INTERNAL MEDICINE CARE GROUP

Name: _____ Date of birth:_____ Age:_____
Marital Status: S M W D
Occupation: _____
Gender: M F

Who was your last physician? _____ Date last seen:_____
LIST OF PREVIOUS PHYSICIANS WE NEED TO OBTAIN RECORDS FROM:

_____ _____
_____ _____
_____ _____

Past Medical History:

_____
_____
_____
_____

Hospital Admissions and Surgeries: Please list with Dates:

_____ _____
_____ _____
_____ _____
_____ _____

Family History:
Is your mother alive? _____ If so, what year was she born? _____ If not, age of death? _____ What was her cause of death? _____ Did she have any other medical problems? If so, please state: _____
_____
Is your father alive? _____ If so, what year was he born? _____ If not, age of death? _____ What was his cause of death? _____ Did he have any other medical problems? If so, please state: _____
_____
Please indicate any other medical problems that run in the family & specifically state relative affected (i.e. maternal grandmother vs. paternal grandmother):

High Blood Pressure_____ High Cholesterol_____
Heart disease or heart attack_____ Diabetes _____
Stroke_____ Cancer_____
Tuberculosis_____ Arthritis_____
Mental Illness_____ Kidney Disease_____
Glaucoma_____ Other_____

Current Medications: (attach additional sheet if needed)

Name:	Strength (mg)	#taken per day	For what illness do you take it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: Please list the medicines to which you are allergic and tell us what happens when you take it.

Medication:	Reaction:
_____	_____

INTERNAL MEDICINE CARE GROUP

Name: _____ Date of birth:_____ Age:_____

Habits:
Do you smoke cigarettes?_____ How many packs per day? _____ Do you use chewing tobacco or snuff? _____ If yes, how many years have you smoked or chewed? _____
Do you drink beer, wine or mixed drinks? _____How many drinks per day do you have? _____
How many years have you drank alcohol? _____ How many caffeinated drinks do you have each day? _____ Have you ever taken any street drugs or misused prescription drugs?_____

What is the reason for your visit today?

WOMEN ONLY

Last Menstrual Period: _____ How many times have you been pregnant? _____
How many miscarriages or abortions have you had? _____
Date of last PAP?_____Have you ever had an abnormal PAP?_____
When was your last mammogram? _____ Ever abnormal? _____

Vaccination History:
_____
_____

REVIEW OF SYSTEMS:

Please indicate if you have experienced any of the following within the past 6 weeks:

General: fever chills fatigue unintentional weight change (gain/lost)
Head/Ears/Nose/Throat: headache visual changes ear pain ringing in ears sore throat sinus pain/pressure nasal congestion
Heart: chest pain/pressure heart racing/skipping beats shortness of breath with exertion shortness of breath laying flat
Lungs: cough (productive/non-productive) wheezing shortness of breath coughing up blood
Abdomen: abdominal pain nausea vomiting blood in stool black tarry stool diarrhea constipation early fullness bloating
GYN: vaginal bleeding (post-menopausal) vaginal discharge vaginal itching breast pain breast lump
Urologic: pain with urination blood in urine difficulty starting/stopping stream urinary leakage urinating 2+ times/night
Muscle: muscle aches muscle weakness
Joints: joint pain joint swelling feeling of buckling in knee(s)
Neuro: dizziness numbness/tingling fainting seizure weakness
Skin: rash ulcers itching new skin lesion
Psych: change in mood anxiety problems sleeping concentration issues
Other: Any other symptoms not listed above (please be specific): _____

INTERNAL MEDICINE CARE GROUP

Patient Data Form

PATIENT NAME: _____ MARITAL STATUS: M S D W

D.O.B: _____ SOC. SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

HOME PHONE #: _____CELL PHONE #: _____WORK PHONE #: _____

EMPLOYER: _____

EMAIL: _____ HOW DID YOU HEAR ABOUT US?: _____

OCCUPATION: _____ EMPLOYER PH #: _____

NAME OF INSURANCE CO: _____

PRIMARY INSURED: (if other than patient) _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

HOME PHONE #: _____CELL PHONE #: _____WORK PHONE #: _____

D.O.B: _____ SOC. SECURITY #: _____

EMPLOYER NAME: _____

OCCUPATION: _____ EMPLOYER PH #: _____

EMERGENCY CONTACT & PHONE NUMBER: _____ & _____

NEXT OF KIN/LEGAL GUARDIAN:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

HOME PHONE #: _____CELL PHONE #: _____WORK PHONE #: _____

I acknowledge that Internal Medicine Care Group, P.A. provided me with a written copy of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient/Guardian Signature_____Date_____

INTERNAL MEDICINE CARE GROUP

Controlled Medication Agreement

The purpose of this Agreement is to prevent misunderstanding about certain medicines you may or will be taking. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

- I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.
- I understand that if I break this Agreement, my doctor will stop prescribing these pain control medications.
- In this case, my doctor will taper off the medication over the period of several days, as necessary to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.
- I will not use any illegal controlled substances including but not limited to marijuana and cocaine.
- I will not share, sell or trade my medication with anyone.
- I will not attempt to obtain any controlled medications (including but not limited to opioid pain medication, controlled stimulants, or anti-anxiety medications) from any other doctor without first discussing it with a physician at Internal Medicine Care Group.
- I will safeguard my pain medication from loss or theft. Lost or stolen medications may not be replaced.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine.
- I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood, urine, or saliva test if requested by my doctor to determine my compliance with my controlled medication program.
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- I agree to bring all unused pain medicine to every office visit.

Pharmacy Use

I agree to use _____ Pharmacy, located at _____, telephone number_____, for filling prescriptions for all of my pain medicine.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on this _____ day of _____ , _____.

Patient signature: _____

Physician signature: _____Witnessed by: _____

INTERNAL MEDICINE CARE GROUP

Authorization for Release of Protected Health Information (Medical Records)

Patient's Name:	Birth Date:	Social Security No. (optional)
Maiden/Former Name:	To Release to: **Internal Medicine Care Group**	
I, Authorize:	At Address: **1001 12th AVE, STE 120** **Fort Worth, TX 76104**	
	Or Fax: **877-935-8231**	
Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ Attorney ☐ Other: _____	The following information may be released: ☐ Entire Medical Record ☐ Specific Record from _____ to _____ ☐ Immunizations ☐ Billing Record ☐ Only: _____	

The following information may be released:

	I consent to the release of the indicated sensitive, legally protected records (patient to initial). Mental Health Records……._____ HIV or AIDS……_____ Chemical Dependency……._____ Genetic Testing……_____	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.
4. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of patient or Representative:	**Date:**
Print Name of Representative:	**Relationship to Patient:**

INTERNAL MEDICINE CARE GROUP

Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Internal Medicine Care Group, P.A. to use and/or disclose certain protected health information (PHI) about me to the following person(s) _____ _____.

This authorization permits Internal Medicine Care Group, P.A. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc. or state "all"):

☐ ALL

☐ OTHER_____

The information will be used or disclosed for the following purpose:

☐ At the request of the individual(s) above

☐ OTHER_____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____.

I do not have to sign this authorization in order to receive treatment from Internal Medicine Care Group, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Internal Medicine Care Group
1001 12th AVE, STE 120 Fort
Worth, TX 76104

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____

Print Name of Patient or Legal Guardian

INTERNAL MEDICINE CARE GROUP

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Internal Medicine Care Group, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Internal Medicine Care Group, P.A.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Internal Medicine Care Group, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Internal Medicine Care Group, P.A.'s Privacy Officer at 1001 12th AVE, STE 120, Fort Worth, TX 76104

With this consent, Internal Medicine Care Group, P.A. **may call my home** or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Internal Medicine Care Group, P.A. **may mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

With this consent, Internal Medicine Care Group, P.A. **may e-mail** to patient's email address or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Internal Medicine Care Group, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Internal Medicine Care Group, P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Internal Medicine Care Group, P.A. may decline to provide treatment to me.

_____ _____ _____

Signature of Patient or Legal Guardian Patient's Name Date

_____

Print Name of Patient or Legal Guardian

INTERNAL MEDICINE CARE GROUP

Advance Directive Questionnaire

You have certain rights under Federal and Texas law to make an Advance Directive, a document that allows you to make decisions concerning your medical care; to accept or refuse medical or surgical treatment; and to give instructions to the doctor regarding your health care when you are no longer able to communicate your desires. **If you have an Advance Directive, it is important for you to provide a copy of that document to your doctor.** If you do not have an Advance Directive, it is important for you to know what it is and how to make one.

PLEASE CIRCLE WHETHER OR NOT YOU HAVE THE FOLLOWING DOCUMENTS:

- Living Will Yes No
- Durable Power of Attorney for Health Care Yes No
- Other, please describe

If you wish the physician to follow your Advance Directive, you must provide the Internal Medicine Care Group, PA with a copy.

PLEASE CONFIRM THE FOLLOWING: (INITIAL)

_____ I have been given a copy of *Your Rights as a Patient*, a brochure with information on Advance Directives. This brochure is intended solely for information as required by law. I understand that for further information on Advance Directives, I should discuss this with a nurse or physician. I understand that I may consult with my family attorney, physician or other advisors before making any Advance Directive decisions. I understand that I will not be discriminated against if I do not have an Advance Directive.

IF YOU HAVE A LEGAL GUARDIAN, PLEASE ANSWER THE FOLLOWING:

- Legal Guardian
  Name:
  Address:
  Phone:

Date: _____ Signature _____

Time: _____ Witness _____

If patient is unable to complete this form, please state reason: _____

INTERNAL MEDICINE CARE GROUP

Consent to Treat Page One

I grant permission to the employees of Internal Medicine Care Group to render routine outpatient care to me at Internal Medicine Care Group (IMCG) and to carry out the orders of the physician. I understand that medicine and surgery is not an exact science and there is no guarantee that the outcome of my treatment will be what I want it to be.

ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER
I understand that Texas law provides and I agree, that if any HEALTH CARE worker is exposed to my blood or other bodily fluid, to allow Internal Medicine Care Group to perform tests on my blood or other bodily fluid to determine the presence of any communicable disease; including but not limited to Hepatitis, Human Immunodeficiency Virus (which is the causative agent of AIDS) and syphilis. I understand that such testing is necessary to protect those who will be caring for me. I understand that the results of tests taken under these circumstances do not become a part of my medical record.

INSURANCE COVERAGE AND ASSIGNMENT OF BENEFITS
MEDICARE/MEDICAID BENEFITS: I certify that the information given by me in applying for payment under these programs is correct. I request payment of authorized benefits be made on my behalf directly to Internal Medicine Care Group. I authorize 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 claim.

OTHER INSURANCE: I hereby authorize and transfer any insurance benefit payable to or for my benefit for the payment of such services rendered. I have reported to Internal Medicine Care Group a listing of my additional coverage. I understand that Internal Medicine Care Group will not file a claim for any insurance not reported before the service is rendered.

FINANCIAL RESPONSIBILTIY
I understand that regardless of any assigned insurance benefits, I am responsible for the total allowable charges for services rendered. Payment of charges is due at the time of the appointment. I understand that any amount remaining on this account after applicable insurances have been filed and settled will be due and payable upon receipt of statement.

___ In the event that IMCG is able to verify that I or any dependents have insurance coverage from information that I provided, I understand that I will still be required to pay in full the portion of IMCG billing for any procedure or treatment plan requested for myself or my dependents that IMCG estimates will not be covered by my insurance prior to such treatment being performed by IMCG. I understand that this estimate of insurance by IMCG may differ from the payments ultimately made by my insurance carrier and that I am responsible for any amounts not paid by my insurance.

___ I understand that if a check or other instrument, or any electronic authorization or debit or credit sent or provided to IMCG for payment is not honored upon first presentment, regardless of the reason, even if the check, instrument, or electronic authorization is later honored, I will be charged a service charge. This charge is currently $35.00 and is subject to change without notice.

Initials_____Date_____

INTERNAL MEDICINE CARE GROUP

Consent to Treat Page Two

___ I understand and agree that a check presented to IMCG for payment may be electronically processed and settled at the time of service or later.
___ I understand that I have the right to dispute charges on my account and agree in good faith to resolve such disputed charges with IMCG. To the extent that I am unable to resolve such matters directly with IMCG, I agree to pursue resolution through an informal mediation process with a mutually agreeable independent third part rather than through litigation.
___ I understand that if my account is not paid on a timely basis, IMCG may report such untimely payments to credit rating bureaus, refer my account to a collection agency and take legal action against me in order to receive full payment for services performed on myself or any of my dependents. I agree to pay related reasonable attorney's fees, collection and/or court costs, and a monthly interest charge on my outstanding account at the maximum rate permitted by law.
___ I understand that IMCG reserves the right to charge a fee for any appointment that I do not keep without giving 24 hours notice; our fee is currently $40.00 and subject to change without notice. After two broken appointments or missed appointments, the doctor retains the right to discontinue elective treatment and to dismiss me from the practice.
___ I understand that all insurance claims from treatment that I receive at IMCG are being filed by IMCG with my authorizations as a courtesy to me and are subject to review by my insurance carrier. I acknowledge that I am solely and ultimately responsible for paying all charges not covered by my insurance, including but not limited to, my insurance company denying coverage for any procedure (Advanced Beneficiary Notice must be signed in case of Medicare), policy deductibles and co-pays.
___ With respect to any non-governmental (private) insurance that I may have, I understand that my insurance benefits are derived from a contract between either myself or my employer and the insurance carrier. I also understand that the extent of my insurance coverage depends on the quality of the plan that I or my employer has purchased. I realize that it is solely my responsibility and not the responsibility of IMCG, to confirm which treatments or procedures are covered by my insurance, the extent of this coverage including any applicable exclusions or deductibles or annual or lifetime maximums in my policy and any disparity between fees charged by IMCG for a procedure, for which I am responsible and the amount of the benefit allowed by the insurance carrier's usual and customary fee schedule.

RELEASE OF INFORMATION
I authorize Internal Medicine Care Group to release any medical information pertaining to my diagnosis and treatment at Internal Medicine Care Group to: 1) representatives of local, state or federal agencies in accordance with the law; 2) Medicare; 3) Medicaid; 4) my insurance company representatives or; 5) any person or entities financially responsible for my care. I further authorize release of this information to health care providers associated with my care outside of Internal Medicine Care Group to facilitate further health care. All records concerning my care remain the property of Internal Medicine Care Group. All records are confidential.

Initials_____Date_____

INTERNAL MEDICINE CARE GROUP

Consent to Treat Page Three

ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES
I acknowledge that my treating physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

PRESCRIPTION HISTORY FROM EXTERNAL SOURCES
I grant permission to the employees of Internal Medicine Care Group to view my prescription history from external sources.

I request that this consent and acknowledgement be in effect for as long as outpatient services are rendered at Internal Medicine Care Group.

Signature of Patient or Legal Guardian	Date
Print Name of Patient or Legal Guardian	Patient's Name

INTERNAL MEDICINE CARE GROUP

AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until _____, 20_____

I (we) the undersigned parent, parents or legal guardian of

_____ a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any physician at Internal Medicine Care Group, P.A. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions:_____

_____

Signature of Father, Mother or Legal Guardian: _____Date:_____

Address:_____ City:_____State:_____ Zip:_____

Telephones Where Parents May Be Reached

Father: _____ Home:_____

Work:_____

Mother:_____ Home:_____

Work:_____

Legal Guardian:_____ Home:_____

Work:_____