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

Complete Healthcare Services PA

315 W Houston
Jasper, Texas 75951
PHONE: 409 384 3430 FAX: 409 383 0571

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
Jasper Texas 75951

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:_____

COMPLETE HEALTHCARE SERVICES

315 W Houston St.
Jasper, Texas 75951

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 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.

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: **W**ho 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: ___/___ /_____

Complete Healthcare Services

315 West Houston St
Jasper, Texas 75951
409-384-3430

CHILD CONSENT FORM

Date: _____

I, _____ (parent/guardian) authorize the following individuals to provide informed consent for treatment necessary for my child/children:

_____	_____
Name	relationship to patient
_____	_____
Name	relationship to patient
_____	_____
Name	relationship to patient
_____	_____
Name	relationship to patient

Child/Children's names:

_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birt
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Sex: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code § 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in ImmTrac2. Once in ImmTrac2, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction; a physician, or other health care provider legally authorized to administer vaccines, for treating the child as a patient; a state agency having legal custody of the child; a Texas school or child-care facility in which the child is enrolled; and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.
An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder.
For more information, see Texas Health and Safety Code § 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.
☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.
Parent, legal guardian, or managing conservator:

Printed Name _____ Signature _____ Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2**. **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • https://www.dshs.texas.gov/immunize/immtrac/
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunization Section

Stock No. C-7
Revised 02/2026