____

FEMALE PATIENTS ONLY

Are you currently pregnant? Yes No
Date of your last period: _____
Age of menopause: _____

SUBSTANCE USE (past and present)

Tobacco:	Yes	No	**If Yes:** Amt/Week _____	Age started/stopped _____
Alcohol:	Yes	No	**If Yes:** Amt/Week _____	Age started/stopped _____
Drugs:	Yes	No	**If Yes:** Amt/Week _____	Age started/stopped _____

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Baylor Scott & White HILLCREST MEDICAL CENTER WACO

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name	Date of Birth	Medical Record Number
Street Address	City, State Zip	Telephone Number

Please release this information to:

Individual/Organization Name	Telephone Number	
Baylor Scott & White Health @ **Hillcrest Internal Medicine**	**254-202-7130**	
Street Address	City, State Zip	Fax Number
2201 MacArthur Drive Suite 100	**Waco, TX 76708**	**254-202-7149**

Please release the following information for these treatment dates: _____
Please provide information in this format: ☐ Paper copies ☐ CD ☐ USB Drive
Include this information (if applicable): ☐ Alcohol/Drug ☐ Genetics ☐ HIV/AIDS ☐ Mental Health

Purpose: Continued Care

☐ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary)
☐ EKG/EEG/EMG reports
☐ Immunization records
☐ Laboratory reports
☐ Radiology reports
☐ Radiology images

Previous Physician Contact Information:

_____
_____
_____
_____

I understand the following:

§ I am not required to sign this authorization to obtain treatment.

§ If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to redisclosure by the recipient.

§ I may revoke this authorization in writing at any time except to the extent the healthcare provider has already relied on this authorization. To revoke my authorization, I will provide a written request to _____.

This authorization will expire in 180 days or at the date or event specified here: _____

Signature of Patient or Legal Representative	Printed Name of Patient or Legal Representative	Date
	Representative's Authority to Act for Patient	

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Medical Disclosure Authorization

Patient Name: _____ Date of Birth: _____

I hereby authorize the Hillcrest Internal Medicine and Senior Center to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___X-ray, MRI, or CT Results ___Medications

___Lab Tests/Results ____ Summary of Medical Record ___Care Plan

___ Other (specify): _____

Indicate Confidential Information: ____Mental Health ___HIV information ____ Alcohol/Drug Information

Information may be given to or discussed with:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

□ _____ (specify expiration date or event)

□ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the Hillcrest Spine Center.
- This authorization is giving the Hillcrest Internal Medicine and Senior Center the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment on my providing this authorization.

Signature: _____ Date: _____

Relationship to patient (if signed by personal representative of patient): _____

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MEDICATION LIST

(Please include all prescriptions, over-the-counter medications, vitamins, and herbal supplements)

Medication	Dosage	Times per Day	Reason for Taking

PREFERRED PHARMACY

_____

ALLERGIES

Check if you are allergic to the following:

Penicillin:_____ Codeine:_____ Sulfa Drugs:_____ Latex:_____ Iodine:_____

Please list all other foods and medications you are allergic to and your reaction to them:

Allergy	Reaction