SOUTHWEST DIABETES & ENDOCRINOLOGY PATIENT REGISTRATION

✓ PATIENT DEMOGRAPHICS

DATE:_____

Legal Name: First_____MI_____Last_____Preferred First Name: _____

Parent/Legal Guardian Name_____DOB_____Mobile_____

SS#_____ Sex: □ M □ F DOB:_____

Address:_____Apt #_____City_____State_____Zip _____

Phone: Home_____Work_____Mobile_____

E-Mail_____□ No Email

✓ GENERAL INFORMATION

Marital Status: □ Divorced □ Legally Separated □ Married □ Significant Other □ Single □ Widowed

Race: □ Asian □ Black □ Native American □ Native Hawaiian/Pacific Islander □ Two or More Races □ White

Ethnicity: □ Hispanic □ Non-Hispanic

✓ ADDITIONAL DEMOGRAPHICS

Preferred Communication Method: □ No Preference □ Mail □ Phone □ E-mail □ Patient Portal □ Accept Text Messages
By checking one of the boxes for Preferred Communication Method, I agree to receiving correspondence from Southwest Diabetes & Endocrinology

✓ PCP

Primary Care Physician_____Referred by Dr._____

✓ PHARMACY

Local pharmacy/Phone number/City_____

Mail order pharmacy_____

✓ EMERGENCY CONTACTS

Name_____Rel to Patient_____Home Phone_____Mobile_____

Name_____Rel to Patient_____Home Phone_____Mobile_____

✓ EMPLOYMENT

Employer Name_____Employment Status: □ Disabled □ Full Time □ Part Time □ Retired □ Student □ Unemployed

Occupation_____

✓ OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize SW Endocrinology and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to SW Endocrinology of changes or update. I authorize SW Endocrinology to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

If ***no* answer**, may we leave a message for you ☐ **Appointments** ☐ **Billing** ☐ **Medical Care** Home Phone: □ Y □ N Work: □ Y □ N Mobile: □ Y □ N

□ Only Release Information to Patient

Discuss your personal information, including appointments and treatments with someone other than yourself?

Name_____ Relationship to Patient_____

Home Phone_____ May We Leave a Message? □ Y □ N Mobile_____ May We Leave a Message? □ Y □ N

You may release the information regarding the following services to the person named above: ☐ **Appointments** ☐ **Billing** ☐ **Medical Care**

Name_____ Relationship to Patient_____

Home Phone_____ May We Leave a Message? □ Y □ N Mobile_____ May We Leave a Message? □ Y □ N

You may release the information regarding the following services to the person named above: ☐ **Appointments** ☐ **Billing** ☐**Medical Care**

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet.

✓ **Initials**

✓ FINANCIALLY RESPONSIBLE PARTY – GUARANTOR

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____ MI_____ Last_____ DOB_____

Relationship: Spouse Father Mother Other (Please Specify):_____

Address:_____ Apt #_____ City_____ St_____ Zip_____

Phone: Home_____ Cell_____ Work_____

Employer Name_____ Employment Status: □ Student □ Part Time □ Full Time □ Retired □ Disabled □ Unemployed

✓ INSURANCE INFORMATION

PRIMARY INSURANCE_____ ID_____ Gp _____

Subscriber Name_____ Sex: □ M □ F Patient Relationship to Subscriber_____

Subscriber's DOB_____ Employer_____ Employment Status: □ Part Time □ Full Time □ Retired □ Disabled □ Unemployed

SECONDARY INSURANCE_____ ID:_____ Gp _____

Subscriber Name_____ Sex: □ M □ F Patient Relationship to Subscriber_____

Subscriber's DOB_____ Employer_____ Employment Status: □ Part Time □ Full Time □ Retired □ Disabled □ Unemployed

✓ PATIENT PORTAL

The Patient Portal is internet based and used at a personal computer. The Patient Portal is a secure way to:

☐ Request appointments

☐ Refill Medication

☐ View test results

☐ Send secure messages to your doctor

☐ Acces**s** visit summaries and personal health record

☐ Update your personal information

The Healow app is a secure tool that lets you communicate with your doctor's office and access your medical records via a smart phone. You will be able to access your appointments, lab results and vitals, and manage medications and other personal data all within one app.

Please provide your email address below to obtain access to the Patient Portal.

Email Address: _____ **Signature:** _____

✓ HOW YOU HEARD ABOUT US

□ Family/Friend □ Website □ Internet Search

□ Referring Physician_____□ Other _____

RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

- I authorize the release of all medical records to other physicians and/or specialists if applicable to my care and condition.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Southwest Diabetes & Endocrinology.

✓ PRIVACY PRACTICES

Southwest Diabetes & Endocrinology is committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy

✓ ACKNOWLEDGMENT

I have read, fully understand and agree to the above **release of medical information to others, financial and payment guideline, release of information & assignment of benefits, and privacy practices**. I also certify that all of the information, provided is complete and accurate.

Patient Name_____Signature_____Date_____

Health Information Exchange Authorization

SOUTHWEST DIABETES & ENDOCRINOLOGY participates in health information exchanges.

Frequently Asked Questions document which may be revised at any time.

A Health Information Exchange (HIE) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. A Health Information Exchange is an electronic health information system that stores your patient health information from multiple healthcare providers participating in the HIEs. It allows your other health care providers to view your past health information for continued care and other uses included in the provider's Notice of Privacy Practices. Your information will be stored within the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.

I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may be included.

I authorize the above provider to disclose my medical information described above to the HIEs in which Southwest Diabetes & Endocrinology participates. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by other providers and such information may no longer be protected.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the above provider for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

✓ **I authorize release of my medical information to the Health Information Exchanges in which Southwest Diabetes & Endocrinology participates:**

_____Yes_____No

Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Health Information Exchange Authorization form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

Print Patient's Name	Date of Birth	Address
Signature of patient or authorized representative	Relationship to patient or self	Date
Witness	Title	Date

A "legally authorized representative" is; 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian or a minor, or 6) a person authorized under the Texas Consent To Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. Written evidence of legally authorized representative status must be presented to the clinic prior to release of any information.

Southwest
Diabetes & Endocrinology