FUSIONMD
Mind. Body. Spirit.

First Name:	MI/Nickname:	Last Name:
Date of Birth:	Gender: ◯ Male ◯ Female ◯ Other	SSN:
Primary Language:	Race:	Latino or Hispanic: ◯ Yes ◯ No

Home Phone:	Cell Phone:	Work Phone:

Marital Status:	Email:

Street Address:	City & State:	Zip Code:

Emergency Contact Name:	Relationship:
Address:	Phone:

Insurance Information (please present copy of insurance card(s) to be copied for your chart)

Primary Insurance Name:	Insurance ID:	Group Number:
Policy Holder's Name:	SSN:	DOB:
Secondary Insurance Name:	Insurance ID:	Group Number:
Policy Holder's Name:	SSN:	DOB

Pharmacy Name:	Pharmacy Phone:
Pharmacy Location:	Pharmacy Fax:

I understand that I am responsible for the payment of any services rendered at the time of the visit. I understand that I am responsible for all charges not covered by an insurance plan, including Medicare. I authorize payment of medical benefits to undersigned physician/FusionMD for services rendered. I authorize release of any medical information necessary to process this medical claim.

Patient Signature: _____ Date: _____

FUSIONMD
Mind. Body. Spirit.

First Name:	Middle Initial:	Last Name:
Date of Birth:	Gender: ◯ Male ◯ Female ◯ Other	Primary Care Physician:

Reason for visit: _____ Work Related: yes / no
Is there a possibility that you could be pregnant? Yes / No Date of last menstrual period: _____

List any allergies you have including medications, food or any other reaction: _____
_____
_____

List all long term and recurring medical problems:
1. _____ 2. _____
3. _____ 4. _____

List all previous surgeries you have had including the date of surgery:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

List any pertinent medical problems in your family and identify who (mother, father, sister, brother.)
1. _____ 2. _____
3. _____ 4. _____

Do you smoke or use ANY tobacco products? (check all that apply)
_____ Never _____ I used to _____ I smoke cigarettes _____ I smoke cigars _____ I use chewing tobacco

Do you drink alcohol? (check all that apply)
_____ Never _____ I used to _____ I am in recovery _____ I drink socially _____ I drink regularly

Do you use recreational drugs? (check all that apply)
_____ Never _____ I used to _____Sometimes _____Frequently _____ I have / do use IV drugs

List any medications you are currently taking including over the counter medications. Include the name and dosage.
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

For minor children:
Parent name: _____ Parent name: _____

How were you referred to FusionMD? _____

Patient or guardian signature: _____ Date: _____

FUSIONMD
Mind. Body. Spirit.

Consent to treatment, Payment, and Healthcare Operations

I understand that as part of my health and medical care, FusionMD originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I further understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means for third party payers to verify that services were billed as actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. I understand and have been provided with a Patient Information Notice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PIN prior to signing this consent. I understand that FusionMD reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for other than treatment, payment or healthcare operations and that FusionMD is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.

_____ _____

Signature of patient or personal representative Date of notice effective

I hereby assign FusionMD all payments for all medical services rendered to me or my dependents. I understand that I am responsible for payment of my account(s) and this document does not release me from that obligation. I authorize any overpayment from the insurance companies to one of my FusionMD account(s) to be transferred and credited to any other of my accounts with FusionMD.

This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

By Oklahoma law we are required to notify you:
The information authorized for release may include records which indicate the presence of communicable or venereal disease which may include, but are not limited to, disease such as hepatitis, gonorrhea, and human immunodeficiency virus, also known as HIV/AIDS.

I request the following restrictions to the use and/or disclosure of my health record:

_____

_____ _____

Signature or patient or personal representative Date

FUSIONMD
Mind. Body. Spirit.

Patient Authorization for Healthcare Communications

FusionMD offers patient the opportunity to communicate by Patient Portal and/or email for healthcare matters and may be used to discuss non-sensitive, non-urgent matters. Appropriate matters may include scheduling, appointment reminders, doctor recommendations, pricing/product information, questions about medication/supplements, reporting on self-monitoring measurements such as blood pressure logs and food logs.

Although FusionMD has implemented reasonable technical safeguards, FusionMD cannot and does not guarantee the privacy, security or confidentiality of any email messages sent or received. There is potential that email messages sent or received can be intercepted, altered, forwarded, and/or read by others. FusionMD is not responsible for messages that are lost due to technical errors/failure during composition, transmission, or storage.

Email regarding treatment, medications, patient specific correspondence will be documented in your medical record by placing a copy of each message in your file.

_____ (Initial) I consent to receive email messages from the practice at the email provided to receive communication as stated above. I understand that this request to receive email will apply to all future communication unless I revoke it in writing.

The email address that I authorize to receive email messages from FusionMD is:

_____

I acknowledge that I have read and fully understand this consent form and that I voluntarily request use of email messaging as one form of communication with FusionMD.

_____ _____

Signature of patient, parent, or personal representative Date

_____

Relationship to patient (if other than patient)

FUSIONMD

Mind. Body. Spirit.

HIPAA Authorization Form

I, _____, give permission to FusionMD, the included healthcare medical service providers, and payers to disclose and release information described below to the following individuals:

Name(s)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Health information to be disclosed: (check all that apply)

_____ My complete health record, including but not limited to diagnosis, lab tests, prognosis, treatment, and billing for all conditions.

_____ My complete health record, as above, with the exception of the following information: (check as appropriate)

- _____ Mental health records
- _____ Communicable diseases including HIV/AIDS
- _____ Alcohol/Drug abuse treatment
- _____ Other: _____

This health information may be used to enable the person(s) I authorize to know and understand my condition and my treatment or treatment options, for treatment consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until otherwise revoked in writing.

_____ _____

Printed name of person giving this authorization — Date

_____ _____

Signature of person giving this authorization — Relationship to patient