MIDLAND HEALTH

Name: (Last, First, MI)	Age:	Sex: M F	Birth Date:
Street Address:	City:	Zip	SS#
Mailing Address:	City:		Zip:
Home & Cell Phone:	Email Address:		
Employer:	Address:		Work Phone:
Email Address:	Occupation:		Referred by:

SPOUSE OR LEGAL GUARDIAN

Name: (Last, First, MI)	Legal Guardian: Yes No	Birth Date:
Street Address:	City:	Zip:
Home & Cell Phone:	Work Phone:	Email Address	SS#:
Employer:	Address:	Email Address:

In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)

Name (1): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:
Name (2): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:

INSURANCE INFORMATION (A copy of ALL Insurance cards is required for filing purposes.)

Primary Insurance:		Name of Insuree & SS#:
Group #:	Insuree's DOB:	Insurance ID#
Secondary Insurance:		Name of Insured & SS#:
Group #:	Insuree's DOB:	Other Insurances (cont on back):
Medicare? Yes or No	Medicare #	SS#

Optional: **Decline** ☐

Married Status: ☐ Single ☐ Married ☐ Divorced **Language:** ☐English ☐Spanish Other_____

Race: ☐White/ Hispanic ☐ African American ☐Asian ☐Native American ☐ Other _____

Ethnicity: ☐White American ☐Hispanic/ Latino ☐African American ☐ Native American ☐Indian American ☐ Chinese American ☐Other _____

Assignment of Benefits

I authorize Midland Health/Premier Physicians to release any medical information that may be necessary to process medical/surgical claims for myself or my dependents. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health plans to issue payments on my behalf to Midland Health/Premier Physicians. I understand that I am responsible for amounts not covered by insurance, unless covered by contracted employer agreement. This order will remain in effect until revoked by me in writing.

_____ _____

DATE SIGNATURE of PATIENT (or Parent/Legal Guardian if Patient is a minor)

MIDLAND HEALTH

Authorization Form For Release of Protected Health Information

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by patient, or an agent given medical power of attorney, your private health information and/or treatments will not be disclosed.

By signing this form, I authorize you to use and disclose the protected health information described below.

The health information you may release subject to this authorization is as follows:

☐ Medical ☐ Financial ☐ Other: _____

Release my protected health information to the following person(s)/entity:

Name: _____Relation _____ Phone: _____

Name: _____ Relation _____ Phone: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Privacy Officer Midland Health/Premier Physicians 4214 Andrews Hwy, Ste.240 Midland, TX 79703

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.**

_____ _____ _____

Signature of Patient Date of Birth Date

_____ _____

Signature of Personal Representative Relationship to patient (or other authority)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **Midland Health** to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Midland Health has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment. I voluntarily consent to receive medical and health care services provided by Midland Health/Premier Physicians, employees and such associates, assistants, and other health care providers. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that Midland Health/Premier Physicians may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

Please mark if you agree to accept artificial messages by:

Phone Calls ☐ Yes ☐ No **Text Messages ☐ Yes ☐ No** **Emails ☐ Yes ☐ No**

How to contact our Privacy Officer: PREMIER PHYSICIANS/MIDLAND HEALTH 4214 Andrews Hwy, Ste.240 Midland, TX 79703 Attention: Privacy Officer Telephone: (432) 686-6600 Facsimile: (432) 682-2284

Acknowledgement and Consent

I have received the Notice of Privacy Practices for MIDLAND HEALTH/PREMIER PHYSICIANS. MIDLAND HEALTH/PREMIER is authorized to use and disclose health information about patient listed below for treatment, payment and healthcare operations purpose consistent with its Notice of Privacy Practice.

_____ _____

Signature of Patient Date

_____ _____

Name of Personal Representative Relationship to patient (or other authority)

Workers' Compensation Disclaimer

(Please read carefully and sign the program that applies to you)

Premier Physicians appreciates your business. Our goal at Premier Urgent Care is to provide excellent care to the community and those injured while on the job. Due to the rising cost of healthcare, lower reimbursements to providers, billing deadlines and rules associated with the Texas Workers Compensation Program, we have had to make some adjustments in how we process work related injuries.

Read and sign statement below if you are not being treated today for a WORK RELATED injury.

The injury/condition that I am seeking treatment for today is NOT work related. I will NOT be filing a workers' compensation claim. I understand that failure to disclose this information will result in all charges becoming my responsibility. I understand that in the event I inform my personal health insurance company this injury/condition is work related, my personal insurance company may not accept responsibility for the charges incurred therefore, I will be responsible for payment in full.

_____ _____ _____

Print Patient Name Signature Date

MIDLAND HEALTH

Cancellation/Missed Appointment/Late Policy

Midland Health: Health and Wellness Center strives to provide quality medical care in a timely manner to all of our patients. In order to do so, we ask that you be aware of the below policies as they pertain to appointments only. These policies enable us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:
It is the policy of the Practice that patients requesting appointment cancellations will be accommodated as efficiently as possible.

In order to be respectful to the medical needs of other patients, please be courteous and call The Health and Wellness Center office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:
To cancel appointments, please call 432-685-2310. If you do not reach the receptionist you may leave a detailed message on our secure voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show Policy:
It is the policy of the Practice to monitor and manage appointment no-shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than 24 hours prior to the scheduled time is considered a "no-show". A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show.

Late Arrivals:
It is the policy of the Practice that a patient who arrives more than 15 minutes after his or her appointment time is handled as a late arrival and will be asked to reschedule as a courtesy to our other scheduled patients.

Patient Name: _____

Patient, Parent, Guardian Signature: _____ Date: _____

Urgent Care –
Urgent Care Occupational Medicine
709 W. Louisiana Ave., Midland Texas 79701-3248

PATIENT HISTORY FORM

Last Name: _____ First Name: _____ M.I. _____ Today's Date: _____
Date of Birth: _____ Age: _____ Your Doctor: _____
Date of Last Doctor Visit: _____ Referred by: _____

Height _____ Weight _____ Dominant hand Right Left Ambidextrous

MAIN PROBLEM / REASON FOR THIS APPOINTMENT: _____

Date of injury or date problem began _____

Was this an on the job injury? No Yes Employer notified? No Yes

Is the injury/problem due to an auto accident? No Yes At fault? No Yes
Insurance/attorney? _____
Have you had prior treatment for this injury? No Yes By whom? _____
If yes, please describe treatment _____

PHARMACY: _____ **Location:** _____

Current Medications – please list prescribing doctor	**Dose**	**Times/Day**

Please list any Herbs, Vitamins, or any Supplements you take: _____

ALLERGIES:
No Known Allergies Medications Allergies: _____
Food Allergies: _____ Environmental Allergies: _____
Have you ever had an allergy to Latex? No Yes IV contrast No Yes Topical Iodine No Yes
Do you have an allergy to metal? No Yes If yes, what kind of metal? _____

SOCIAL HISTORY / PREVIOUS HEALTH CARE: Circle/mark those that apply

Marital status:	Education:	Living Arrangement:	Tobacco Products:	Diet/Exercise:
Single	Grade School	Alone	Dip/Chew No Yes	Want to lose / gain weight
Married	High School	Spouse/Parents/Children	How much? _____	Eats regular, daily meals
Divorced	College	# of children _____	Smoking No Yes	Exercise Type _____
Separated	Professional /Technical	Roommate	How much? _____	Rarely Never Daily
Widowed	Other: _____	Significant other	Year quit? _____	Weekly Monthly
		Other: _____	Second-hand	Caffeine
				Coffee/Tea _____ cups/day
				Soft Drinks _____ oz/day

Employed (occupation _____) Work in home Student Retired
Chemical Exposures: _____

Last Name: _____ First Name: _____

SOCIAL HISTORY / PREVIOUS HEALTH CARE continued: Circle/mark those that apply
Is there any possibility of being pregnant? No Yes NA (If yes, please tell X-ray Tech prior to any x-rays)
Recreational drugs? No Yes, what? Marijuana Cocaine Heroin Methamphetamine Other:_____
Do you have a history of mental or psychological problems? No Yes, Describe: _____
Major stressors in last six months: No Yes Money Job Marriage Children Home Life Health Physical Abuse Mental Abuse
Immunizations Received: Hepatitis A Hepatitis B DTP Hemophilus Influenza B Pneumococci Polio MMR
Varicella Meningococcal Influenza (flu shot) BCG Small Pox Gamma Globulin Other _____
Approximate Date of: Last Tetanus Shot: _____ Last Antibiotic: _____
Last Complete Physical: Date _____ Findings: _____
List any out of town places you have visited or any contact with animals, including pets in the past six months: _____
_____

SURCIAL/HOSPITAL/ILLNESS HISTORY:
Have you ever had general anesthesia? Yes No Any problems? Describe _____

OPERATIONS	DATE	OTHER HOSPITALIZATIONS/ILLNESSES	DATE
Women only: Hysterectomy? N or Y Ovaries? N or Y			

PERSONAL AND FAMILY HISTORY (Check those that apply)
Mother: Living No Yes Current age, or age at time of death? _____
Father: Living No Yes Current age, or age at time of death? _____

SYSTEMS	ILLNESS OR DISEASE (Check those that apply)	Self	Mother	Father	Grand-Parents	Sister/Brother	Children
Aids / HIV							
Alcohol Abuse							
Allergies or Hay Fever							
Alzheimer's							
Anemia							
Arthritis:	Degenerative Rheumatoid						
Back Pain:	Neck Thorasic (middle) Lumbar (Lower)						
Black Outs							
Bleeding Disorder :	Blood Clots (DVT) Hemophilia Plebitis						
	History of Bruising Easily History of Bleeding Easily						
Bowel Problems:	Constipation Diarrhea Bloody Stool						
Breathing Problems:	Asthma Chronic Cough COPD						
	Emphysema Pneumonia Pulmonary Embolus (PE)						
	Shortness of Breath (SOB) Sleep Apnea						
Cancer:	Bladder Bone Brain Breast Lung Prostate						
	Skin Other _____						
Cardiovascular-Heart Problems:	Angina Chest Pain						
	Congestive Heart Failure (CHF)						
	Heart Attack (MI)						
	Pace Maker Stents						
	Irregular Heart Beat Murmur						
	Swelling in Legs Feet						
Chills							

Last Name: _____ First Name: _____

ILLNESS OR DISEASE Continued.. (Check those that apply)	Self	Mother	Father	Grand-Parents	Sister/ Brother	Children
Colds: Frequent Chronic						
Coughing: Frequent Chronic Bloody						
Depression						
Diabetes: Type I Type II						
Dizziness or Fainting Spells						
Epilepsy						
Ears: Chronic Infections Deaf Hard of Hearing						
Eyes: Blindness Blurred Vision Double Vision Glaucoma						
Fever/Temp: _____						
Gallbladder Problems						
Gout						
Fibromyalgia						
Hardening of the Arteries						
Head: Headaches Migraines						
Hepatitis Type A B C						
Hernia						
High Blood Pressure (HTN)						
Kidney/Urinary Problems: Frequent Bladder Infections						
Kidney Disease (ESRD) Kidney Stones Problems Urinating						
Liver Disease: Cirrhosis Jaundice						
Neuropathy:						
Weakness in: Arms Hands Legs Feet						
Numbness in: Arms Hands Legs Feet						
Tingling in : Arms Hands Legs Feet						
Loss of Sensation: Arms Hands Legs Feet						
Nose Bleeds						
Osteoporosis						
Rheumatic Fever						
Scarlet Fever						
Seizures						
Sexually Transmitted Disease: Chlamydia Gonorrhea Herpes						
HIV Syphilis						
Skin Problems						
Sleeping Problems						
Stomach: Ulcers Ulcerative Colitis Gastric Reflux (GERD)						
Irritable Bowel Syndrome (IBS)						
Stroke						
Suicide or Attempted Suicide						
Swollen or Painful Joints						
Throat						
Thyroid Problems						
Tuberculosis						
Weight Loss, How much? _____						
Weight Gain, How much? _____						

Additional information that the provider should know: _____