Genesis Medical Group

YOUR VISIT

Dear Patient,

Welcome to Genesis Medical Group!

Our goal here at Genesis Medical Group is to provide you with the highest level of care and get you back to living life to the fullest.

We want to make your first appointment an easy and pleasant experience. Here are a few reminders about your first appointment:

- Please bring the following items to your new patient appointment:
- Medical insurance card
- Driver's license or state id
- Medical records, we will request your medical records that need authorization. Bring all records you have in your possession as well.
- Current medication list
- Allergy list
- Completed new patient forms

Please plan to arrive to your appointment 30 minutes prior to your scheduled appointment time, this will allow you to complete the new patient paperwork if you have not completed beforehand. The new patient paperwork is located on our website at www.genesisdoctors.com.

Please be prepared to spend up to two hours at your first appointment; your first appointment will be a comprehensive visit including a physical exam and review of your medical history. We also want to allow enough time for you to communicate any questions or concerns you may have.

Be prepared with a list of questions for your physician; this will allow you to effectively communicate all your questions during your appointment.

We will verify your insurance and obtain any required referrals/authorizations prior to your appointment. In the event we encounter any issues in verifying or obtaining referral/authorization we will contact you prior to the appointment.

Your copay or patient responsibility will be due at the time of service.

If you have any questions regarding your new patient appointment please contact our new patient coordinators at 832-289-5801.

We look forward to meeting you at your first appointment and taking care of your healthcare needs.

Sincerely,
Genesis Medical Group

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NEW PATIENT MEDICAL QUESTIONNAIRE

Please complete this questionnaire by answering each question as accurately as possible.

GENERAL INFORMATION

Patient Name: _____ _____ Date of Birth: _____ Sex: Male Female

Social Security:_____ -_____ -_____ Insurance Carrier: _____Insurance ID#: _____

Address:_____ City: _____ Zip Code: _____

Phone: (_____) _____ - _____ Cell/Wk: : (_____) _____ - _____ Email: _____

Referring Physician: _____ Primary Care Physician: _____

How did you hear about us? Advertising Facebook Insurance Co. Hospital Patient in the Practice

Primary Care Doctor Specialists Other: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widow ___ Other

Emergency Contact Name: _____ Phone: (_____) _____ - _____

CHIEF COMPLAINT/REASON FOR VISIT

What is the reason for your visit today? _____

Are you experiencing any pain? (circle one) **YES** **NO** , if yes where is the pain location _____

If you marked yes, please indicate on the scale of 1 to 10 with 10 being the highest your level of pain **1 2 3 4 5 6 7 8 9 10**

MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please give copy to the front desk)**

Medication Name	Dose (ex. 50mg)	Frequency (ex. Once a day)	Reason for Taking

ALLERGIES

Are you allergic to any medications? **YES** **NO** if yes please list medications _____
Are you allergic to intravenous contrast? **YES** **NO** if yes please list your reaction _____
Any other allergies? Incl. Latex **YES** **NO** if yes please list _____

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PHARMACY INFORMATION

Name: _____ Phone #: _____

Address:_____

SOCIAL HISTORY

1. Select All That Apply:

___Current smoker, every day ___Current smoker, some days ___ Smoker, status unknown

___ Light tobacco smoker ___Heavy tobacco smoker ___ Former Smoker ___ Never Smoker

Cigarettes Amount: _____ per day Cigars Amount: _____ per day

Smokeless Amount: _____ per day Pipes Amount: _____ per day

2) Have you had exposure to second hand smoke? (circle one) **YES** or **NO**

3) Do you drink alcoholic beverages? (circle one) **YES** or **NO**, if yes how often _____

FAMILY MEDICAL HISTORY

Please list if any of your family members below have or had any of the following diseases or medical conditions:
Bleeding/Clotting Disorders, Cancer (list type if known), Diabetes, Heart Disease, Hypertension, Leukemia, Lymphoma, Heart Attack, or stroke.

Mother: **Alive** **Deceased** Age: Medical Condition _____

Father: **Alive** **Deceased** Age: Medical Condition _____

Sister(s): **Alive** **Deceased** Age: Medical Condition _____

Brother(s): **Alive** **Deceased** Age: Medical Condition _____

Grandmother: **Maternal** **Paternal** Age: Medical Condition _____

Grandfather: **Maternal** **Paternal** Age: Medical Condition _____

Aunts: **Maternal** **Paternal** Age: Medical Condition _____

Uncles: **Maternal** **Paternal** Age: Medical Condition _____

PAST MEDICAL HISTORY

1) Have you had any of the following tests within the last 6 months? (Select All That Apply, if yes where and when?)

Pet Scan When _____ Where _____
CT Scan When _____ Where _____
Ultrasound When _____ Where _____
Other (specify) When _____ Where _____

2) Have you been hospitalized in the last 6 months? **YES** **NO**

If YES, when and reason for hospitalization _____

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REVIEW OF SYSTEMS

Check the symptoms you currently have or have had in the past year. Please check all that apply.

GENERAL	**CARDIOVASCULAR**	**SKIN**
___ Chills	___ Chest Pain	___ Any Chronic Rashes Or Eruptions
___ Depression/Nervousness	___ High/Low Blood Pressure	___ Change In Moles
___ Dizziness/Fainting	___ Irregular/Rapid Heart Beat	___ Hives
___ Excessive Weight Gain or Loss	___ Poor Circulation	___ Itching
___ Fever	___ Shortness Of Breath	___ Irregular Scars
___ Headache	___ Swelling In Ankles	___ Poor Healing Of Lesions or Wounds
___ Numbness	___ Varicose Veins	___ Poor Healing Of Foot Lesions
EYE, EAR, NOSE, & THROAT	**GASTROINTESTINAL**	**HEMATOLOGIC**
___ Bleeding Gums	___ Bloating	___ Anemia
___ Blurred Vision	___ Black Or Tarry Stools	___ Easy Bruising
___ Crossed Eyes	___ Bowel Changes	___ Excessive Bleeding
___ Difficulty Swallowing	___ Change In Appetite	**RESPIRATORY**
___ Double Vision	___ Constipation	___ Chronic Cough
___ Earache Or Ear Discharge	___ Diarrhea	___ Coughing Up Blood
___ Hay Fever	___ Excessive Thirst	___ Wheezing Or Asthma
___ Hoarseness	___ Gas	**URINARY**
___ Loss of Hearing	___ Hemorrhoids	___ Blood In Urine
___ Nosebleeds	___ Indigestion/Heartburn	___ Frequent Urination
___ Persistent Cough	___ Nausea	___ Lack Of Bladder Control
___ Ringing In Ears	___ Rectal Bleeding	___ Painful Urination
___ Sinus Problems	___ Stomach Pain	
___ Vision – Flashes or Halos	___ Vomiting	
NEUROLOGICAL	**MEN ONLY**	**WOMEN ONLY**
___ Double Vision/Vision Loss	___ Erection Difficulties	___ Abnormal Pap Smear
___ Prior Stroke	___ Lump In Testicles	___ Bleeding Between Periods
___ Muscular Weakness/Tingling	___ Penis Discharge	___ Breast Lump
___ Speech Difficulty	___ Sore On Penis	___ Extreme Menstrual Pain
___ Transient Paralysis	___ Other Issue	___ Hot Flashes
___ Transient Neurologic Deficit		___ Nipple Discharge
MUSCLE/BONE/JOINT		___ Painful Intercourse
___ Pain, Weakness, Numbness In:		___ Vaginal Discharge
___ Arms		
___ Back		Date of Last Period:_____
___ Feet		Date of Last Pap Smear: _____
___ Hands		Date of Last Mammogram: _____
___ Hips		Are you pregnant? Yes or No
___ Legs		
___ Neck/Shoulders		Number of Children: _____

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REVIEW OF SYSTEMS CONTINUED

Circle all the conditions you have or have had in the past.

Aids	Chicken Pox	HIV Positive	Polio
Atrial Fibrillation	COPD	Kidney Disease	Prostate Problem
Appendicitis	Diabetes	Liver Disease	Rheumatic Fever
Arthritis	Emphysema	Measles	Scarlet Fever
Asthma	Epilepsy	Migraine Headaches	Stroke
Bleeding Disorders	Glaucoma	Multiple Sclerosis	Thyroid Problems
Blood Clots	GERD	Mumps	Tuberculosis
Breast Lump	Heart Disease	Pacemaker	Ulcers
Cancer	Hepatitis	Pneumonia	Venereal Disease
Cataracts	Herpes		
Chemical Dependency	High Cholesterol		

Surgical History

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Relationship to Patient**

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ADVANCE DIRECTIVES INFORMATION SHEET

An **advance directive** is a legal document that tells your family, friends and healthcare professionals the care you would like to have if you become unable to make medical decisions. Through advance directives, you can make legally valid decisions about your future medical treatment.

You do not need a lawyer to complete your advance directives. However, you should be aware that each state has its own laws for creating advance directives.

There are three advance directives recognized in Texas:

• The **Texas Medical Power of Attorney** appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Your attending physician must certify in writing that you are unable to make health care decisions and file the certification in your medical record. If you would like more information and a copy of the Texas Medical Power of Attorney form please ask the front desk staff.

• A **living will**, officially known in Texas as the Directive to Physicians and Family or Surrogates, describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will should be signed, dated and witnessed by two people, preferably individuals who know you well but are not related to you and are not your potential heirs or your health care providers. If you would like more information and a copy of the Directive to Physicians and Family Members form please ask the front desk staff.

• The **Out-of-Hospital Do Not Resuscitate (DNR) order** provides you with the right to withhold or withdraw cardiopulmonary resuscitation (CPR) or other treatments such as defibrillation and artificial ventilation. If you would like more information and a copy of the Texas Department of Health Services Standard Out of Hospital Do Not Resuscitate form please ask the front desk staff.

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

In order to make your directive legally binding, you must sign it, or direct another to sign it, in the presence of two witnesses who must also sign the document.

It is our responsibility to inform all competent adult patients about Advance Healthcare Directives and ask whether they have one in place. The staff is instructed to know the different types of advance directives. All staff members know where to direct patients who have questions or want more information about advance directives. If a patient provides an advance directive to Genesis Physicians, the physicians and staff should know the patients' decisions related to treatment.

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ADVANCE DIRECTIVES CONFIRMATION FORM

Under Texas law you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas any person age 18 years or old who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

☐ **YES**, I have an Advance Healthcare Directives *(select which advance directive you have below).*

- Texas Durable Medical Power of Attorney
- Living Will, officially known as the Directive to Physicians and Family or Surrogates
- Out of Hospital Do Not Resuscitate (DNR)

****If you have selected YES, please provide a copy of your advance directive to the front office staff.*

☐ **NO**, I do not have Advance Healthcare Directives *(select which advance directive you have below).* I understand that I can request more information about advance directives.

- I have received the information sheet about advance directives.
- I would like additional information about the three advance directives recognized in Texas.

_____ _____

Patient Name (Print) Patient Signature

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GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

MEDICAL CONSENT: I consent to all medical care, treatment, laboratory, imaging and other medical procedures performed or prescribed by a physician of Genesis Medical Group and his/her designees as directed in his/her judgement.

RIGHT TO REFUSE TREATEMENT: I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices.

ADVANCE DIRECTIVES: I understand that I have an opportunity to make known my wishes, in writing regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

RELEASE OF MEDICAL INFORMATION: I authorize Genesis Medical Group to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to my care/treatment with Genesis Medical Group. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

FINANCIAL AGREEMENT: I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I understand I am financially responsible to Genesis Medical Group for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. Genesis Medical Group will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles, and co-insurance. I am responsible to pay all copays, deductibles, and patient responsibility at the time of service unless other arrangements have been made in advance.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance and any other health / medical plan, to issue payment check(s) directly to **Genesis Medical Group** for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

LATE POLICY: If a patient is more than 15 minutes late to their appointment, the appointment may be canceled and need to be rescheduled. Patients arriving late may also be asked to wait to be seen until the provider has an opening in their schedule. After 2 or more late visits, you are subject to dismissal from the practice.

NO SHOW POLICY: We request that you please give our office at least 24-hour notice in the event that you need to reschedule your appointment. If you do not provide us with a 24-hour notice, or if you do not show up for a scheduled appointment, you may be charged a $25 fee for primary care and $50 fee for specialist. After 2 or more no show visits, you are subject to dismissal from the practice.

By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Legal Representative to sign this document.

_____	_____	_____
Patient /Legal Representative Name (Print)	Patient/Legal Representative Signature	Date

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PATIENT AUTHORIZATION TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner *(Check All That Apply):*

___ Home Telephone
__Leave message with detailed information.
__Only leave message with call back details.

___ Cell Telephone
__Leave message with detailed information.
__Only leave message with call back details.

___ Work Telephone
__Leave message with detailed information.
__Only leave message with call back details.

___ Written Correspondence
__ Mail to my home address on file
__ Email to address on file

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.

Authorized Designees:

Name: _____Relationship: _____ Telephone: (_____) -_____-_____

Name: _____Relationship: _____ Telephone: (_____) -_____-_____

Name: _____Relationship: _____ Telephone: (_____) -_____-_____

Name: _____Relationship: _____ Telephone: (_____) -_____-_____

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.

• I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
• I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.

_____ _____ _____
Patient/Legal Representative Print Name Patient/Legal Representative Signature Date

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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: (_____) – _____ - _____

I hereby authorize:

_____ _____ _____

Name of Provider/Hospital/Physician Provider/Hospital/Physician Address Telephone Number

To release the following information from my health record covering the period of
From _____ to _____ , if I do not specify a period I am authorizing the release of records for entire duration of care with the provider. *(check all that apply below)*

____Complete Medical Record (includes information regarding insurance, demographic, referral documents, and medical Records). ***If this box is checked, do not check any additional boxes.***

____ Progress/Office Visit Notes ____ Radiology/Imaging Reports ____Chemotherapy/Radiation Records

____ Lab Reports ____ Pathology Reports ____ Billing/Payment Records

Information is to be released to:

Genesis Medical Group _____ Telephone: (_____) -_____- _____ Fax: (_____) -_____- _____
Office Address

The information is being released for the following purposes:

____ Continued Care/Treatment ____ Disability ____ Attorney/Litigation ____ Other

I understand that this authorization will remain in effect until I revoke it in writing.
I understand that according to applicable state and or/federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

_____ _____ _____

Patient/Legal Representative Print Name Patient/Legal Representative Signature Date