CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS)
PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____- _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM _____/DD _____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work hone: _____ Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

Health History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____
Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____
Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____
Do you or have you used the following in the last three months? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Crack ☐ Methamphetamine

Are you allergic to any medications? Yes or No (If yes, please list.)

Current Medications	Dosage

Previous Surgery	Date

Have you ever had any of the following? Circle all that apply: Asthma Stomach Problems Bladder problems Jaundice-Liver Gout Alcoholism Kidney Disease Prostate Skin Disease Joint Disease Stroke Epilepsy-Seizures Depression-Anxiety Thyroid Blood Clot High Blood Pressure Tuberculosis Diabetes Cancer Lung Disease Heart Disease Psychiatric Disorder

Do any of these conditions run in your family? Circle all that apply: Alcoholism Addiction Joint Disease Stroke Blood Clots Diabetes Psychiatric Disorder Heart Disease

Primary care physician information:

Name: _____ Phone number: _____
Address: _____

Pharmacy information:

Name: _____ Phone number: _____
Address: _____

How did you hear about us? Circle any that apply:

Website Family/Friend Internet Search

Former or current patient (please provide name so we can thank them!) _____

Physician (please specify): _____

Other Healthcare facility (please specify): _____

Insurance Network (please specify): _____

Other (specify): _____

CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS)

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) any insurance or other third-party benefits available for health care services provided to me. I understand CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) , I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) , or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS) or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

CYPRESS FAIRBANKS NEUROLOGY ASSOCIATES (CYFAIR MEDICAL PARTNERS)

Patient Name: _____

Date of birth: _____

Patient HIPAA Acknowledgment and Consent Form

_____(Patient/Representative initials) **Notice of Privacy Practices**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the privacy officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the provider and/or the provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

Do you want to designate a family member of other individual with whom the provider may discuss your medical condition? If yes, whom?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an Electronic Health Record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I understand that once I have consented to receive communication via text or email, I still have the right to revoke that consent at any time.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the practice.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____ (Patient/Representative initials) I **consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

OR

_____ (Patient/Representative initials) I decline to receive communication via text.
_____ (Patient/Representative initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent, please complete the following form:

Revocation (I do not consent to the use of my cell or email any longer.)

___ *I hereby revoke my request for future communications via email and/or text.*
___ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text.*
___ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

Patient Name: _____

Patient/patient representative signature: _____

Date: _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick up a prescription order (script) from your provider's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/parent/guardian/patient representative name (signature) _____ Date: _____

Patient/parent/guardian/patient representative name (printed) _____

Patient name (printed): _____ Date of birth: _____