MIDLAND HEALTH

Name: (Last, First, MI)	Age:	Sex: M F	Birth Date:
Street Address:	City:	Zip	SS#
Mailing Address:	City:		Zip:
Home & Cell Phone:	Email Address:		
Employer:	Address:		Work Phone:
Email Address:	Occupation:		Referred by:

SPOUSE OR LEGAL GUARDIAN

Name: (Last, First, MI)	Legal Guardian: Yes No		Birth Date:
Street Address:	City:		Zip:
Home & Cell Phone:	Work Phone:	Email Address	SS#:
Employer:	Address:		Email Address:

In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)

Name (1): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:
Name (2): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:

INSURANCE INFORMATION (A copy of ALL Insurance cards is required for filing purposes.)

Primary Insurance:		Name of Insuree & SS#:
Group #:	Insuree's DOB:	Insurance ID#
Secondary Insurance:		Name of Insured & SS#:
Group #:	Insuree's DOB:	Other Insurances (cont on back):
Medicare? Yes or No	Medicare #	SS#

Optional: **Decline** ☐

Married Status: ☐ Single ☐ Married ☐ Divorced **Language:** ☐ English ☐ Spanish Other_____

Race: ☐ White/ Hispanic ☐ African American ☐ Asian ☐ Native American ☐ Other _____

Ethnicity: ☐ White American ☐ Hispanic/ Latino ☐ African American ☐ Native American ☐ Indian American ☐ Chinese American ☐ Other _____

Assignment of Benefits

I authorize **MIDLAND HEALTH** to release any medical information that may be necessary to process medical/surgical claims for myself or my dependents. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health plans to issue payments on my behalf to **MIDLAND HEALTH**. I understand that I am responsible for amounts not covered by insurance. This order will remain in effect until revoked by me in writing.

_____ _____

DATE SIGNATURE of PATIENT (or Parent/Legal Guardian if Patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **MIDLAND HEALTH** to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. **MIDLAND HEALTH** has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment. I voluntarily consent to receive medical and health care services provided by **MIDLAND HEALTH**, employees and such associates, assistants, and other health care providers. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that **MIDLAND HEALTH** may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.
Please mark if you agree to accept artificial messages by:

Phone Calls □ Yes □ No **Text Messages □ Yes□ No** **Emails □ Yes □ No**

How to contact our Privacy Officer: **MIDLAND HEALTH** 4214 Andrews Hwy, Ste 240 Midland, TX 79703
Attention: Privacy Officer Telephone:(432) 686-6600 Facsimile: (432) 682-2284

Acknowledgement and Consent

I have received the Notice of Privacy Practices for **MIDLAND HEALTH**. **MIDLAND HEALTH** is authorized to use and disclose health information about patient listed below for treatment, payment and healthcare operations purpose consistent with its Notice of Privacy Practice.

_____ _____
Signature of patient Date
(or patient's personal representative)

_____ _____
Name of Personal Representative Relationship to patient
(or other authority)

Authorization Form for Release of Protected Health Information

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by patient, or an agent given medical power of attorney, your private health information and/or treatments will not be disclosed.

By signing this form, I authorize you to use and disclose the protected health information described below.

The health information you may release subject to this authorization is as follows:

☐ Medical ☐ Financial ☐ Other: _____

Release my protected health information to the following person(s)/entity:

Name: _____Relation _____ Phone: _____

Name: _____ Relation _____ Phone: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Privacy Officer: Midland Health 4214 Andrews Hwy, Ste.240 Midland, TX 79703

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.**

_____ _____ _____

Signature of Patient Date of Birth Date

_____ _____

Signature of Personal Representative Relationship to patient (or other authority)

MIDLAND HEALTH

Cancellation/Missed Appointment/Late Policy

Midland Health strives to provide quality medical care in a timely manner to all of our patients. In order to do so, we ask that you be aware of the below policies as they pertain to appointments. These policies enable us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:
It is the policy of the Practice that patients requesting appointment cancellations will be accommodated as efficiently as possible.

In order to be respectful to the medical needs of other patients, please be courteous and call your physicians office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:
To cancel appointments, please call_____. If you do not reach the receptionist you may leave a detailed message with the answering service. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show Policy:
It is the policy of the Practice to monitor and manage appointment no-shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than 24 hours prior to the scheduled time is considered a "no-show." A no-show patient can be charged a fee, as established by the Practice, for failure to show. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. A patient who is a no-show more than three times is dismissed from the Practice.

Late Arrivals:
It is the policy of the Practice that a patient who arrives more than 15 minutes after his or her appointment time is handled as a late arrival and may be asked to reschedule as a courtesy to our other scheduled patients.

Patient Name: _____

Patient, Parent, Guardian Signature: _____ Date: _____

Financial Policy

Thank you for choosing Midland Health as your healthcare provider. Our offices are committed to providing the best medical care through communication and understanding. Confirmation and updating of personal address and phone/cell numbers for contact will assure our ability to communicate with you. At any time you have questions or concerns requiring further information, whether it is medical or business, our staff is available to assist you.

The following information outlines our policies regarding the payment of your doctor's bill.

The cost of medical care is determined by the nature and complexity of the illness. There is no *"flat* rate" for examinations and treatment. You are given an **estimated** amount at time of visit before checkout. After reviewing the Physicians/Providers documentation for the visit additional services/procedures maybe added to the visit.

Out-Of-Network Insurance Patients will be expected to pay the Out-of – Network Co-Insurance and Deductibles at the time services are rendered. Midland Health will file with your Insurance Company as a courtesy.

Contracted Insurance Patients at each visit, your current insurance card(s) will require presentation when *"signing in" at* the front desk. The Patient, or (in the case of minors) the accompanying Parent/Guardian, will be responsible for any co-pays, deductibles, or non-covered services at the time of the visit. The contracted allowable fees, of the specific contracted insurance, will be considered when payment is requested. Co-pays will not be billed since this is a requirement on your part by your insurance. If the insurance company is unable to process a claim due to inaccurate or missing information from you, you are responsible for the bill.

Non-Insured Patients will be expected to pay in full the estimated total at the time of service.

A statement of your unpaid balance plus additional services not covered by insurance will be sent to you for full payment within 30 days. To avoid collection procedures your account must be kept current.

Please sign to acknowledge you agree and understand policy:

Patient Name Print: _____

Patient or Legal Guardian: _____ Date:_____

MIDLAND HEALTH

Rheumatology

HEALTH ASSESSMENT QUESTIONNAIRE

Please help us get an accurate idea of your current health status and history by filling out this form. Please answer every question, even if you think it does not relate to you at this time. There are no "wrong" answers. Thank you!

SELF ASSESSMENT:

1. Please check (✓) the ONE best answer for your abilities at this time:

	EASY	OK	HARD	CAN'T
a. Dress yourself, tie shoelaces, fasten button	_____	_____	_____	_____
b. Get in and out of bed	_____	_____	_____	_____
c. Lift a full cup or glass to your mouth	_____	_____	_____	_____
d. Walk outdoors on flat ground	_____	_____	_____	_____
e. Wash and dry your entire body	_____	_____	_____	_____
f. Bend down to pick up clothing from the floor	_____	_____	_____	_____
g. Turn regular faucets on & off	_____	_____	_____	_____
h. Get in/out of a car, bus, train, plane	_____	_____	_____	_____
i. Walk two miles	_____	_____	_____	_____
j. Participate in sports/games as you would like	_____	_____	_____	_____
k. Get a good night's sleep	_____	_____	_____	_____
l. Deal with feelings of anxiety/being nervous	_____	_____	_____	_____
m. Deal with feelings of depression/feeling blue	_____	_____	_____	_____

2. Mark on the line below to indicate the severity of your pain OVER THE PAST WEEK:
   NO PAIN ●----------● ***EXTREMELY BAD PAIN***

3. Please check (✓) the ONE best answer describing you TODAY:
   _____1: I can do everything I want to do
   _____2: I can do most of what I want to do
   _____3: I can do some of what I want to do
   _____4: I can barely do anything I want to do

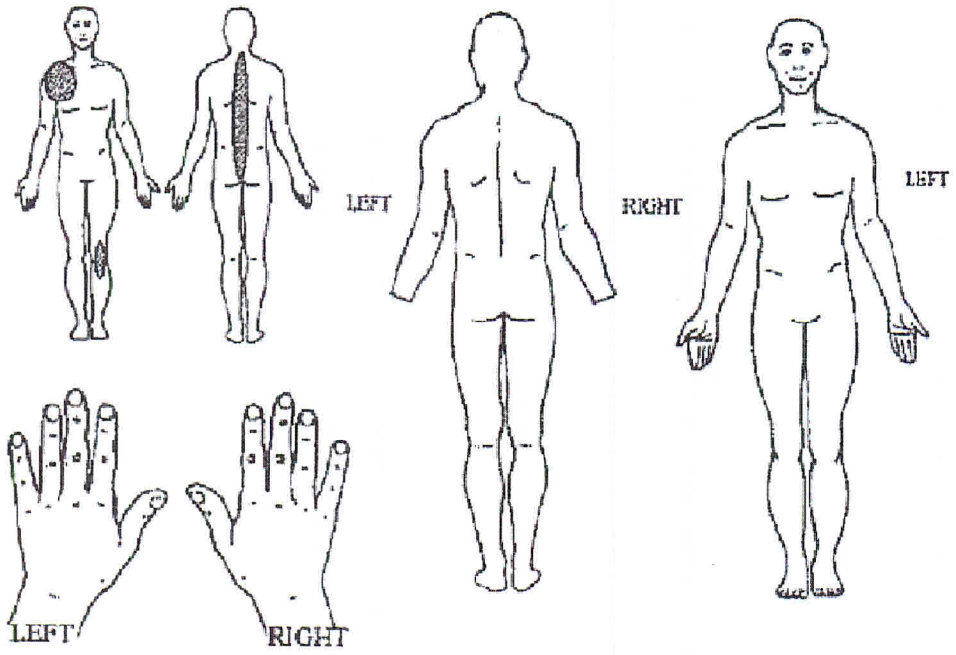
4. When you get up in the morning, do your joints feel stiff? _____YES _____NO
   If YES, how long does stiffness last? _____.

5. Mark on the line below to indicate the severity of your fatigue OVER THE PAST WEEK:
   NO FATIGUE ●----------● ***EXTREME FATIGUE***

6. When did your symptoms start?_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-803. Used by permission.

7. **[MEDICAL HISTORY]** Please check (✓) YES if you have/had any of these conditions previously Diagnosed: write your AGE or the YEAR when the condition began

	AGE OR YEAR↓		AGE OR YEAR↓
Alcoholism	___Yes_____	Heart Disease	___Yes_____
Allergies	___Yes_____	High Blood Pressure	___Yes_____
Anemia	___Yes_____	Kidney/Bladder problems	___Yes_____
Back Problems	___Yes_____	Lung Problems	___Yes_____
Broken bone after age 50	___Yes_____	Lupus	___Yes_____
Bronchitis/Emphys	___Yes_____	Mental Illness	___Yes_____
Cancer	___Yes_____	Osteoarthritis	___Yes_____
Cataracts	___Yes_____	Osteoporosis	___Yes_____
Depression	___Yes_____	Parkinson's disease	___Yes_____
Diabetes	___Yes_____	Prostate	___Yes_____
Dry eyes	___Yes_____	Rectal bleeding	___Yes_____
Dry mouth	___Yes_____	Rheumatoid Arthritis	___Yes_____
Eye pain/redness	___Yes_____	Stomach Ulcer	___Yes_____
Fibromyalgia	___Yes_____	Stroke	___Yes_____
Gastrointestinal Disease	___Yes_____	Thyroid Problems	___Yes_____
Gynecological	___Yes_____		
Heart Attack (MI)	___Yes_____	Other _____	

8. **[SURGERIES]** Please list below all of the operations you have ever had:

	Operation	year	surgeon	hospital,city,state
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

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9. **[FAMILY MEDICAL HISTORY]** Please complete your biological family history below:

	Living	Deceased	Age	RA	Lupus	Heart Disease	Kidney Disease	Thyroid Disease	Diabetes	Psoriasis
Mother										
Father										

Number of siblings: _____ Number living _____
Number of children: _____ Number living _____ List ages of each _____
Health of children: _____
_____

10. **[RECENT SYMPTOMS]** Please check (✓) if, **IN THE LAST MONTH,** you have experienced any of the following.

__Fever
__Weight gain >10lbs
__Weight loss < 10lbs
__Feeling sickly
__Headaches
__Unusual fatigue
__Swollen glands
__Loss of appetite
__Skin rash or hives
__Unusual bruise/bleeding
__Other skin problems
__Loss of hair
__Dry eyes
__Other eye problems
__Hearing problems
__Ringing in ears
__Stuffy nose
__Sores in mouth
__Dry mouth
__Smell or taste problems

__Lump in your throat
__Cough
__Shortness of breath
__Wheezing
__Chest pain
__Heart pounding (palpitations)
__Trouble swallowing
__Heartburn or stomach gas
__Stomach pain or cramps
__Nausea
__Vomiting
__Diarrhea
__Constipation
__Dark or bloody stools
__Urination problems
__Gynecology problems (female)
__Dizziness
__Losing your balance
__Muscle pain/cramps/aches
__Muscle weakness

__Paralysis of legs or arms
__Numb/tingling in arms or legs
__Fainting spells
__Swelling-hands
__Swelling-ankles
__Swelling-other joints
__Joint pain
__Back pain
__Neck pain
__Drug use (not sold in stores)
__Cigarette/tobacco use
__Alcohol use more than 2/days
__Depression-feeling "blue"
__Anxiety-felling nervous
__Thinking problems
__Memory problems
__Sleeping problems
__Sexual problems
__Sex organ burning
__Social activity problems

11. **[CURRENT MEDICATIONS]**

Please list below all pills taken **IN THE LAST TWO WEEKS**. Include *prescription and non-prescription pills.* Include aspirin, birth control, pain pills, vitamins, supplements, over-the-counter, and health food store drugs.

	Name of drug/alternative therapy	dose (mg)	#per day/week		Name of drug/alternative therapy	dose (mg)	#per day/week
1.				9.			
2.				10.			
3.				11.			
4.				12.			
5.				13.			
6.				14.			
7.				15.			
8.				16.			

Have you noticed any side effects from your meds? _____YES List below which drug(s) and the side effects(s):

_____.

[MEDICATION ALLERGIES] Please list all medication that you cannot take because you are allergic to them.

_____.

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12. **[OTHER ALLERGIES]** Please list anything else (LATEX, grass, molds, pollens, etc.) you are allergic to:

_____.

Thank you for taking the time to fill this form out. We want to give you the best care possible, and this helps us to do just that.

Medication Information

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Information

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Name: _____

Dosage: _____

Frequency: _____

Medication Name: _____

Dosage: _____

Frequency: _____