Galveston Physical Medicine
2724 61st Street, #5
Galveston, TX 77551
409.744.9355

PATIENT INFORMATION--APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT)

Today's Date _____

Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Your Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Your Social Security # _____

Your Driver's License # _____ Exp:_____/_____/_____

Emergency Contact: _____ Phone # _____

How did you hear about us? _____

If referred by someone, who? (please name) _____

How payment will be made:

_____ Cash _____ Check _____ Credit Card

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I understand that should my account go to collections, I am responsible for all costs associated with collections and any costs charged by the collection company. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.
Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.
I hereby assign, transfer, and set over to **Galveston Physical Medicine** all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____ **Date:**_____
Or Guardian Signature _____ **Date:**_____

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Initial Confidential Patient Case History

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

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CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Chorea	☐ Epilepsy	☐ Malaria	☐ Rheumatic Fever
☐ Anemia	☐ Cold sores	☐ Fever Blisters	☐ Measles	☐ Recreational Drugs
☐ Anorexia	☐ Depression	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Appendicitis	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Arteriosclerosis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Bulimia	☐ Drug Abuse	☐ Hypoglycemia	☐ Pleurisy	☐ Typhoid fever
☐ Cancer	☐ Eczema	☐ Influenza	☐ Pneumonia	☐ Ulcers
☐ Candidacies	☐ Emphysema	☐ Lumbago	☐ Polio	☐ Venereal disease
			☐ Psychiatric Disorder	☐ Whooping cough

If you answered YES to any of the above conditions, please explain:_____

_____

_____

Have you ever been hospitalized or been under medical care for any operation/psychiatric care/alcohol or drug rehab? ☐ Yes ☐ No If yes, please explain:_____

_____

ALLERGIES/INTOLERANCES

☐ None ☐ X-Ray Dye ☐ Sulfa ☐ Pollen ☐ Food ☐ Soaps/Lotions ☐ Environment ☐ Adhesives

☐ Medication ☐ Other: (List Substance and reaction)_____

What is your major complaint?

_____

_____

List surgical operation and years:

_____

_____

FAMILY HISTORY: Please specify members of your family including extended family who have these illnesses.

CANCER: _____
HYPOTHYROIDISM:_____
HIGH BLOOD PRESSURE: _____
HYPOGLYCEMIA: _____
OBESITY: _____
HEART DISEASE: _____

Current Medications: Prescriptions Only

Medication/Dose/How often	Reason for Taking	Prescribing M.D.

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HIPAA FORM

Introduction

At **Galveston Physical Medicine** we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31th, 2003 and applies to all protected health information as defined by federal regulation.

Uses and Disclosures

1. We use your health information to document and plan treatment, progress, planning, etc.
2. We use your health information for payment. For instance, we need to send health information including procedures done and diagnoses to your insurance company, or your financial institution
3. We use your health information for regular health operations. For example, our compliance officer regularly chooses medical records for audits. This practice ensures that we are constantly working towards improved quality and effectiveness.
4. There are services provided in our organization through contacts with business associates. Examples include outside labs, x-ray, transcription services.
5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which **Galveston Physical Medicine** is permitted or required to disclose confidential information without the individual's written authorization.

1. Uses and disclosures for public health activities;
2. Reporting victims of abuse, neglect, or domestic violence;
3. Disclosures for judicial and administrative proceedings;
4. Disclosures for law enforcement purposes;
5. Uses and disclosures for cadaveric organ, eye or tissue donation purposes;
6. Disclosures to avert a serious threat to health or safety; and
7. Uses and disclosures for specialized government functions.

Separate Statements for Certain Uses or Disclosures **Galveston Physical Medicine** may contact patients with appointment reminders, requests for the patient to contact **Galveston Physical Medicine** for appointments, notices and letters concerning medical findings. **Galveston Physical Medicine** may also contact the patient about treatments alternatives or other health related benefits and services that may be of interest to the individual. Effective Date of this notice is April 1, 2003; Updated April 10, 2008.

Individual Rights

Although your health record is the physical property of **Galveston Physical Medicine** the information belongs to you. You have the right to:

1 The right to request restrictions on certain uses and disclosures of your information;
2 The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
3 The right to receive confidential communications;
4 The right to obtain a copy or inspect your health information;
5 The right to amend protected health information;
6 The right to receive an accounting of disclosures of protected health information.

Galveston Physical Medicine Center's Rights

1. **Galveston Physical Medicine** has 30 days with which to comply with a patient's request to review or copy their health information **Galveston Physical Medicine** is allowed an additional 30 days if the record is off site Galveston Physical Medicine**)** may charge a fee for copying the health record.
2. The physicians have the right to review the record and remove any information that they deem to be harmful to either the patient or to another individual;
3. The patient will be supervised by Medical Center staff during any review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record 1.**Galveston Physical Medicine** will charge staff time for this service.

Galveston Physical Medicine Medical Center's Duties

1. **Galveston Physical Medicine** is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. **Galveston Physical Medicine** is required to abide by the terms of this Notice; and
3. **Galveston Physical Medicine** reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted in the patient waiting area.

Complaints

Individuals may complain to the Office Manager in writing to address above. You may also contact the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., S.W.,Rm. 509F, HHH Building, Washington DC 20201.
Further Information-Please contact the SMC administrator at 747-5861 for further information.
I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Date of Birth:_____

Signature:_____ Date:_____

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PATIENT'S RELEASE OF THE PROVIDER OF SERVICE AND THE CLINIC

The undersigned hereby represents that I have disclosed all my pertinent information regarding my health profile to the provider of service during my examination. Patient further represents and guarantees that I have disclosed all medications that I am currently consuming to this provider of service during my examination and from whom, if any, I am obtaining my medications.

I understand that this provider of services makes a determination based on full disclosure from the patient.

I acknowledge that this provider of services reserves the right to limit any patient's medications to an appropriate amount based on the disclosed information from the patient during the examination.

Should information be obtained that in any way suggest false representation were made to this provider of service by the patient, I, without reservation, waive any and all rights to any claim, of any type or nature whatsoever including but not limited to monetary damages, which I have now or in the future may accrue against the provider of service and this clinic.

Please be advised that Galveston Physical Medicine requires that all patients have a yearly diet panel drawn to give us a thorough perspective of our patient's general health. We also require all new patients and returning patients have a diet panel drawn within the first two weeks of their initial visit and **will not dispense any further medications until this is done**; however, extenuating circumstances will be taken into consideration. This is to protect our patients and allow us to provide safe, effective assistance for weight loss and lifestyle change.

As the patient, I have read and understand this release. I also understand that this release constitutes a legal and binding document.

Patient signature: _____ Date: _____

Patient Printed name: _____

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Medication Release Form

By signing this form, I certify that I received patient education and verbal counseling information on one or more of the following drugs:

- ☐ Phentermine Hydrochloride
- ☐ Phendimetrazine
- ☐ Phendimetrazine Tartrate
- ☐ Diethylpropion Hydrochloride
- ☐ Hydrochlorothiazide
- ☐ Human Chorionic Gonadotropin (HCG)

I understand that it is in my best interest to read and understand the material I have received. I furthermore do not hold **Galveston Physical Medicine** or any of its practitioners responsible if I do not read or follow the instructions for taking any of these drugs.

Date:_____

Patient Signature:_____

Printed Name: _____

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I understand and acknowledge:

- **Galveston Physical Medicine** has provided me with information concerning self-injections.

  _____ Initials

- The injections do expire on the expiration date printed on label and **I do not get a refund for any unused injections.**

  _____ Initials

- By taking the injections home I **cannot** bring back any of the injections for any reason unless in a Bio-Hazard Container.

  _____ Initials

- **To throw away injections in a regular garbage can is illegal.** I either have access to a Bio-Hazard Container or I will purchase one from Galveston Physical Medicine at the price of $5.00 plus tax. I can bring the full container back to Galveston Physical Medicine for safe disposal.

  _____ Initials

- Injections need to be kept away from children and I have been offered a Bio-Hazard Container for safe storage of my used injections.

  _____ Initials

- I have received the "Giving Self Injections" sheet and the staff at Galveston Physical Medicine has answered all of my questions regarding self-injections.

  _____ Initials

- By taking my injections home**, Galveston Physical Medicine is not liable for any consequences that may come from giving myself an injection at home**.

  _____ Initials

_____ _____

Patient's Signature Date