

Complete Healthcare Services PA

315 W Houston

Jasper, Texas 75951

PHONE: 409 384 3430 FAX: 409 383 0571

PATIENT REGISTRATION

Patient Information

Name:	SSN:
Address:	Date of Birth:
	Sex:
	Language
Home Phone:	Race:
Cell Phone:	Ethnicity:
Work Phone:	Marital Status
Email Address:	Preferred method of contact: Printed Electronic Phone/Text

Insurance Information

Primary Insurance	
Subscriber Name:	Subscriber DOB:
Subscriber ID:	Group Number:
Secondary Insurance	
Subscriber Name:	Subscriber DOB:
Subscriber ID:	Group Number:

Emergency Contact

Emergency Contact Name:	Phone Number:
Relationship:	DOB:

Pharmacy Information

Pharmacy Name:	Phone Number:
Address:	

RX History Consent: I hereby authorize **Complete Healthcare Services, PA** to obtain my previous prescription/medication history through external sources: (Initial)

Health Information Exchange: I hereby authorize **Complete Healthcare Services, PA** to send and receive my health information from other providers within our CommonWell and CareQuality networks, to include but not limited to hospitals and other specialist, upon request. (Initial)

The above information is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to **Complete Healthcare Services, PA**. I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I also understand that I am responsible for any office visit copayment due at the time of services and/or deductibles, additional fees for form processing, returned checks, copying of medical records, and missed appointments that may apply. If this account is assigned to an attorney for collection and/or suit, a copy of the signature is valid as the original.

Patient or Guarantor Signature

Date

Witness Signature

Date

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CONSENT FOR TREATMENT

Initial

I understand various screening/diagnostic procedures may be necessary to diagnose my condition and that I will be given various treatment options following diagnosis. I hereby give Complete Healthcare Services providers and ancillary staff the authority to perform the screening/diagnostic studies deemed necessary and/or the treatment options of my choice.

I understand that Complete Healthcare Services employs the services of mid-level practitioners (Physician Assistants and/or Nurse Practitioners) to assist in patient care. I understand that under certain circumstances the physician will not be available and, as such, I will be offered the services of the PA and/or NP. By circling the answer and my signature below I am indicating my willingness or unwillingness to be treated by a mid-level provider in the event the physician is unavailable. I understand that physician availability is determined by appointment schedule, surgery schedules, emergencies, and/or on-call status. If I present to the clinic without an appointment, I will be offered the services of the PA and/or NP or asked to make an appointment with the physician at another time if no appointment time is available.

* I am willing to be seen by a mid-level provider in the event a physician is unavailable. Yes No

ELECTRONIC PRESCRIBING CONSENT

Initial

Complete Healthcare Services provides electronic prescriptions (E-Prescribing) to pharmacies through SureScripts. E-Prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need or a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective and safe. By signing below, you are indicating you understand the above listed refill policies and authorize Complete Healthcare Services to electronically transmit prescriptions to the pharmacy of your choice, review pharmacy benefit information and medical dispense history as long as you are a patient at this office or until you withdraw that consent.

OUTSIDE SERVICES BILLING

Initial

I understand that certain laboratory studies will have to be sent out to a reference lab, i.e. Quest or LabCorp. This lab will send a separate bill for those studies. I understand that Complete Healthcare Services charges a technical fee for equipment, technicians and other operating expenses. I understand I will be receiving a separate bill from the reference lab for any lab work sent to them.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Initial

I acknowledge I have reviewed this office's Notice of Privacy Practices available on the office website, which explains how my medical information will be used and disclosed. I have been given an opportunity to ask questions, if I do not understand. I understand I am entitled to a copy of this document upon request.

RELEASE OF INFORMATION

I give Complete Healthcare Services permission to release and/or receive protected health information as requested by other healthcare providers in the continuity of my care.

Patient/Guardian Signature

Printed Name

Date

Witness Signature

Printed Name

Date

Age: _____ Date of Birth: _____
Address: _____ Phone
Number: _____ Alternate Phone Number: _____
Name of Insurance: _____ ID Number: _____
Current Primary Care Physician: _____

Specialists-seen within the past 2 years (Cardiologist, Pulmonologist, etc):

Current Medications:

1. _____	11. _____
2. _____	12. _____
3. _____	13. _____
4. _____	14. _____
5. _____	15. _____
6. _____	16. _____
7. _____	17. _____
8. _____	18. _____
9. _____	19. _____
10. _____	20. _____

Current Pharmacy:

Local: _____ Mail order: _____

Medical Problems (circle):

Hypertension Diabetes Heart Disease
Stroke (CVA) Chronic Pain Peripheral vascular disease (PVD)
Anxiety Depression
Cancer (list type): _____

Other Medical Problem (list): _____

Surgeries (Circle):

None Appendectomy Tonsillectomy Cholecystectomy (gallbladder) Hysterectomy: Total or
Partial
Joint replacement (circle joint and side): Hip L/R Knee L/R Shoulder R/L
Cardiac Surgery: CABG / Stent
Other (Please List): _____

Reason for appointment: Establish Care _____ Medication Refill _____ Acute Problem _____
Other (please explain): _____

ALLERGIES: Please list medications and/or food allergies and your reactions

HOSPITALIZATIONS: (DATES AND REASONS, FACILITY)_____

FAMILY HISTORY: Please list any medical conditions of immediate family members and relationship with them.

CONDITION	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

WOMEN:
Pregnancies: _____
Living Children: _____
Date of last Pap Smear: ____/____/____
Date of Last Menstrual Cycle: ____/____/____
Contraception Use?: **Yes** **No** **Type?** _____
Are you currently sexually active?: _____
Date of Last Mammogram: ____/____/____
Self Breast Exams: **Yes** **No**

SOCIAL HISTORY:
Current Tobacco User: **Yes** **No** TYPE OF TOBACCO: _____ Vape User: **Yes** **No**
Packs per day use: _____
What age did you start?: _____ Are you interested in quitting? **Yes** **No**

Current Alcohol Use: **Yes** **No** Type of Alcohol? _____
Drinks per day/week: _____ Are you interested in quitting? **Yes** **No**

COMPLETE HEALTHCARE SERVICES

315 W Houston St
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NO CONTROLLED MEDICATION ACKNOWLEDGMENT

Please carefully read and initial each section of this form. By initialing and signing this form you agree with the terms listed on this form.

_____ I understand that Complete Health Care is not currently accepting any patients that are requiring care for chronic pain. If I am accepted by this practice I understand the physicians/practitioners will NOT prescribe any pain medications for me.

_____ I understand that if I am currently taking any pain medications on a routine basis I will need to be seen by a Pain Management Specialist for these medications to be continued. I also understand that this office will NOT prescribe any controlled medications while I am waiting to be seen by pain management.

_____ In anticipation of a potential change in health care, I give Complete HealthCare authorization to obtain information from my current healthcare provider, pharmacy, and/or state pharmacy database to review my current health status.

_____ I understand that if I am accepted by Complete HealthCare and scheduled to see one of the providers in this practice, I will not be under the physician's care until I am actually seen in the office. If I need any medication refills or urgent care before I am seen in the office I will need to see my current primary care doctor or local ER for treatment.

_____ I understand that completing and submitting this paperwork does NOT guarantee that I will be accepted as a patient by this practice. I further understand that filling out and submitting this form does not constitute a doctor-patient relationship, and does not entitle me to refills, visits, or care by Complete Healthcare Services.

Signature: _____ Date: _____

Printed Name: _____

INTERNAL USE ONLY

Date Received: _____ Initial: _____ Date Reviewed: _____ Initial: _____

Action:

Accepted- _____

Denied:

_____ Condition(s) exceeds our scope of practice

_____ Discrepancy on screening history or data

_____ High Risk – recommend specialty care

_____ Other: _____

Patient Notified:

Date: _____ Appt date/time: _____ Provider: _____ Initial: _____

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PRESCRIPTION REFILL POLICY

- If you are prescribed medications, you will be provided with an initial prescription and refills to last until the suggested follow-up visit. **It is your responsibility** to schedule your follow-up appointment before the prescription runs out to ensure a continued supply of medication.
- Medication refill requests will not be authorized if you fail to keep your follow-up appointments. To give good clinical care patients must be seen on a regular basis.
- Only minor changes in your medication regimen can be made between appointments. If a major change in your medication regimen is needed you will need to be seen by your provider before these changes can be made.
- **We do not accept faxed refill requests from your pharmacist.**
- It may take up to 48 hours for reviewing your medical history and deciding if the requested refill is appropriate. It may take longer due to long weekends and/or holidays.
- Please call your pharmacy to see if your request was processed before calling the office to request the same refill a second time.
- Routine prescription refills will not be provided on the weekends.
- All medications are to be taken as prescribed. If patient takes medication in excess of what is prescribed and runs out of medication early (prior to refill date), the refill will not be authorized until refill date.
- In general, if a patient is already being treated by a pain management physician, all pain medications will need to be managed by the patient's existing pain management specialist.
- Regular blood work is required for all patients on prescription medication, which is necessary for monitoring the safety and effectiveness of the medication. The interval will vary based on the medication prescribed. Patients who do not schedule for their regular intervals of blood work will not have their prescriptions refilled.
- Complete Healthcare Services provides electronic prescriptions (E-Prescribing) to pharmacies through SureScripts. E-Prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need for a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective and safe.

By signing below, you are indicating you understand the above listed refill policies and authorize Complete Healthcare Services to electronically transmit prescriptions to the pharmacy of your choice, review pharmacy benefit information and medical dispense history as long as you are a patient at this office or until you withdraw that consent.

Patient Name: _____ **DOB:** ____/____/____

Patient Representative: _____ **Relationship:** _____

Signature of Patient or Representative: _____ **Date:** ____/____/____

Complete Healthcare Services, PA

Limited/Restricted Patient Authorization for Disclosure of Protected Health Information

Patient Name: _____ SSN: _____ - _____ - _____ DOB: ____ / ____ / ____

Purpose of request: Who will be authorized to receive information about me or be restricted from access to my information)

I authorize the practice to disclose or restrict protected health information, about me, to:

Entity/Person _____ can receive _____ cannot receive _____

Relationship to you: _____ Phone Number: _____

Entity/Person _____ can receive _____ cannot receive _____

Relationship to you: _____ Phone Number: _____

Entity/Person receiving information: _____ can receive _____ cannot receive _____

Relationship to you: _____ Phone Number: _____

Description of Information to be disclosed: I authorize the practice to disclose the following protected health information about me to the entity, person or persons identified above.

_____ Lab Results _____ Medical Imaging _____ Diagnostic Results _____ Billing/Collections
_____ Any and all information in my health record including, but not limited to, the above mentioned,
as well as, diagnosis(es), treatment plans and prognosis.

Expiration or termination of authorization: This authorization will expire one year from the date of your signature below, unless you specify an earlier termination date. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our office manager, in writing, if you decide to terminate the authorization prior to the identified expiration date.

Please list an earlier date of expiration if less than one year ____/____/____.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Office Manager. This can be done in person or by mailing a request to the attention of the office manager at:

Complete Healthcare Services
315 W Houston Street
Jasper, Texas 75951

Disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Complete Healthcare Services.

Patient Signature: _____ Date: ____/____/____

Patient Representative/Guardian: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____