Hong Xiao, M.D.
Board Certified Family Physician

PATIENT INFORMATION

Last Name: ___________________________First Name: ____________________________ MI: _____ Suffix: ________

Mailing Address: ____ Apt/Suite ___________________

City: _____________________________ State: _____________________ Zip: __________________________________

DOB: ____________________________ Male ❒ Female ❒ Social Security # ___________________________________

Email: ___________________________________ Cell: _____________________❒ Single ❒ Married ❒ Other: _____

Pharmacy: _____________________________ Address: ____

Current Medications

Prescribed:	**Over the Counter:**	**Vitamins/Supplements:**
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Allergies: ____

*** We reserve the right to perform urine drug tests or any similar test
to determine appropriate use of controlled substances. You have the right to decline the test ***however***
some of your medications may ***not*** be able to be prescribed.

Emergency Contact: ____ Phone: ______________________________

Emergency Contact's Relationship to Patient: ____

NOTE: The emergency contact listed above may have authorization to call in for you to book, cancel or reschedule your appointments, request prescription, ask information about your account or file, should you be unable to do so.

❒ I authorize the contact listed above to obtain access of my medical records as they see fit in accordance with HIPAA guidelines.

____ _________________
Signature Date

4100 Fairway Drive, Suite 320, Carrollton, Texas 75010
Phone: 972.236.7608 Fax: 972.236.7606
E-mail: info@fairwayfamilydoctor.com
Website: fairwayfamilydoctor.com

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Please read and initial each statement below and sign at the bottom.

Patient HIPPA Information

____I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

____I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practice and Office Protocol handout, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Insurance Authorization and Assignment of Insurance Benefits

____I hereby authorize Fairway Family Medicine to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided by Fairway Family Medicine. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by me.

Consent for Treatment and Understanding of Financial Responsibility

____I agree to general medical treatment and consent to the review and use of my medical records by Fairway Family Medicine. All professional services rendered are charged to me, the patient. I am aware that the patient is responsible for all fees, including remainder of deductible, regardless of insurance coverage. It is customary to pay for services when rendered, unless other arrangements have been made in advance. I understand my responsibility as a patient of Fairway Family Medicine.

Patient Signature: ____ Date: ____________________

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