PCA – PRIMARY CARE ASSOCIATES
4211 Joe Ramsey Blvd. Ste 100
Greenville, Texas 75401

Today's Date	Reviewed By

PLEASE PRINT CLEARLY
USE BLUE OR BLACK INK

ADULT PATIENT INFORMATION

Last	First	MI
☐ Male ☐ Female	Date of Birth _____/_____/_____	
Social Security Number	Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single	
Physical Address	Apartment #	
City	State	Zip Code
Mailing Address (if different than physical address)		
Email Address		
☎ Home Phone ( ) -	Ok to leave a message? ☐ YES ☐ NO	
☎ Work Phone ( ) -	Ok to leave a message? ☐ YES ☐ NO	
☎ Cell Phone ( ) -	Ok to leave a message? ☐ YES ☐ NO	
Person to contact in case of emergency	Relationship to patient	☎ Home Phone / ☎ Work Phone

PATIENT AUTHORIZATION

I hereby grant consent to all healthcare providers of PCA-Primary Care Associates to evaluate and treat. I authorize PCA – Primary Care Associates to release to my insurance company any information required, including the diagnosis and records in the course of my exam or treatment. I understand it is the patient's responsibility to let us know if pre-certification is required for any office visit, in-patient, out-patient admissions as well as any surgeries. I understand that the failure to notify our office may cause me increased out of pocket expenses such as denied claims and reduced benefits. I also understand that is it the patient's responsibility to select a PCP prior to my services and it must be a PCA provider. I hereby authorize payment directly to PCA – Primary Care Associates for the medical and/or surgical benefits otherwise payable to me, but not to exceed charges made for such treatment. I understand that I am financially responsible for the charges not covered by my insurance.

X _____

Patient OR Responsible Party Date

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Adult Medical History

NAME: _____ **DOB:** ____/_____/____
PHARMACY: _____

MEDICINES YOU ARE ALLERGIC TO: _____

_____

PAST SURGERIES AND DATES:

Appendectomy_____Cholecystectomy_____C-section_____Cataract_____
Hernia_____ Tonsillectomy_____ Hysterectomy_____ Heart Surgery _____
Others (please list) _____

# of Pregnancies_____ Live Births_____ Miscarriages_____ Abortions_____ C-Sections_____

CHRONIC MEDICAL CONDITIONS:

_____
_____
_____
_____
_____

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____

SOCIAL HISTORY:

Marital status: Single Married Divorced Widowed
Do you drink alcohol? No Yes If yes, how often? _____
Do you smoke? No Yes
Cigarettes? No Yes If yes, how many packs per day? _____ How many years? _____
If quit, when? _____ How long did you smoke? _____ packs per day? _____
Have you ever used illegal drugs? No Yes If yes, did you use IV drugs? No Yes
Have you ever received a blood transfusion or blood product? No Yes If yes, when? _____

FAMILY HISTORY:

	Living Age:	Deceased Age:	Illnesses:
Mother:	_____	_____	_____
Father:	_____	_____	_____
Brothers:	_____	_____	_____
Sisters:	_____	_____	_____

Has any blood relative had: (check and give relationship, use N/A if not applicable)

Stroke _____ Epilepsy _____ Heart attack_____ Nervous breakdown _____
Cancer _____ Diabetes _____ Stomach ulcer _____ Hypertension _____
Migraine _____Asthma _____ Kidney disease _____ Leukemia _____ Arthritis _____

GIVE THE DATE OF YOUR LAST:

1.)Pap smear: _____
2.) Mammogram: _____
3.) Bone Density: _____
4.) Colonoscopy: _____
5.) Pneumonia Vaccine: _____
6.) Flu Shot: _____
7.) Tetanus Shot: _____
8.) Physical Exam: _____

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Insurance Information

Patient Name	Date of Birth

Primary Insurance

Name of Insurance Co.	Employer
Policy Holder Name: (Person who hold the insurance policy)	□ Male □ Female
Date of Birth:	Social Security Number:
Relationship to Patient:	

Secondary Insurance:

Name of Insurance Co.	Employer
Policy Holder Name: (Person who hold the insurance policy)	□ Male □ Female
Date of Birth:	Social Security Number:
Relationship to Patient:	

Guarantor (person responsible for payment)

Name	Relationship to patient	Date of Birth	Social Security Number
Address of Guarantor if different than Patient:			

X_____ _____ _____

Patient OR Responsible Party | Relationship | Date

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ADULT HIPAA / RELEASE OF INFORMATION PER PATIENT'S ASSIGNMENT

I have acknowledged/received a written copy of PCA's "Notice of Privacy Practices".

Patient's name _____ DOB _____ /_____/_____

_____ Initial here if you **DO NOT** authorize assignment of any person(s) to communicate with PCA-Primary Care Associates, P.A, for any reason, including your emergency contact.

OR

I hereby give permission to Primary Care Associates to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient / Representative: X _____ Date _____

Relationship (if other than patient) _____

A COPY OF THIS DOCUMENT IS VALID AS AN ORIGINAL

PCA-Primary Care Associates, PA

Notice of Privacy Practices

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

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about his notice or our privacy practices and policies, please contact the person listed below.

Treatment, Payment, Health Care Operations:

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, (your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care). OR (the physician in this practice is a specialist. When we provide treatment, we may requests that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he/she can appropriately treat you for other medical conditions, if any)

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurance. The form will contain medical information, such as a description of the medical services provided to you; that your insurance needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example (we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law) OR (we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice).

Disclosures that can be made without your authorization

To request a restriction, submit the following in writing: 1. The information to be restricted, 2. What kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and 3. To whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable request. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decision about your care. Texas law requires that requested copies be made in writing and we ask that request for inspection of your health information also is made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information is listed below:

1. Psychotherapy Notes
2. Identity of a person who provided information if it was obtained under a promise of confidentiality.
3. Is subject to the Clinical Laboratory Improvements Amendments of 1988.
4. Has been complied in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be

lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

1. Wasn't created by this practice or the physicians in the practice.
2. Is not part of the Designated Record Set
3. Is not available for inspection because of an appropriate denial
4. If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing, allow the amendment to be made and tell others that we know they have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permits you to request, and us to provide, an accounting of disclosures that are other than treatment, payment, healthcare operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person below. Your first accounting of disclosures (within a 12 month period) will be free. For additional request within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any cost is incurred.

Appointment Reminders, Treatment, Alternatives, and Other Health Related Benefits.

We may contact you by (telephone, mail, or both) to provide appointment reminder information about treatment alternatives, or other health related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the Government or Us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Compliant
7500 Security Blvd. C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information.