# Patient Registration Form

Patient Name: Last _____ First _____ MI _____ DOB: _____

Social Security #: ___-___-___ Gender: M / F Home Ph:(__)_____Cell Ph: (__)_____

Address: _____ Apt #_____City: _____

State: _____ Zip: _____ **Email:** _____

Single_____ Married_____ Widow_____Race_____Ethnicity _____Language pref _____

**How did you hear about us?**_____Have you been here in the past year? Yes ___ N___

Reason for Today's Visit:_____

Is this related to a **Work Accident**? Yes___No___ **Auto Accident**? Yes___No___**Other Accident**? Yes___No____

Employer: _____ Phone: (__)_____ Employer Contact_____

Employer Address:_____ Primary Care Doctor_____

Emergency Contact: Name _____ Phone: (____)_____ Relationship:_____

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**Guarantor/ Responsible Party (if patient is under 18)**

Last Name: _____ First Name: _____ MI: _____ DOB:_____

Relationship to patient: _____ Gender (circle one): M / F Social Security #: ___-___-___

Employer: _____ Home: (___)_____Cell: (___)_____Other: (____)_____

Address: _____ City: _____ State: _____ Zip:_____

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**Insurance Coverage**

**PRIMARY** Insurance Company:_____

Insurance Policy #: _____ Group #: _____

Claim Mailing Address: _____ Suite: _____

City: _____State: _____ Zip: _____

**Name of Insured:** _____ Relationship to Patient: _____

**Insured DOB**: _____ **Insured Social Security #:** ___-___-___ Phone: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

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**SECONDARY** Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Claim Mailing Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

**Name of Insured**: _____ Relationship to Patient: _____

**Insured** DOB: _____ **Insured Social Security #:** ___-___-___ Phone: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

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**Consent for services and/or disclosure of Protected Health Information**

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of OZ HealthCare PLLC dba Gentle Primary Care. I also understand that OZ HealthCare PLLC dba Gentle Primary Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor and agree to pay any remaining balance once my Insurance Plan has processed my claim.

_____ _____

Signature of patient or parent/guardian if minor Date

# Patient Medication and Preferred Pharmacy Form

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

**PERSONAL INFORMATION:**

Preferred Name:_____ DOB:_____ Date: _____

**MEDICATIONS:** (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

| MEDICATION | DOSE | FREQUENCY | MEDICATION | DOSE | FREQUENCY |
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**Preferred Pharmacy**

Pharmacy Name:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

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# Controlled Substance Use Agreement

*Patient must sign with initials in order for this agreement to be effective.*

_____I understand that I have a medical condition which requires use of controlled substance medication(s) because this medical condition has not been adequately controlled with non-controlled medications and that my function is limited by this medical condition. I understand that the intent of this medication is to increase my ability to do more, though the controlled substance medication is unlikely to eliminate my condition.

_____I will take the medication only as prescribed. I will not take any sedatives, alcohol, or other pain medications without the prior approval of my doctor.

_____I understand that the medication will be prescribed only by Dr._____and only according to the agreed upon schedule. Prescriptions will be provided only during regular business hours. Medications will not be called in to the pharmacy.

_____I will not seek or accept any additional controlled substance medications (i.e. pain, anxiety or stimulants) other than those prescribed by my doctor. This includes prescriptions from other doctors, medications borrowed or accepted from family or friends and any illicit or street drugs.

_____Medication refills will be provided as written prescriptions only. No refills will be given prior to 30 days. I understand that I must make appointments with my doctor at least every (3) months or sooner if my doctor recommends. No refills will be given if I do not keep these appointments. Two (2) no show appointments will constitute grounds for immediate dismissal from the practice.

_____Medication refills will be made only during regular office hours -Monday through Friday, 8:00am -4:30pm. No refills on nights, holidays, or weekends. I must call at least (5) business days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** No early or emergency refill may be made.

_____I understand that my doctor is under no obligation to provide these medications to me, and that he/she reserves the right to discontinue these medications at any time. If I refuse, I understand the medications will be stopped.

_____I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure my medications. This includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen controlled substance prescriptions.

_____I understand that my doctor may request specialist evaluation of my treatment and I agree to keep appointments. My doctor will send a copy of my medical record and care to the referred physician.

_____I understand that my doctor by law is required to report all controlled substances dispensed to me to the state monitored prescription monitoring program.

___ Patient Initials: _____ MD Initials: _____

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_____In addition to the above agreements, I accept the right of my doctor's staff to terminate this agreement for any of the following reasons:

a) I seek or obtain any pain medication from a source other than my doctor.
b) I in any way attempt to forge or alter a prescription.
c) I distribute my prescribed medication(s) to any other person.
d) My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents danger to my well-being or safety.
e) There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.
f) At every office visit urine will be collected. Refusal of collection is grounds for termination.

_____I agree to fill my prescriptions only at the pharmacy listed in the pharmacy form. If I change pharmacies, I will contact my doctor's office with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time.

_____I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of medication prescriptions and immediate dismissal from my doctor and the practice.

_____I understand that if I default from this agreement and I am having a medical condition I should call 911 or go to the nearest emergency room.

Patient Name: (printed) ————————————————————————

Patient Signature: _____

Date Signed:_____ Date of Birth: _____

Physician Signature: ————————————————————————

Date Signed: _____

_____

# NOTICE OF PRIVACY PRACTICES

**This notice describes how your medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.**

From time to time, OZ HealthCare PLLC dba Gentle Primary Care uses and discloses confidential personal health information about patients. We know this information is private. We call this information "protected health information" (PHI). We are required to protect the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This notice describes how we may use and disclose your PHI and certain rights you have with respect to your PHI.

**Uses and Disclosures for Treatment, Payment and Health Care Operations**

HIPAA privacy rules permits us to use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining a specific written permission from you, known as an "authorization."

**FOR TREATMENT**: We may use or disclose information (PHI) about you to coordinate your healthcare. We may consult with other health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.

**FOR PAYMENT:** We may use or disclose information to get payment for the health care services you receive. For example, we may provide PHI to bill your health plan for services provided to you.

**FOR HEALTH CARE OPERATIONS**: We may use or disclose information in performing business activities, which are called health care operations. Health care operations allow us to improve the quality of care we provide.

**APPOINTMENTS AND OTHER HEALTH INFORMATION:** We may send you reminders for medical services. We may send you information about health services that may be of interest to you.

**Other uses and disclosures for which authorization is not required.**

In addition to using and disclosing PHI for treatment, payment and health care operations, the HIPAA Privacy Rule permits (or requires) us to use and disclose PHI without your written authorization under the circumstances described below:

**AS REQUIRED BY LAW AND FOR LAW ENFORCEMENT:** We will use and disclose information when required or permitted by federal or state law or by a court order. If federal or state law creates higher standards of privacy, we will follow the higher standard.

**FOR ABUSE REPORTS AND INVESTIGATIONS:** If we reasonably believe a patient has been a victim of abuse or neglect, we may disclose PHI as required by law.

**FOR GOVERNMENT PROGRAMS:** We may use and disclose information for public benefits under other government programs. For example, we may disclose information for the determination of Supplemental Security Income (SSI) benefits.

**TO AVOID HARM:** We may disclose PHI to law enforcement agencies in order to avoid a serious threat to the health, welfare and safety of a person or the public.

**FOR RESEARCH:** We may use information for studies and to develop reports.

**DISCLOSURES TO FAMILY, FRIENDS AND OTHERS:** We may disclose information to the family or others persons who are involved in the patient's medical care. You have the right to object to the sharing of this information.

**Please list the names of the persons to whom we may disclose the patient's PHI and state how the individual is related to the patient:**

**Name:** _____ **Relationship:** _____

**Name:** _____ **Relationship:** _____

**Name:** _____ **Relationship:** _____

**Other uses and disclosures require your written authorization**

**For other situations, we will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. We cannot take back any uses or disclosure already made with your authorization.**

# NOTICE OF PRIVACY PRACTICES

**Your Privacy Rights:**

**RIGHT TO INSPECT AND COPY MEDICAL RECORDS:** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records

**RIGHT TO REQUEST RESTRICTIONS:** You have the right to ask us to limit how your information is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom you want the limits to apply. We are not required to agree to the limit. You can request in writing that the limit be terminated.

**RIGHT TO AMEND:** You may ask us to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request

**RIGHT TO RECEIVE CERTAIN DISCOSURES:** You have the right to ask us for a list of disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment or health care operations. This list will not include information provided directly to you or your family or information that was sent with your authorization

**RIGHT TO OBTAIN A PAPER COPY:** You have the right to ask for a paper copy of this notice at any time.

**RIGHT TO FILE A COMPLAINT:** You have the right to file a complaint with us at the address listed below and with the Secretary of the United State Department of Health and Human Services if you do not agree about how we have used or disclosed information about you.

**RIGHT TO REVOKE PERMISSION:** If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

**RIGHT TO CHOOSE HOW WE COMMUNICATE WITH YOU:** You have the right to ask that we share information with you in a certain way or in a certain place. For example, you can ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the reason for your request.

**RIGHT TO RECEIVE NOTICE OF CHANGE TO OZ HEALTHCARE PLLC DBA GENTLE PRIMARY CARE PRIVACY STATEMENT:** You have a right to receive notice of changes in our privacy statement that affect you on or after the effective date of the change.

**If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.**

**OZ HealthCare PLLC dba Gentle Primary Care**
**6909 Brisbane Court, Suite 300**
**Sugar Land Texas 77479**
**(281) 801-7855**

**I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that they practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way.**

**Print Patient or Representative Name** _____ **Patient or Representative Signature** _____ **Date** _____

Patient or Representative refused or unable to sign because of _____

Date: _____ Witnessed by: _____

This notice was published and becomes effective on January **1, 2021.**

# Payment Policy

**Thank you for choosing OZ HealthCare PLLC dba Gentle Primary Care for your healthcare needs. Payment is due at the time of service.**

**If your insurance plan requires you to pay a co-payment, deductible, or co-insurance, you will be expected to pay this amount today.**

**If you do not have insurance, we will provide you with the visit cost based on our Self Pay Fee Schedule. Patient's who would like to go on a payment plan will be required to pay 30% of the visit cost at the time of service. Patient's who are able to pay for the entire visit may be eligible for a discount.**

**If you are covered by an insurance plan that we are not currently contracted with, you will be asked to pay your applicable co-payment, deductible or coinsurance amount today. We will courtesy file your claim with your insurance carrier and accept any out-of-network benefit amount paid to us. If patient deductible and coinsurance amounts cannot be determined and paid in advance today, you will be billed.**

**No Show Fee: For any missed appointements, without prior notification, there will be a No Show cancelation Fee of $35**

**Late Fee: There is a $25 late fee for all accounts over 60 days past due.**

**If you have a balance due on your account, you will be expected to pay the balance at check-in in order to be treated today.**

**Thank you for your acceptance of this Policy**

**Signed_____**