Clear Form

WELCOME TO PROGRESSIVE MEDICINE ASSOCIATES, LLC

Today's Date:_____/_____/_____

Name:_____ What You Prefer To Be Called:_____

Street Address:_____ City:_____ State:_____ Zip:_____

S.S.#:_____ Drivers License #:_____ Referred By:_____

Birth date:_____/_____/_____ Age:_____ ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Employer:_____ Occupation:_____

Employers Address:_____ City:_____ State:_____ Zip:_____

Email Address: _____

Spouse Name:_____ Birth date:____/____/_____ S.S.# _____

Spouse Employer:_____ Phone:_____ Occupation:_____

Spouse Insurance Co.:_____ Phone:_____ Policy No:_____

Emergency Contact (if different than spouse): _____ Phone:_____

Please check any and all insurance coverage you or your spouse have, that is applicable in this case.

☐ Major Medical ☐ PPO / HMO ☐ Auto Accident ☐ Work Injury ☐ Other_____

Name Of Insured:_____ Method Of Payment: ☐ Cash ☐ Check ☐ Credit Card

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Co. Name:_____ Adjuster:_____ DOA:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Effective Date:_____/_____/_____ Claim/Policy No:_____/_____

PLEASE BRING INSURANCE CARD AND DRIVERS LICENSE TO THE FRONT DESK TO COPY

Reason For Your Visit Today:_____

Other Providers Seen For This Condition:_____ Result:_____

Have You Had This In The Past? ☐ Yes ☐ No Explain:_____

When Did Symptoms Start:_____ Is It Getting Worse? ☐ Yes ☐ No

Does It Interfere With ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Is It Painful To ☐ Sit ☐ Walk ☐ Bend ☐ Lie Down ☐ Lift Objects

ASSIGNMENT AND RELEASE

I, The undersigned, have insurance coverage with_____
Name of Insurance Company

and assign directly to Progressive Medicine Associates, LLC. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____ / /
Signature of Insured/Guardian Date

Progressive Medicine Associates, LLC
Health History and Pain Questionnaire

Past Medical History:

1. Other than the problem that you are here for today, would you consider yourself in good health: ☐ Yes / ☐ No
   If no, please describe: ☐

2. When was your last routine physical exam: _____ By whom: _____

   If applicable: Last Pap smear: _____ Mammogram (or exam): _____
   Pregnant? ☐ Yes ☐ No

3. Have you ever been diagnosed with any form of Hepatitis? ☐ Yes / ☐ No
   If yes, describe: _____

4. Do you currently have or ever had (Include the approximate year of diagnosis)

Condition	Yes	No	Describe
Heart Disease	☐	☐	_____
Lung Disease	☐	☐	_____
Kidney Disease	☐	☐	_____
Liver Disease	☐	☐	_____
Thyroid Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Bleeding Tendencies	☐	☐	_____
Anemia	☐	☐	_____
Stroke	☐	☐	_____
Cancer	☐	☐	_____
Seizures	☐	☐	_____
Diabetes	☐	☐	_____
Arthritis	☐	☐	_____
Ulcers	☐	☐	_____
Emotional Problems	☐	☐	_____
Other	☐	☐	_____

5. Operations/Procedures: Please list any previous operations/procedures/hospitalizations.

   For current pain problem:

Date	Operation/Procedure	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

   For other present or past medical conditions:

Date	Operation/Procedure	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Please list and describe any past or current serious illnesses or injuries not already covered:

7. Have you had any problems with surgery or anesthesia in the past: _____

8. Do you have any allergies to medicines: ☐ Yes / ☐ No If yes, please list medications:

_____

9. Does any medicine make you sick: _____

10. Describe your reaction: _____

11. Please list all medications that you are currently taking:

12. Family History

Family Member	LivingK		Age	Major Medical Problems or Cause of Death
	Yes	No		
Father	☐	☐		
Mother	☐	☐		
Siblings				
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
Children				
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO PROGRESSIVE MEDICINE ASSOCIATES, LLC

Patient Name: _____ _____
(**Previous Or Other Names Used**)

Address: _____

Date of Birth: ____/____/____ **Social Security Number**: _____

I understand that the specific purpose of this Authorization is to release PHI for treatment or follow up care at PROGRESSIVE MEDICINE ASSOCIATES, LLC.

I authorize release of medical records FROM: NAME: _____

ADDRESS: _____City, State, ZIP: _____

PHONE #:_____ FAX #: _____

Please send (**preferably fax**) requested medical records TO:

Progressive Medicine Associates, LLC
8811 Westheimer Road, Suite 101
Houston, TX 77063
Phone: 713-978-6337
Fax: 713-532-6337

I specifically authorize Progressive Medicine Associates, LLC. to obtain the following PHI: For continuing care

☐ Complete Records _____ ☐ Hospital Records _____ ☐ Clinic Records _____
☐ Radiology Reports _____ ☐ Lab Reports _____ ☐ Operative Reports _____
☐ Psychiatric/Mental Health Diagnosis ☐ Drug and/or alcohol use info _____ ☐ Discharge Summary_____
☐ Other _____

By signing this Authorization Form, I understand that I am giving my authorization for PROGRESSIVE MEDICINE ASSOCIATES, LLC (herein known as "PMA") to receive all protected health information (PHI) relating to my diagnosis, testing or treatment. I understand that my expressed consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. I may revoke this authorization at any time by notifying PMA in writing at 8811 Westheimer Road, Ste. 101 Houston, TX 77063 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by PMA before PMA received my written notice of revocation. I understand that the information disclosed pursuant to this authorization may be re-disclosed by PMA and any re-disclosure to other recipients may no longer be protected under federal and Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that signing this Authorization Form is not required in order for me to receive treatment, but may influence the type of treatment received from PMA.

_____ ____/____/____

Signature of Patient **Date**

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO:

Progressive Medicine Associates, LLC
8811 Westheimer Road, Suite 101
Houston, TX, 77063
Phone: 713-978-6337
Fax: 713-532-6337

PROGRESSIVE MEDICINE ASSOCIATES, LLC

Patient Privacy Notice

Patient Name: _____

We are providing this notice to inform you of the privacy Standards which will be applied to your medical records at our office which is now called your "Protected Health Information". We have been mandated by federal law to make you aware of your rights and our responsibilities regarding your medical records. You will need to sign a new consent for treatment and financial policy that will outline how you would like our office to handle privacy issues related to your Protected Health Information.

Please read and complete the following carefully

1. I hereby give consent to receive medical treatment from the provider(s) of this practice and/or their associates.

2. **For treatment**. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

3. **For Health Care Operations**. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can be Made Without Your Consent or Authorization.

- As required during an investigation by law enforcement agencies.
- To avert a serious threat to public health safety.
- As required by military command authorities for their medical records.
- In response to a legal proceeding.
- To a coroner or medical examiner for identification of a body.
- As required by the U.S. Food and Drug Administration.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
I understand that the authorized person(s) will be required to furnish proof of their identity when making an inquiry. I understand that this authorization will remain in force in its entirety until it is replaced by a new signed agreement by me. I further agree to release this practice, its employees, or agents on its behalf from any and all liability resulting of my "Protected Health Information" being released to any individual herein authorized.

☐ Authorize MYSELF ONLY ☐ Authorize others as well (fill out information below)

1. _____ _____ N/A ☐ Initial: _____
Authorized Person Relationship

2. _____ _____ N/A ☐ Initial: _____
Authorized Person Relationship

Further Instructions: _____ N/A ☐ Initial: _____

I understand and consent to the above authorization.

_____ DATE _____/_____/_____
Patient Signature

Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

Progressive Medicine Associates, LLC

Physician Assistant Consent Form

This facility has on staff a Physician Assistant to assist in the delivery of medical care. A Physician Assistant is not a Medical Doctor. A Physician Assistant is a graduate of an accredited graduate program and is licensed by the state medical board. Under the supervision of a Physician (MD or DO), a Physician Assistant can diagnose, treat and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, rather the overseeing of activities of and accepting responsibility for the medical services provided.

A Physician Assistant may provide such medical services that are within his/her education, training and experience. These services may include but are not limited to:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I, _____ have read the above and hereby consent to the services of a Physician Assistant for my healthcare needs. I understand that at any time I can refuse to see the Physician Assistant and request to see a Physician.

_____ ____/____/____

Signature of Patient/Legal Guardian Date

Print Form **Save Form**