NEW PATIENT INFORMATION

PLEASE PRINT ALL INFORMATION COMPLETELY **TODAY'S DATE:**_____

PATIENT INFORMATION:

PATIENT'S NAME:_____
First Middle Last

PATIENT'S ADDRESS: _____

_____
City State Zip Code

PATIENT'S HOME#: _____ **CELL#:** _____ **WORK#:** _____

PATIENT'S DRIVERS LICENSE#/STATE: _____

PATIENT'S DATE OF BIRTH:_____**AGE:** _____ **MALE/FEMALE (Please circle one)**

PATIENT'S SOCIAL SECURITY #: _____

IF PATIENT IS A STUDENT (Please check one) _____ **FULL TIME**_____ **PART TIME**

PATIENT'S MARITAL STATUS (Please circle one): **S** **M** **D** **Sep** **W**

PATIENT'S EMAIL ADDRESS:_____

PATIENT'S OCCUPATION:_____ **EMPLOYER:** _____

SPOUSE'S NAME _____ **CONTACT#:** _____

RESPONSIBLE PARTY INFORMATION (If different than above)

NAME:_____ **HOME#:** _____
First Middle Last

WORK#:_____

CELL#: _____

ADDRESS:_____

_____
City State Zip Code

REFERRING DOCTOR:_____ **OFFICE#**_____

FAX#: _____

REASON FOR TODAY'S VISIT: _____

TREATMENT YOU HAVE USED FOR THIS PROBLEM: _____

PLEASE LIST ALL ALLERGIES TO MEDICINES: _____

OVER

CIRCLE MEDICATION YOU ARE TAKING OR OCCASIONALLY TAKE: (PLEASE CIRCLE ALL THAT APPLY)

ANTIBIOTICS ASPIRIN STOMACH MEDICINE VITAMINS IRON BIRTH CONTROL PILL

LAXATIVES BLOOD THINNERS HEART MEDICINE TRANQUILIZERS BLOOD PRESSURE MEDICINE

SLEEPING PILLS

OTHERS:_____

HAVE YOU HAD ANY OF THE FOLLOWING: (PLEASE CIRCLE ALL THAT APPLY)

X-RAY TREATMENTS TB CANCER BAD SCARS CHICKEN POX ULCERS OR INTESTINAL DISEASES

HIGH BLOOD PRESSURE BLEEDING TENDENCY DIABETES ANEMIA SEIZURES HEART DISEASE

LIVER DISEASE KIDNEY DISEASE

HABITS:

DO YOU USE TOBACCO NOW?_____ **HOW OFTEN?**_____

DO YOU USE ALCOHOL NOW?_____ **HOW OFTEN?**_____

DO YOU USE RECREATIONAL DRUGS?_____

DO YOU EXERCISE REGULARLY?_____**PLEASE DESCRIBE**_____

DO YOU FOLLOW ANY SPECIAL DIET? (low cholesterol)_____

WOMEN ONLY:

ARE YOU OR COULD YOU BE PREGNANT AT THIS TIME?_____

DO YOU PLAN ON BECOMING PREGNANT IN THE NEAR FUTURE?_____

INSURANCE INFORMATION:

INSURANCE COMPANY NAME:_____

NAME OF SUBSCRIBER/INSURED:_____
First Middle Last

SUBSCRIBER/INSURED SOCIAL SECURITY# AND ID #:_____

SUBSCRIBER/INSURED DATE OF BIRTH:_____
Month Day Year

GROUP OR POLICY #:_____

I, the undersigned (patient or legal guardian), authorize medical and/or surgical treatment to be rendered by Doctor Golden and his staff.

In addition, I hereby authorize my insurance benefits to be paid directly to Doctor Golden, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Also in addition, due to contract language between the physician and the insurance company, I understand that I am financially responsible for all charges deemed to be "non-covered benefits" by my insurance company even if the insurance's Explanation of Benefits state that the procedure is a "non-covered benefit" and "patient is not responsible".

Signature:_____
(Patient or Legal Guardian)

Date signed:_____

METHOD OF PAYMENT: CASH CHECK MASTER CARD/VISA (PLEASE CIRCLE ONE)

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Michael P. Golden, M.D., P.A., and/or its member physicians, Michael P. Golden, to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

Date:_____

Patient Name:_____

Patient or Legal Guardian Signature:_____

- Proof of insurance and identification is required at time of check in.

- All co-pays and/or deductibles are collected at time of service.

- If your insurance requires a referral, it is the patient's responsibility to obtain referral and the referral must be presented before your appointment. As a *courtesy*, our office will assist you in this process.

- If your insurance requires a referral and you want to be seen without a referral, you will be responsible for payment in full.

- If your referral or insurance is not valid, you will be responsible for payment in full.

Patient signature:

_____ Date: _____

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

Michael P. Golden M.D. P.A., 4100 West 15h Street Suite 212, Plano, Texas 75093

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of August 12, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Michael P. Golden M.D. 972 596 4121 for more information, in person or in writing.

Name (please print):_____

Signature:_____

Date:_____

OR

I am a parent or legal guardian of _____(patient name). I hereby acknowledge receipt of _____'s Notice of Privacy Practices with respect to the patient.

Name (please print)_____

Signature:_____

Date:_____