EPIC
INTERNAL MEDICINE

PATIENT REGISTRATION FORM

SOCIAL SECURITY#	LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	SEX: ☐ MALE ☐ FEMALE	DATE OF BIRTH
EMPLOYER		EMPLOYER ADDRESS		
EMPLOYER PHONE		EMAIL ADDRESS		
REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN	MARITAL STATUS ☐SINGLE ☐MARRIED ☐DIVORCED ☐WDOWED ☐ SEPARATED ☐OTHER		

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Policy ID/ Member ID:	Policy ID/ Member ID:
Group No.:	Group No.
PREFERRED PHARMACY:	

SPOUSE INFORMATION

FIRST NAME:	LAST NAME:	
ADDRESS	CITY	STATE
HOME PHONE	WORK PHONE	CELL PHONE
EMPLOYER	EMPLOYER ADDRESS	

EMERGENCY CONTACT

☐CHECK IF SAME AS PERSON RESPONSIBLE FOR PAYMENT/ IF NOT, PLEASE COMPLETE BELOW:

NAME:	HOME PHONE:	CELL PHONE:	WORK PHONE:	RELATIONSHIP TO PATIENT

ADVANCED DIRECTIVES/LIVING WILL: YES ☐ NO ☐

Name: _____ DOB:_____ Age:_____ Sex: Male___ Female___

Please check one: Single___ Married___ Divorced___ Separated___ Widowed___

With whom do you currently live? _____

Current job: _____Previous job: _____

MEDICATIONS (Please include all prescriptions, over-the-counter, vitamins, and supplements)

NAME/DOSE OF MEDICATION/REASON FOR TAKING	MEDICATIONS CONTINUED

ALLERGIES TO ANY MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? YES NO

(If yes, please list name of medication and type of reaction) _____

_____

SURGERIES/HOSPITALIZATIONS— Please list date and details; circle either surgery or hospitalization for each

DATE	SURG/HOSP	REASON/DETAILS
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	

SEVERE INJURIES Please list dates and details of any injuries you have ever had _____

_____

HEALTH MAINTENANCE

Date of last PSA and/or prostate exam? _____

Date of your last pap smear? _____

Date of your last bone density test? _____

Date of last wellness exam? _____

Date of last Tetanus vaccine? _____

Date of Hepatitis B Series? _____

Date of las Pneumonia vaccine? _____

Date of last colonoscopy? _____

Date of last mammogram? _____

Date of your last eye exam? _____

Date of TB screening? _____ POS NEG

Date of shingles disease of Zoster vaccine? _____

Date of last Flu vaccine? _____

History of Chicken Pox? _____

What kind of exercise do you do? _____ How often? _____

Do you wear seatbelts? YES ___ NO ___ Do you feel safe at home? YES ___ NO ___

Do you drink coffee/soda/tea? YES___ NO___ If yes, how many cups/cans a day? _____

What type of birth control is used between you and your partner? _____

Which of the following conditions are currently being treated or have you been treated for in the past?

___Allergies ___Asthma ___Arthritis ___Anxiety ___Anemia
___Acid Reflux ___Blood clots ___Bleeding Problems ___Back Problems ___Breast problems
___Cancer ___Chest Pain ___Concussion ___Diabetes ___Depression
___Dizziness ___Diarrhea ___Erectile Dysfunction ___Epilepsy/Seizures ___Eye Problems
___GI Problems ___Gallbladder Disease ___Gout ___Headaches ___Hearing Problems
___Heart Disease ___Hepatitis ___High Blood Pressure ___Hemorrhoids ___High Cholesterol
___Insomnia ___Kidney Disease ___Kidney Stones ___Liver Disease ___Lung Problems
___Meningitis ___Muscle Disease ___Pancreatitis ___Psychiatric Issues ____STD
___Stroke ___Skin Disease ___Sinus Disease ___Thyroid Disease ___Stomach Ulcers
___Urinary Infections ___Other_____

Please briefly describe primary medical problems: _____

_____

FAMILY HISTORY (Please put a checkmark in all applicable boxes)

Were you adopted? **YES___ NO___**

Illness	Father	Mother	Siblings	Other
Living?				
Heart disease/attack				
High cholesterol				
High blood pressure				
Diabetes				
Stroke				
Kidney disease				
Liver disease				
Bleeding/clotting disorder				
Asthma				
Colon/bowel problems				
Cancer/type:				
Glaucoma				
Thyroid disease				
Drug/alcohol addiction				
Depression/anxiety				
Suicide				
Seizures/epilepsy				
Other:				
Other:				

OB/GYN HISTORY

Age of first menses: _____ Date of last period: _____

Have you ever had an abnormal pap? **YES___ NO ____** If yes, date and results _____

Pregnancies: Total Number ____ Full Term ____ Miscarriages ____ Abortions___ Premature___ Tubal____

SOCIAL HISTORY

Are you sexually active? **YES__ NO__** Have you ever had sexually transmitted disease? **YES__ NO__** Diagnosis: _____

Do you smoke cigarettes? **YES__ NO__** How many per day? ___ Have you ever smoked? **YES__ NO__** How long: _____

Do you use other tobacco products? **YES __ NO __** What and how often? _____

Do you drink alcohol? **YES__ NO__** How many drinks per week, on average? ____ What type? _____

Have you ever had a problem with alcohol in the past? **YES__ NO __** Explain: _____

Has anyone ever expressed concerns about your alcohol use? **YES__ NO __** Explain: _____

Do you currently use any recreational drugs? **YES __ NO __** What types? _____

Have you ever had a drug problem in the past (prescription drug addiction/illegal drug use)? **YES __ NO __**

If yes, explain _____

REGISTRATION CONSENTS & ACKNOWLEDGMENTS

PRIVACY ACKNOWLEDGEMENT

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? YES __ NO __
   If no, is there another number at which we may try to reach you? _____

2. May we mail to the address you provided information regarding your appointment or test results? YES __ NO __
   If no, is there another address at which we may send you information? _____

3. Do you wish us to share health information regarding you with a family member or friend? YES __ NO __
   If yes, please provide name of person(s): _____

4. May we contact you via e-mail with information about our practice, educational programs and general health information? YES __ NO __

   If yes, I understand that email transmissions may not be secure and will not be used for the purpose of communicating my personal health information.

NOTE: To protect your information, we reserve the right to use professional judgment and discretion when communicating information/ test results which may be "sensitive" in nature.

I have received a copy of EPIC Internal Medicine group's "Notice of Privacy Practices for Protected Health Information."

REFERRALS FOR SERVICES

Welcome to the EPIC Internal Medicine. In an effort to make treatment for our patients as enjoyable and timely as possible, our department has adopted the following policy regarding scheduling and cancellations. If you are up to 20 minutes late, your physician may not be able to see you. Please understand that if you are treated, your treatment may be modified to accommodate other scheduled patients. If you are 30 minutes late, you may need to reschedule your appointment for another time. Failure to keep 3 scheduled appointments without giving notice may result in your discharge from the physician. Failure to keep 5 scheduled appointments, even with advance notice, will result in your discharge from the physician.

CONSENT TO TREAT

I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant, and nurse practitioner, and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

I agree and consent to the withdrawal and testing of my blood without further consent by me. If there is an accidental blood borne pathogen exposure to any medical, nursing, or other clinical staff, to test such blood for the presence of Hepatitis B virus or HB\I, Hepatitis C virus or HC\I, and Human Immunodeficiency Virus or HIV. I understand and agree that the results of such laboratory testing shall be maintained confidential, except to my treating healthcare providers, any clinical staff so exposed, and as may be allowed by any applicable state or federal statute, regulation, or rule of law.

This means that if any medical practice personnel or physicians are exposed to my blood through a needle stick, blood splash or other means while I am being treated, I agree to allow my blood to be drawn and tested for HIV or Hepatitis. The results will be kept confidential except to my physician, any healthcare personnel caring for me, the medical practice personnel exposed or as required or allowed by law. This will be at no charge to me.

REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS

FINANCIAL AGREEMENT

The patient and/or guarantor is responsible for charges incurred. Any charges shall be based on the prevailing rate for the specific services rendered or items provided, that is in effect in the charge master on the date such services are rendered, or items provided. It is a courtesy of our office to file your insurance; however, you are responsible for your co-pay and/or percentage which the insurance company is not liable for on the day of your visit. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor, we will place your account with a collection agency, and you agree to be responsible for additional expenses incurred (if applicable including but not limited to, court costs and attorney fees) if legal action is necessary for collections.

By signing this form, I am authorizing contact for purposes of financial matters and account collection through any telephone number provided. Patient and/or guarantor agrees to permit EPIC Internal Medicine or its agents to review financial ratings and credit reports when necessary. I have read and fully understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to this medical practice. I also authorize the release of any information acquired in the course of my treatment to my insurance company or any third party obligated to pay all, or part of my medical bill as needed to issue benefits.

To ensure the accuracy of your information, photo identification is required. Without photo identification, we require your photograph. I certify all identification information is true and correct. I understand that providing false identification is a crime and may be reported to local law enforcement.

CONSENT TO PHOTOGRAPH:

I understand that photographs, videotapes, digital or other images may be made or recorded to document my care. I understand that EPIC Internal Medicine retains ownership rights to these recordings or other images, but that I will be allowed to view them or obtain copies. I understand that these images will be stored in a secure manner to protect my privacy and that they will be kept for the time required by law policy. Images that identify me will be released and/or used only upon written authorization from me or my legal representative.

MEDICARE AND MEDICAID INFORMATION

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare/Medicaid claim. I further certify that I have provided any required information concerning any other liability for medical practice charges in order to complete the Medicare Secondary Payor (MSP) form. I request that payment of authorized benefits be made on my behalf.
I authorize EPIC Internal Medicine to secure formation from the Department of Human Services regarding my qualification for Medicaid.

BY SIGNING AND DATING THIS ATTACHED SPACE, I ACKNOWLEDGE NOTICE AND RECEIPT OF THE ABOVE INFORMATION PRIOR TO TREATMENT.

Patient/Authorized Representative Signature _____ Date: _____ Time: _____
If Authorized Representative, relationship to Patient: _____

If person other than patient is responsible for payment: _____

Guarantor Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Patient Consent and Agreement:

I consent to participation in the facility Patient Portal (Portal) and understand that my personal health and individually identifying information is made available to me in the Portal.

I understand that the use of the Portal is for non-emergency purposes.

I understand that I have the ability to provide Portal access to my Authorized Representatives. (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.

I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.

I understand that my e-mail address is required to initiate Portal access and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.

I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions.

I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal.

I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

Patient Name		
Patient Signature	Date	Time
O Patient Refused Access to the Portal		
Clinical Staff Signature (witness to refusal)	Date	Time

APPENDIX I

Controlled Substance Agreement

I understand that I am taking a controlled substance for medical reasons. To be a patient in this practice, I understand have responsibilities regarding the use of these medications and agree to the following:

1. I understand that controlled substance medications can possibly cause physical dependence/addiction.
2. I agree to participate in the Risk Assessment by honestly answering the questions.
3. Prescription refills can only be approved by my primary care physician.
4. Changes in controlled substance medications can only be made by my primary care physician.
5. I will not change how much or how often I am taking the medicine without discussing changes with my primary care physician.
6. I will keep all follow-up appointments as scheduled. If I miss an appointment, my medication will not be refilled until the appointment has been rescheduled.
7. I will request refills before I run out of medicine, allowing 3-4 days to process refills.
8. I will not request refills after office hours or on weekends because my physician may not be available during that time.
9. I understand that requests for early refills will only be considered by my primary care physician. Lost or stolen medications will not be acceptable reasons for early refills. A copy of a police report will be required for any lost or stolen medications or medication prescriptions.
10. I will use the same pharmacy for all controlled substances and will supply my physician with the name, address, and phone number of the pharmacy so that my physician may monitor refills.

    Pharmacy Name: _____ **Phone Number:** _____

    Address: _____

11. I will not obtain any other controlled substance medications for pain or anxiety from any other physicians or health-care practitioners, prior to seeking counsel from my primary care physician, and, if warranted, authorization. In the event of an emergent situation whereby controlled substances are indicated, and my physician is not able to be contacted, I will notify and disclose this usage to my primary care physician at the earliest opportunity.
12. I will provide a list of all controlled substance medications prescribed by my primary care physician to all other physicians and health-care practitioners (e.g., dentist).
13. I may bring all of my prescribed medications with me to every office visit, and I understand that my physician and/or his staff will count my medications at each visit.
14. I will not use any illegal or recreational drugs or use prescription drugs purchased without a prescription.
15. I will not share my medicine with anyone else.
16. I will not sell my prescription medications.
17. I agree to random urine drug screening by my physician if he/she requests it. If I refuse, I understand that my physician will no longer prescribe the medications.
18. I understand that this practice does not provide long-term pain management care. If such care is needed, I will be referred to the appropriate specialist.
19. I hereby give consent for my physician or a representative from this practice to call the following person and to discuss my medication use, compliance, and overall treatment with him/her:

    Name: _____ **Phone Number:** _____

    Relationship to Patient: _____

20. I understand that this practice will routinely query the State prescription monitoring program.
21. In addition to the above agreements, I accept the right of my primary care physician to terminate this agreement for any of the following reasons:
    a. I seek or obtain any pain medication from a source other than my physician.

b. I fail to notify my primary care physician appropriately when I have been given controlled substances in an emergent situation.
c. I give, sell or in any way distribute prescribed medications to any other person(s).
d. I, in any way, attempt to forge or alter a prescription.
e. My medical condition declines to the point at which, in the judgment of my physician, continued therapy with this medication presents a danger to my well-being or safety.
f. There is evidence that I am no longer receiving reasonable therapeutic benefit from the medication, or it is determined that I am no longer a good candidate to continue the medication.

It is my primary care physician's responsibility to determine how and if these medications will be prescribed. Decisions will be based on ongoing evaluation of my medical conditions. These guidelines are designed to protect me from dangers associated with controlled medications. If I violate these guidelines, my primary care physician may decide to discontinue or reduce the dose of my medication or discharge me from his/her practice.

Prescribing Primary Care Physician	Printed Name	Date

Patient's DOB: _____

Patient's Signature	Patient's Printed Name	Date

STATE LAWS GOVERNING CHRONIC PAIN MANAGEMENT UTILIZING CONTROLLED SUBSTANCES DIFFER. IF YOU ARE UNSURE WHETHER THIS AGREEMENT IS COMPLIANT WITH THE LAW OF YOUR STATE, CONSULT YOUR IN-HOUSE OPERATIONS COUNSEL.

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected information.

Patients/Authorized Representative

Signature:_____ Date: _____ Time: _____

If Authorized Representative, Relationship to Patient: _____

Witness' Signature: _____

24 HOUR CANCELLATION & "NO SHOW" FEE POLICY

Each time a patient misses an appointment without providing proper notice, Another patient is prevented from receiving care. Therefore, Epic Internal Medicine reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") appointments which, without a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

EPIC
INTERNAL MEDICINE

Patient Information (Please Print)			
First Name: Middle Initial: Last Name:			
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ____/____/____ through ____/____/____

___Progress Notes ___Emergency Room Record ___Discharge Summary ___ History and Physical
___Consultation(s) ___Lab Reports ___Pathology Report ___Operative Note(s) ___Imaging/X-Ray Films
___Imaging/X-Ray Reports __Entire Record ___Fetal Heart Monitor Strips

Sensitive Information: ___Alcohol Abuse ___Drug Abuse ___Communicable diseases, including HIV status.
___Genetic Testing ___Psychiatric/Behavioral Diagnoses
___Other (specify): _____

_____

How would you like your records delivered?

_____Paper
_____Electronic: _____ Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.)
____USB or CD
____Password Protected _____Not Password Protected
____Mail to address below _____I will pick up in person.

If mailing, where do you want the information sent? (Fill in boxes below):

Please provide my records to: ____Myself ____Personal Representative (indicated below) ____Other Third Party

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship (please print)**

Signature of Patient or Personal Representative	Date/Time

Please return completed form to:

Facility Name: EPIC Internal Medicine, S. Arramraju M.D. Address: 515 Gaslight Blvd City/State Zip: Lufkin, TX 75904	Phone: 936-631-5600 Fax: 936-631-5607

This Healthcare Facility recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

PATIENTS NAME: _____

DATE OF BIRTH: _____

PLEASE LIST ALL PREVIOUS DOCTORS AND SPECIALIST

PHYSICIANS NAME	ADDRESS	PHONE NUMBER