Lewis
FAMILY MEDICINE

REGISTRATION FORM

Patient Information

Date:			
Name:	Date of Birth: / /	Social Security #: - -	
Address:	City:	State:	Zip:
Cell phone #:	Home phone #:	I would like text reminders on my cell? YES NO	
Email address:		I would like reminders sent to my email? YES NO	
Please circle appropriate: Minor Single Married Widowed Separated Divorced		Gender: Male Female	
Race: American Indian or Alaskan Native Asian African American Caucasian Pacific Islander Other Declined			
Ethnicity: Non-Hispanic Hispanic	Language:		
Person to contact in case of emergency:		Phone #:	
How did you find us? Zocdoc Search Engine Radio I Was Referred By Someone			
Whom may we thank for referring you (if applicable)?			

Responsible Party

Relationship to patient: Self Spouse Parent Other			
Name:	Social Security #:		
Address:	City:	State:	Zip:
Phone #:			

Insurance Information

Name of Insured:	Date of Birth: / /	Social Security #: - -	
Relationship to patient: Self Spouse Parent Other			
Name of Employer:		Work Phone #:	
Insurance Company:	Group #:	Member ID #:	
Insurance Company Address:		Insurance Company Phone #:	
Do you have additional Insurance? YES NO If yes, please complete the following:			
Name of Insured:	Date of Birth: / /	Social Security #: - -	
Relationship to patient: Self Spouse Parent Other			
Name of Employer:		Work Phone #:	
Insurance Company:	Group #:	Member ID #:	
Insurance Company Address:		Insurance Company Phone #:	
Name of Insured:			

Notice to Private Pay Patients

For Self-Pay patients, an office visit is $125 for both new patients and established patients. The fee is to see the provider and be medically evaluated. Additional services such as labs, point of care testing (i.e. rapid strep, rapid flu tests, etc.), in-office imaging will be charged at check out. Please sign below to acknowledge financial responsibility for private pay patients. Please be aware that you are financially responsible for anything the provider may order while being seen.

Signature:	Date:

13830 Sawyer Ranch rd. Ste 102, Dripping Springs, TX 78620 Office: (512)301-6400 Fax: (512)301-6401

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PATIENT MEDICAL HISTORY

Patient Information	
Name:	Date of Birth:

Past Medical History (list all prior diagnosis)	
Last Mammogram Date:	Last Colonoscopy Date:

Hospitalization / Surgeries (list most recent first with date)	

Family History	**Relation / Disease state**
Prostate cancer? YES NO	
Colorectal cancer of a relative? YES NO	
Breast or cervical cancer? YES NO	
Heart attack/stroke at less than 55 yrs of age? YES NO	

Social History						
Single Married Divorced	Tobacco use?		Amount		Frequency	
Number of children:	Alcohol use?		Amount		Frequency	
Occupation:	Drug use?		Amount		Frequency	
	Ever treated for substance abuse?					

Have you ever had any of the following (please check)				**Females**	
Heart attack		Pulmonary embolism		Number of pregnancies	Number of living children
Kidney failure		Seizure		Last menstrual period	Regular / Light (please circle)
Heart failure		Cancer		Heavy / Light (please circle)	
Blood clots		Respiratory failure			
Discolored Nails					

Medications (list all medications currently taking) Please mark N/A of not applicable.		
Name	Strength	Frequency Taken

Allergies (list any known skin / drug allergies) Please mark N/A if not applicable.		

PREFERRED PHARMACY & PHONE NUMBER:	
Name (please print):	Date:
Signature:	

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ASSIGNMENT OF PROCEEDS

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of Lewis Family Medicine / Dr. Kevin Lewis ("Dr. Lewis") or "Office" such sums as may be owing to Lewis Family Medicine / Dr. Lewis for charges exclusively in the name of Lewis Family Medicine Urgent Care or Dr. Kevin Lewis. I further grant a lien to Lewis Family Medicine / Dr. Lewis with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purpose of this Agreement, Lien, and Authorization (herein, "Agreement"), "benefits" shall include, but not limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relation to commercial health or group insurance, attorney retainer Agreements, medially payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein. In the event that I retain one or more attorneys to represent me in this matter, I will direct attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

FINANCIAL POLICY

I authorize this office to release any information regarding my treatment or pertinent to may case(s) to all payers as defined above to facilitate collection under this Agreement. I further authorize and direct all payers to release to Lewis Family Medicine / Dr. Lewis any information regarding any coverage or benefits which I may have included, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims, I hereby direct this office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Lewis Family Medicine / Dr. Lewis to endorse (sign) my name on any and all checks listing me as the payee which are presented to this office for payment of an account relation to me, my spouse, or any of my dependents. I further authorize Lewis Family Medicine / Dr. Lewis to apply all credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these charges are related to my condition. Further, I understand that I will be personally responsible for any deductions taken from payments by my insurance carrier for services rendered to me but withheld by the insurance company to offset other expenses. I understand that I remain personally responsible for the total amounts due LFMUC / Dr. Lewis for their services. **Additionally, I understand that any appointment that I schedule and miss without notice of cancellation at least 24 hours in advance will accrue a $40 No-Show Fee.** This Agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Lewis Family Medicine / Dr. Lewis for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

FREEDOM OF CHOICE

This office practices patient freedom of choice in all aspects of patient care. By signing below I'm acknowledging that I have freedom of choice to choose the hospital, pharmacy and laboratory of my preference for the medications or blood work/urine cultures prescribed by Lewis Family Medicine / Dr. Lewis. Further, it is patient understanding that this office has a financial interest in Westlake Hospital and some pharmacies and laboratories that may be used. Patients have the right to select the hospital, pharmacy and laboratory of their choice.

This Agreement shall not be modified or revoked without the mutual written consent of Lewis Family Medicine / Dr. Lewis and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to extent that the terms of those authorizations conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Lewis Family Medicine / Dr. Lewis and me. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print):	Date:
Patient Signature:	
Parent / Guardian (please print):	Date:
Parent / Guardian Signature:	

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WELLNESS UPDATE

Patient Information		
Name:	Date of Birth:	Date:

Do you experience any of these symptoms?		
Runny Nose	Yes	No
Itchy Nose	Yes	No
Stuffy Nose	Yes	No
Itchy Eyes	Yes	No
Watery Eyes	Yes	No
Frequent Sneezing	Yes	No
Itchy Mouth / Lips / Throat	Yes	No
Post Nasal Drip (drainage down the back of the throat, clearing throat)	Yes	No

How often do you experience these symptoms?
Occasionally (2-3 times per year) _____
Over 3 times a year _____
A few long periods of time per year (Spring, Summer, Fall, Winter) _____
Most of the year _____

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms?	Yes	No
If yes, name of medication and last date taken:		

Please indicate below symptoms / conditions you've experiences during the last 1-2 years			
	Sinus related issues (sinus pressure/pain, headaches, sinusitis)		Consistent of re-occurring coughing
	Re-occurring seasonal colds		Feeling of fatigue, irritability and restlessness
	Chronic colds (lasting longer than 2 months)		Asthma
	Migraine headaches		Skin conditions
	Restless sleep, challenges sleeping through the night, snoring		

Patient / Guardian Signature:	Date:

-- FOR PROVIDERS ONLY --			
	Educate patient on testing and treatment options		Do not contact patient
	Other		

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HIPAA NOTICE TO PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please review carefully.* This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information - Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. *Treatment*: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services; this includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example would be your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. *Payment*: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. *Healthcare Operations*: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, Communicable Diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroner, funeral directors, and organ donation, Research: Criminal Activity: Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500. Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. *Your Rights:* Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You then have the right to use another healthcare professional. You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us (upon request) even if you have agreed to accept this notice alternatively (i.e. electronically). You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. *Complaints*: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on / or before January 4, 2009.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Name (please print):	Date:
Signature:	

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