Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender: □ male □ female	SSN:

Race:	Latino or Hispanic: □ yes □ no	Primary Language:

Street Address:	City & State:	Zip Code:

Home Phone:	Cell Phone:	Work Phone:

Marital Status:	Email:

Pharmacy Information

Pharmacy Name:	Pharmacy Phone:

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:

Please read and sign

- 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 that are not covered by 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: ______________________

Patient History Questionnaire

Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender: □ male □ female	Primary Care Physician:

Reason for visit: ____ Work Related: □ yes □ no

Is there a possibility you could be pregnant? □ yes □ no Date of last menstrual period: ____________________

List any allergies you have including medications, food, or any other negative reaction: ____________________
____
____

List all long term and recurring medical problems: □ none
1. ______________________ 2. ______________________
3. ______________________ 4. ______________________

List all previous surgeries you have had including the date of surgery: □ none
1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

List any pertinent medical problems in your family and identify who (mother, father, sister, brother). - □ none
1. ______________________ 2. ______________________
3. ______________________ 4. ______________________

Do you smoke or use ANY tobacco products?
□ never □ I used to □ I smoke cigarettes □ I smoke cigars □ I use chewing tobacco

Do you drink alcohol?
□ never □ I used to □ I am in recovery □ I drink socially □ I drink regularly

Do you use recreational drugs?
□ 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. ______________________

How were you referred to FusionMD? ____

Patient signature: ______________________________ Date: ____________________

Consent to the 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 or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the 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 payer 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 Patient Information Notice 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 thereon.

____ ______________________________

Signature of patient or personal representative Date notice effective

I hereby assign FusionMD all payments for all medical services rendered to me or my dependents. <u>I understand that I am responsible for payment of my account(s) and this document does not release me from that obligation.</u> I authorize any overpayment from the insurance companies to one of my FusionMD account(s) 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, diseases such as hepatitis, gonorrhea, and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

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

____ _____________________________________

Signature of patient or personal representative Date

Patient Authorization for Healthcare Communications

FusionMD offers patients 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 medications/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 a 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 receiving 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 person representative Date

____

Relationship to patient (if other than patient)

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 diagnoses, lab tests, prognosis, treatment, and billing for all conditions.

-OR-

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

- □ Mental health records
- □ Communicable diseases including HIV and AIDS
- □ Alcohol/Drug abuse treatment
- □ Other (please specify) ____
  ____

This health information may be used to enable the persons 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

____ ________________________
Signature of person giving this authorization Date

Consent for Medical Treatment

Patient name: ____ Date of Birth: ______________________________

In the event of an emergency or non-emergency situation requiring medical treatment, I, the undersigned parent or legal guardian, hereby grant permission to the following person(s) to authorize any and all medical treatment for the child listed above as they in their discretion see fit.

Person(s) authorized:

Name:	Relationship:
____	______________________________________
____	______________________________________
____	______________________________________

This consent shall remain in effect until otherwise revoked in writing.

____ ______________________________

Signature of parent or legal guardian Date

Parent/Legal Guardian phone number: ____