Uptown Physicians Group
4144 North Central Expressway, Suite 750
Dallas, TX 75204
(214) 303-1033 fax (214) 303-1032

Personal Information:

*Patient Name:*_____
(Last) *(First)* *(Middle)*

*Address:*_____*Date:*_____

*City:*_____ *State:*_____ *Zip:*_____ *Sex: M / F*

*Home Phone:*_____ *Cell:*_____ *Other:*_____

*Social Security #:*_____ *Date of Birth:*_____

*Employer:*_____ *Phone:*_____

*Spouse/Partner:*_____ *Physician:*_____

*Emergency Contact:*_____ *Phone:*_____

*Reason for Visit:*_____ *Previous Doctor:*_____

*How did you hear about us?:*_____ *Pharmacy:*_____

Insurance Information: (for office use)

*Primary Insurance:*_____ *Policy Holder:*_____

*Group Number:*_____ *Policy Number:*_____

*Effective Date:*_____ *Office Copay:*_____ *Referral: Y/N*

Benefits Payable at _____ *After*_____ *Deductible*_____*Met?: Y/N*

Pre-Exist Clause: Y/N _____ *Vaccines Covered: Y/N*

*Bill labs in office: Y/N Deductible for labs Y/N Deductible amount:*_____

*Benefits quoted by:*_____ *Verified by:*_____ *Date:*_____

*Secondary Insurance:*_____ *Policy Holder:*_____

*Group Number:*_____ *Policy Number:*_____

Uptown Physicians Group Consent Form

Authorization To Release Information:
I hereby authorize Uptown Physicians Group to release to my insurance carrier(s) and to Evergreen Medical Billing any information acquired in the course of my examination or treatment required for payment of any insurance claim.

Signed:_____Dated:_____

Assigment of Benefits:
I hereby authorize payment directly to Uptown Physicians Group for medical benefits. I understand that I am financially responsible for the charges not covered by the insurance company.

Signed:_____Dated:_____

Electronic Privacy Waiver:
I understand that my medical records may be transmitted electronically. Although every effort will be made to assure the records are sent/received by the appropriate third party, I absolve Uptown Physicians Group/David M Lee MD PA from liability should they be received in error by a third party. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

Signed:_____ Dated:_____

Acknowledgement of Office Policies:
I am aware that I will be charged $25-75 for missed appointments not cancelled 24 hours in advance. I am also aware that $25 will be charged for preparation of FMLA/private disability forms at the time the forms are dropped off at the office.

Signed:_____ Dated:_____

Permission to Share Medical Information:
You have my authorization to share my medical records and medical information with the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signed:_____ Dated:_____

If you would like them released to no one then sign here:_____

Permission to Leave Messages on Answering Machine:
By signing below you authorize us to leave messages regarding appointment reminders, referral information, etc. on the numbers below. We will use your email address to create a portal account for you so you can access your labs/appointment reminders/messages though our secure portal:

Email Address: _____

Mobile Number (_____)_____-_____ Other Number (_____)_____-_____

Signed:_____ Dated:_____

By signing below you additionally authorize your physician to leave messages regarding abnormal lab values/other clinical information on the above numbers.

Signed:_____ Dated:_____

Uptown Physicians Group Patient Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *a basis for planning my care and treatment*
- *a means of communication among the many health professionals who contribute to my care*
- *a source of information for applying my diagnosis and surgical information to my bill*
- *a means by which a third-party payer can verify that services billed were actually provided*
- *and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

___Accepted _____ Denied

_____
(Signature of Patient or Legal Representative)

_____
(Printed Name of Patient or Legal Representative)

_____
(Date Notice Effective)

*Name:*_____ *Age:*_____ *Sex:*_____ *Date:*_____

*Spouse/Partner Name:*_____ *Children:*_____ *Occupation:*_____

*Smoke?*_____ *Alcohol?*_____ *Drug Use?*_____ *Exercise Regularly?*_____

Have you ever had?	*Yes*	*No*
Anemia		
Allergies		
Anxiety		
Asthma		
Arthritis		
Cancer		

	Yes	*No*
Depression		
Ear Trouble		
Eye Trouble		
Heart Disease		
Hepatitis		
HIV/AIDS		

	Yes	*No*
Lung Disease		
Prostate Trouble		
Reflux/Ulcers		
Skin Problems		
Thyroid Disease		
STD		

Other Medical Problems	*Previous Surgeries/Hospitalizations*	*Medications*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you now have?	*Yes*	*No*
Weight Loss		
Loss of Energy		
Fever/Chills		
Loss of Appetite		
Headache		
Dizziness		
Fainting Spells		
Blurred Vision		
Swollen Glands		
Poor Hearing		

	Yes	*No*
Sore Throat		
Trouble Breathing		
Wheezing		
Coughing		
Chest Pains		
Racing Heart		
Swelling/Edema		
Nausea/Vomiting		
Abdominal Pain		
Diarrhea		

	Yes	*No*
Constipation		
Blood in Stool		
Abnormal moles		
Painful Urination		
Discharge		
Muscle Pain		
Painful/Red Joints		
Rash		
Depression		
Anxiety		

Who in your family has been diagnosed with?

*Heart Disease:*_____

*High Blood Pressure:*_____

*Diabetes:*_____

*Cancer:*_____

*Stroke:*_____

Health Maintenance – When was you last?

*Tetanus Shot?*_____

*Pneumonia Shot?*_____

*Flu Shot?*_____

*Pap smear/Mammogram?*_____

*Colonoscopy?*_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective January 1, 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name UPTOWN PHYSICIANS GROUP
Address 4144 N CENTRAL EXPRESSWAY, SUITE 750
City DALLAS State TX Zip Code 75204
Phone (214) 303-1033 Fax (214) 303-1032

REASON FOR DISCLOSURE
(Choose only one option below)

- ☒ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☒ **All health information**
- ☒ Physician's Orders
- ☒ Progress Notes
- ☒ Pathology Reports
- ☒ History/Physical Exam
- ☒ Patient Allergies
- ☒ Discharge Summary
- ☐ Billing Information
- ☒ Past/Present Medications
- ☒ Operation Reports
- ☒ Diagnostic Test Reports
- ☒ Radiology Reports & Images
- ☒ Lab Results
- ☒ Consultation Reports
- ☒ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

__X__ Mental Health Records (excluding psychotherapy notes)
__X__ Drug, Alcohol, or Substance Abuse Records
__X__ Genetic Information (including Genetic Test Results)
__X__ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to other covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.506(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective January 1, 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests.

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization.

Authorizations for Marketing Purposes - If this authorization is being provided or obtained for marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must also clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code § 181.152; 45 C.F.R § 164.508(a)(3)).

Limitations of this form - This authorization form should not be used for: (1) the disclosure of any health information as it relates to health benefits plan enrollment and/or related enrollment determinations (45 CFR §§164.508(b)(4)(ii), .508(c)(2)(ii)); or (2) the use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(3)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.