NORTHWEST MEDICAL GROUP
1919 N LOOP WEST STE 218
HOUSTON, TX 77008

PATIENT INFORMATION

Please Print

TODAY'S DATE:_____ SS#_____

PATIENT NAME_____
Last First Middle Initial

( ) Single ( ) Married ( ) Divorced ( ) Widowed

DATE OF BIRTH_____ AGE:_____ ( ) Male or ( ) Female

ETHNICITY_____RACE _____PRIMARY LANGUAGE _____

ADDRESS_____HOME #(____)_____

CITY:_____STATE:_____ ZIP CODE:_____CELL # (_____)_____

EMAIL ADDRESS _____

OCCUPATION:_____WORK # (____)_____

EMPLOYER:_____ADDRESS: _____

IN CASE OF EMERGENCY, CONTACT:_____RELATIONSHIP _____

PHONE # (____)_____

REFERRED BY:_____ OTHER FAMILY MEMBER SEEN:_____

RESPONSIBLE PARTY INFORMATION

PATIENT COVERED BY INSURANCE? Yes ☐ No ☐ (self-pay)

PRIMARY INSURANCE CARRIER:

INSURANCE COMPANY:_____SUBSCRIBER:_____

INSURED'S EMPLOYER_____INSURED'S WORK PHONE:_____

INSURED's SS#_____ DOB: _____Relationship to Patient_____

GROUP #_____ ID #_____

SECONDARY INSURANCE CARRIER:

INSURANCE COMPANY:_____POLICY HOLDER:_____

INSURED'S EMPLOYER_____INSURED'S WORK PHONE:_____

INSURED's SS#_____DOB: _____Relationship to Patient_____

GROUP #_____ ID#_____

NORTHWEST MEDICAL GROUP

CONSENT FOR TREATMENT AND RELEASE OF PROTECTED HEALTH INFORMATION

Consent for Treatment/Assignment of Benefits

I, _____, hereby request and authorize Northwest Medical Group to examine and treat me. I understand that I will be required to sign a separate release for medical records transfer to any other source. I authorize payment(s) of medical benefits to Northwest Medical Group. If services are denied and considered non-covered by my insurance carrier, I will be responsible for the balance due.

Consent for Release of Protected Health Information

I, _____, consent to the release of protected health information that is required to carry out treatment, payment and healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

1. I have the right to place restrictions on the way my protected health information is used or disclosed.
2. I understand that Northwest Medical Group is not required to agree with my restrictions. I also understand that once Northwest Medical Group agrees to my restrictions, it must comply with those restrictions.
3. I have the right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
4. I understand that Northwest Medical Group must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
5. Northwest Medical Group has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practice, we will modify the Notice accordingly; and we will inform you via posted notice

I give permission to the following individuals to receive health information on my behalf. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification.

_____
Name

_____
Relationship (ex: husband, wife, son)

Individual:

Witness:

_____
Printed Name

_____
Printed Name

_____
Signature

_____
Signature

_____
Date

_____
Date

NORTHWEST MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Northwest Medical Group is permitted to make uses and disclosures of protected health information for treatment, payment, and healthcare operations, as described in the following examples:
    a. For treatment – consultation, lab work, etc.
    b. For payment – claim filing, collection of payments due, etc.
    c. For health care operations – chart maintenance, regulatory requirements, accounting, HIPAA compliance activities, etc.
2. Northwest Medical Group is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Other uses and disclosures will be made only with the authorization, and the individual may revoke such authorization.
3. Northwest Medical Group may engage in the following activities:
    a. Northwest Medical Group may contact the individual to provide appointment remainders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
    b. Northwest Medical Group may contact adult immediate family members to provide appointment remainders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
4. The individual has the following rights regarding protected health information:
    a. The right to request restrictions on certain uses and disclosures of protected health information. However, Northwest Medical Group is not required to agree to a requested restriction.
    b. The right to receive confidential communications of protected health information, as applicable.
    c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
    d. The right to amend protected health information, as provided in the Privacy Regulation
    e. The right to receive an accounting of disclosures of protected health information.
    f. The right to obtain a paper copy of the Notice from the covered entity upon request. The right extends to an individual who has agreed to receive the Notice electronically.
5. Northwest Medical Group is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.
6. Northwest Medical Group is required to abide by the terms of the Notice currently in effect.
7. Northwest Medical Group reserves the right to change the terms of this Notice. The new Notice will be effective for all protected health information that it maintains.
8. Northwest Medical Group will provide individuals or patients with revised Notice as requested.
9. Individuals may complain to Northwest Medical Group and the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. Complaints may be submitted in writing to 1919 N. Loop West, Ste 218, Houston, TX 77008.
10. Northwest Medical Group contact person for matters relating to complaints is: Irma Saenz 713-862-5797
11. This Notice is in effect on April 30, 2004.
12. Northwest Medical Group elects to limit the uses or disclosures that it is permitted to make by law.

I hereby acknowledge that I have received a copy of Northwest Medical Group's Notice of Privacy Practices.

_____ _____

Individual's Signature Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize **Northwest Medical Group** to ☐ release to: ☐ receive from:

Person or Organization Address

Phone Fax

Information/copies from the medical records on:

Patient Date of Birth Social Security

Date(s) of Service

INFORMATION TO BE RELEASED:

____ History & Physical ____ Medication list(s) ____ Billing Records
____ Consultations Notes ____ Diagnostic Procedure Report
____ Progress Notes ____ EKG reports (most recent)
Other_____

This information is being released for the following purpose:

____ Continued Care ____ Attorney/Litigation ____ Insurance ____ Disability Services
____ Billing Purposes ____ Other _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire _____ days from the date of my signature.
If no time period is specified, it shall expire in 180 days from the date of signature.

I understand that if the recipient authorized to receive the information is not a covered entity. e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulation (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Signature of Patient or Legally Authorized Representative Date

Relationship to Patient

Print Name of Legally Authorized Representative (if applicable)

Witness – Printed Name/Signature Date

Patient or Legally Authorized Representative Driver's License/ID #

MEDICAL RECORDS FAX# 713-862-0166

NORTHWEST MEDICAL GROUP 1919 NORTH LOOP WEST, SUITE 218 HOUSTON, TEXAS 77008-1366

Narcotic Agreement

This agreement is between patient and Northwest Medical Group / Thomas Family Practice. It is agreed that **Dr. Van Tran, or Dr. Sally Thomas** will give narcotic medication to patient **only** if the following terms are met:

1. By signing a contract for narcotic administration, the patient indicated that he/she has understood the discussion about the use of narcotic medications, including side effects, and is agreeable to start this treatment under the terms set by Dr. Van Tran, or Dr. Sally Thomas.
2. The patient has the chance to ask questions regarding alternatives to the use of narcotic medications.
3. Northwest Medical Group / Thomas Family Practice should be the **one and only source** of narcotic medications unless written permission is given by physician for the patient to get narcotic prescriptions from another physician.
4. **Only one pharmacy** will be used for filling narcotic prescriptions.
   The name of pharmacy: _____
   Pharmacy phone number: _____
5. If it is found that the patient received prescriptions for narcotic medications from a source other then physician, without written permission physician, may void this agreement and discontinue any prescriptions of narcotic medications to the patient.
6. **The patient agrees to have urine tests for medications done randomly at the physician's request.**
7. The patient must agree to allow the physician to communicate with the referring physician and any pharmacists regarding the patient's use of controlled substances.
8. The patient must supply documentation of treatment by other physician for co-existing, or related condition, including psychiatric conditions.
9. **The patient understands that Northwest Medical Group / Thomas Family Practice will not replace any lost or inaccessible narcotic prescriptions or narcotic medications, for ANY REASON WITHOUT A POLICE REPORT**
10. The patient must take the narcotic medications **exactly as instructed** by the Physician.
11. Any unauthorized increase in the dose of narcotic medication may be viewed as a cause for discontinuation of the treatment with narcotic medications.
12. If the patient demonstrates unacceptable behavior patterns, the physician may discontinue prescribing the narcotic medications for the patient.
13. The patient must **keep all regular follow up appointments** as recommended by the Physicians. Failure to comply may cause discontinuation of narcotic prescriptions.
14. The patient must comply with **all** aspects of the treatment plan, including, but not limited to, Physical Therapy, Behavioral Management, and Pain Management programs.
15. All prescriptions must be picked up by the patient himself/herself. If the patient is too debilitated or sick, an exception may be allowed.
16. **No narcotic prescriptions will be refilled on weekends or after hours**

17. **Narcotic prescriptions WILL NOT be refilled early.**
18. The patient understands that the benefit of the narcotic medications will be evaluated periodically using the following criteria of pain relief, increase in general functions, increase in exercise, completion of rehabilitation program, return to work, maintenance of job, etc.
19. The patient understands the narcotic medications can be discontinued immediately, at the treating physician's discretion, if the patient does not fulfill the terms of this agreement. Medication can also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or if significant side effects develop.
20. The patient certifies or agrees to the following:
    a) That he/she is **not currently abusing illicit** or prescription drugs.
    b) That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substance (narcotics, sleeping pills, nerve pills, or pain killers).
    c) That she is not pregnant and that she will use appropriate contraception during her course of treatment.
    d) **Sharing your narcotics is strictly prohibited**. Any sharing will result in immediate cancellation of your prescription refills.
21. Evidence of medication hoarding, increasing the amount of medication with out communication to your physician, refilling your prescription too frequently, getting the medication from multiple physicians, increasing the amount of medication despite significant side effects, altering prescription, medication sales, unapproved use of other drugs (alcohol, sedatives, or using non-prescription, medications inconsistent with drug labeling) during narcotic analgesic treatment or other unacceptable behavior will result in tapering and discontinuing of narcotic therapy.
22. **If the patient is non-compliant or un-cooperative with the Physician or Office Staff we reserve the right to discharge you at any time.**

I fully understand the explanations regarding the benefits and the risks of this method of treatment. I agree to the use of narcotic medication in treatment of my pain problem.

This for has been fully explained to me, I have read it or have had it read to me, and I understand it. I have had the opportunity to ask questions, and have received acceptable answers. I agree to the terms of this contract.

Date: _____

Patient Signature:

Patient Printed Name:

NORTHWES MEDICAL GROUP
1919 NORTH LOOP WEST, SUITE 218
HOUSTON, TX 77008

MEMORANDUM

TO: ALL CURRENT & NEW PATIENTS

FROM: Northwest Medical Group

Re: CHANGES IN APPOINTMENT POLICIES
Effective 07/21/2006

Due to repetitive cancellations of appointments, including missed/no show appointments without a 24- hour notification, there will be a $25.00 fee incurred per occurrence. After the occurrence, you will receive a statement for this amount. Same day cancellations must be received 2 hours prior to appointment. We regret having to enforce our request for prior notification but this will enable us to service other patients in need of medical treatment who are able to come in for an appointment.

Sincerely,
Management

Revised: 08/01/2010