Houston Medical Group

Downtown	North	South	East	Southwest	Katy
3033 Fannin	123 Northpoint, #170	4002 Burke Road	1140 Westmont Dr #547	8783 S. Gessner Rd.	4521 Hwy 6 N, #C
Houston, TX 77004	Houston, TX 77060	Pasadena, TX 77504	Houston, TX 77014	Houston, TX 77074	Houston, TX 77084
713-652-0011	281-445-6944	281-487-0280	713-445-7074	713-981-4311	281-463-2020
F: 713-652-0015	F: 281-445-8009	F: 713-378-4852	F: 713-522-6767	F: 713-981-4302	F: 281-463-2029

Patient Registration

Type of Visit:	**Appointment Date/Fecha de Cita:**	**Current Date/Fecha**

Name:	**Home Address**/Dirección de casa:	**City**/Ciudad	**State**/Estado	Zip

Date of Birth/Fecha de Nacimiento:	**Phone#**:	**Cell#**	Email Address:	Social Security Number

Sex:	**Driver's License**/Licencia:	**Emergency Contact Name/Phone #**/Contacto de Emergencia:	**Relation:**

Next of Kin #1 Name/Phone	**Next of Kin #2 Name/Phone**	**Next of Kin #3 Name/Phone**

Employer:	**Work Phone:**	**Occupation:**

Work Address/Dirección de casa:	**City**/Ciudad	**State**/Estado	Zip

Purpose of Visit: ☐ **Auto Accident** ☐ **Work Injury** ☐ **Private Health Insurance** **INJURY DATE**

Primary Insurance/Attorney:	**Primary Insurance Address:**	**City**	**State**	**Zip**

Claim/Group#:	**Primary Insurance Phone#:**	**Primary Insurance Contact/Adjuster:**

Is this ☐ YOUR insurance, or ☐ insurance of the other party?

Secondary Insurance/Attorney:	**Secondary Insurance Address:**	**City**	**State**	**Zip**

Claim/Group#:	**Secondary Insurance Phone#:**	**Secondary Insurance Contact/Adjuster:**

Is this ☐ YOUR insurance, or ☐ insurance of the other party?

Tertiary Insurance/Attorney:	**Tertiary Insurance Address:**	**City**	**State**	**Zip**

Claim/Group#:	**Tertiary Insurance Phone#:**	**Tertiary Insurance Contact/Adjuster:**

Is this ☐ YOUR insurance, or ☐ insurance of the other party?

Health insurance /informacion del seguro

Insured Name/Nombre del Suscriptor:	**Insured DOB**/Fecha de Nacimiento:	**Social Security**/# del seguro social:	**Relation to Patient**/Relación al Paciente

If a minor, name/address of person responsible for care/**Si un menor**, el nombre y la dirección de persona responsable del cuidado:

I give permission for this minor to be seen at this office/Doy el permiso para este menor a ser visto en esta oficina.

Signature/Firma:_____ **Date:** _____

Mailing Address: Houston Medical Group, 3033 Fannin, Houston, TX 77004
Phone: (713) 652-0011 Fax: (713) 652-0015

website: www.houstonmedicalgroup.org
email: info@houstonmedicalgroup.org

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713-652-0011	281-445-6944	281-487-0280	713-451-2100	713-981-4311	281-463-2020

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date of 1st request _____ Date of 2nd request _____

TO: _____
(Name of Doctor, Clinic, Hospital, or Medical Center...)

Address:_____
Phone:_____Fax: _____

I, _____request the following information

- X-RAYS Report(s)
- Film(s)
- Medical Records
- Other
- Medical Reports

To be released to: **Houston Medical Group DOWNTOWN**
Address: 3033 Fannin, Houston, Texas 77004
Phone: (713) 652-0011 Fax: (713) 652-0015

_____

Patient Information:

Name:_____

Date of Birth:_____/_____/_____

Date of Injury:_____/_____/_____

Social Security Number:_____-_____-_____

Signature_____**Date**_____
Patient( ), Spouse( ), Parent( ), Guardian( )

*According to section; 1795/CA Health and Safety Code. The information must be released within 15 business days of receipt of this notice.

AUTHORIZATION & CONSENT FOR CARE

I, the undersigned, hereby authorize Houston Medical Group Downtown, to administer treatments ordered by my physician, the doctor of chiropractic and/or other licensed doctors at the facility who now, or in the future, render treatment, including chiropractic adjustments and other chiropractic procedures, examination testing, diagnostic testing, X-Rays and other advanced imaging studies as medically necessary, and physical therapy techniques to include cardiovascular, exercise, stretching, proprioceptive, and any other physical rehabilitation techniques to me or the patient named below for whom I am legally responsible.

Houston Medical Group Downtown is authorized to release medical records the provider deems apt, regarding my physical state to any insurance group, attorney or adjuster to aid in compensation of fees incurred. I permit direct payment be made to Houston Medical Group Downtown for any & all services rendered.

I understand I am responsible for charges if services are not covered by the insurance, or if Houston Medical Group Downtown is unable to verify my eligibility. I realize if a check is dishonored or if I refuse to pay, I am liable for collection costs, including but not limited to, returned check and attorney fees.

I grant Houston Medical Group Downtown exclusive and irrevocable rights to coordinate benefits with other insurance coverage, and to collect from other parties for expense reimbursement if my injury or illness was caused by, or is reimbursable by that party.

I understand Houston Medical Group Downtown does not employ physicians, nor controls my physician's medical decisions. I acknowledge that no warranty or guarantee has been made as to result or cure.

PREGNANCY DISCLAIMER

I do hereby state and assure that it is not possible that I am or might be pregnant at this time. I understand that this facility and /or employees will take every precaution to safeguard my well-being. Therefore, I release Houston Medical Group and/or whomever they may designate and/or their assistants from any and all responsibility and liability regarding this matter.

MINOR'S RELEASE

I hereby give written authorization to whoever is designated to administer such treatment as prescribed by himself or the designated doctor and/or assistant(s) to my minor child. I hereby certify that I have read and fully understand the above mentioned authorization for treatment, the reasons why treatment is considered necessary, its advantages, and possible complications, if any, which were explained to me by the doctor and/or a designated assistant. I further certify that no guarantee of assurance has been made as to the results that may be obtained. I also release and authorize whoever is designated to release any medical information necessary in the processing of this claim to an insurance carrier(s) and/or attorney.
I certify that I understand this statement.

Patient Name (Please Print): _____ **Date**: _____

Patient (or guardian's) Signature: _____

If patient is a minor, Guardians name (Please Print): _____

Relationship to patient (if not signed by patient): _____

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IRREVOCABLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE LIEN INTEREST

(Not a Statutory Lien)

_____

_____

Re: Medical Reports and Lien for _____.

I hereby authorize Houston Medical Group Downtown, and all medical professionals that provide medical care at such facility, (hereafter "HMG"), to furnish my attorney and/or insurance carrier with reports of any examination, treatment, prognosis, (including notes, x-rays, and other medical data, as deemed necessary by my doctor), relating to treatment with regard to the injuries I have sustained, the medical condition which required my seeking medical care, or other contributing incident giving rise to my need for such health care services.

ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST

- I hereby execute and provide this Irrevocable Lien Interest and Assignment of Proceeds (hereafter referred to as "Lien" in favor of the HMG and/or the doctor's designated treating facility. This Lien shall apply to monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am paid in the form of a settlement(s), claim(s), judgment(s), or verdict(s) resulting from the above identified accident (collectively "insurance proceeds").
- The Insurance Carrier is instructed that pursuant to this Lien the total dollar amount of all sums which I owe on account to the HMG, as evidenced by medical bills submitted by the HMG, shall be paid directly to the HMG by the insurance carrier out of settlement proceeds to which I am entitled, or withheld from any settlement or award which I shall be entitled and be paid directly to the HMG.
- As consideration for my execution of this Lien, I represent that the HMG provided me professional services upon my request, I am aware of the nature and expense of such services provided and that as consideration for forbearance of the HMG's legal right to require payment by me at the time such services were rendered, HMG relied upon my express declaration and intention to execute and instruct that this Lien shall apply to all proceeds to which I am entitled and direct that the amount of such proceeds required to satisfy my balance with the HMG be remitted directly to the HMG, at such time I receive an insurance settlement or other monetary settlement/award.
- In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts determined to be owed, due and payable for my account to HMG and remit payment of all such sums directly to the HMG upon receipt my settlement award(s).
- I fully understand and stipulate that I am ultimately and directly responsible to the HMG for all medical bills incurred by me for services rendered to me, or on my behalf or request, if my charges are not paid by either the Insurance Carrier, The Attorney representing my interest, or the third party who may be liable for them, and this agreement is made solely for the benefit of the HMG, as additional protection and in consideration of the treating facility's agreement to forgo immediate collection of payment for such services rendered. I understand that you are not required to exhaust remedies against a third party before requiring me to pay.
- Demand for Payment: I hereby instruct and make demand on any insurance company owing a duty of payment of any kind to me for treatment rendered by the HMG, its successors and assigns, within 60 days following receipt of such bill for services to the extent such bill is payable under the terms of an insurance policy of insuring agreement. This demand conforms to Article 21.55 of the Texas Insurance Code providing for attorney fees, penalties, court costs and interests from judgment upon violation. I further instruct to make such payment via draft or check to be sent to Houston Medical Group Downtown, 3033 Fannin, Houston, Texas 77004
- Waiver of Statute of Limitations: I waive my right to assert any Statute of Limitation defense against claims for goods or services rendered by the HMG, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

Printed Name of Patient: _____ **Signature:** _____ **DATE:** _____

For or On Behalf of Minor Child: _____, **I hereby assume full financial responsibility.**

Signature:_____**DATE** _____

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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, and Healthcare Operations

I, _____, understand that as part of my health care, Houston Medical Group Downtown, originates and maintains paper and/or electronic records regarding my health history, exam and test results, treatment and plans for future management. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were provided, and
- A tool for clinic operations, i.e. assessing quality & competence of medical professionals.

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete account of information uses and disclosures. I understand I have the following rights:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to restrict how my records are used or disclosed to carry out treatment, payment or health care operations.

I understand that Houston Medical Group Downtown is not required to agree to the restrictions requested. I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this clinic may refuse to treat me, as permitted by Section 164.506 of the Code of Federal Regulations.

I understand Houston Medical Group Downtown reserves the right to alter notice and practices prior to completion, in accord with Section 164.520 of the Code of Federal Regulations. If Houston Medical Group Downtown alters notice, if requested, a copy will be sent to the address I supply (U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand for this organization's treatment, payment or care operations, it may be necessary to release my health records to another entity; I consent to disclosure for these uses, including via fax.

I fully understand and accept/decline the terms of this consent.

_____

Patient's Signature (authorized representative signing for the patient) **Date**

_____

For Office Use Only

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

INFORMED CONSENT & LIABILITY RELEASE

A. INFORMED CONSENT TO CHIROPRATIC MEDICINE:

I have been informed of and acknowledge that participation in physical medicine involving flexibility, strength, balance, agility, and aerobic exercise, including the use of equipment and devices, is a potentially hazardous activity. I have also been informed of and acknowledge that participation in physical medicine can be a test of a person's physical and mental limits and that such participation and training poses potential risks of serious bodily injury or death.

I UNDERSTAND AND AM INFORMED THAT, AS IN THE PRACTICE OF MEDICINE, IN THE PRACTICE OF CHIROPRACTIC THERE ARE SOME RISKS TO TREATMENT, INCLUDING BUT NOT LIMITED TO FRACTURES, DISC INJURIES, STROKES, DISLOCATIONS AND SPRAINS. I DO NOT EXPECT THE DOCTOR TO BE ABLE TO ANTICIPATE AND EXPLAIN ALL RISKS AND COMPLICATIONS, AND I WISH TO RELY UPON THE DOCTOR TO EXERCISE JUDGMENT DURING THE COURSE OF THE PROCEDURE WHICH THE DOCTOR FEELS AT THE TIME, BASED UPON THE FACTS THEN KNOWN TO HIM OR HER, IS IN MY BEST INTEREST.

I HEREBY ACCEPT THE RESPONSIBILITY FOR ANY HARM, INJURY OR DAMAGE THAT MAY RESULT FROM CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES, INCLUDING VARIOUS MODES OF PHYSICAL MEDICINE.

I HEREBY WAIVE, RELEASE, ABSOLVE, INDEMNIFY AND AGREE TO HOLD HOUSTON MEDICAL GROUP Downtown, **ITS OFFICERS, EMPLOYEES AND AFFILIATES FOR ANY CLAIM ARISING OUT OF ANY INJURY TO ME, WHETHER THE RESULT OF NEGLIGENCE OR ANY CAUSE. I VOLUNTARILY AND KNOWINGLY ACKNOWLEDGE, ACCEPT AND ASSUME THESE RISKS.**

I have read this waiver and release of claims and covenant not to sue. I am aware that this is an agreement not to sue and constitutes a complete release of liability by me and by the program participant. I acknowledge that I am signing this document of my own free will, with full knowledge of the risks being assumed.

Participant initial here: _____

I agree to the following:

1. My participation in chiropractic treatment, physical medicine and training is strictly voluntary.
2. My participation in each and every exercise and activity within the physical medicine training program is voluntary and I may choose not to participate, or limit my participation, in any exercise or activity at any time.
3. I am personally responsible for my own safety while participating in the physical medicine program. I will pace myself to maintain a level of participation that is safe and comfortable for me.
4. I will advise my chiropractor/medical doctor/chiropractic assistant of any changes in my physical or mental health prior to participation in each session.
5. My chiropractor/chiropractic assistant/medical doctor is available to answer any questions or concerns that I might have regarding my participation, activities, or safety.
6. I will seek further direction or explanation of anything that I do not fully understand, or that causes me concern.

B. INFORMED AND CONSENT TO MEDICAL SERVICES:

I have been informed of and acknowledge that participation in medical services, involving physical exam, physician prescribing services, medical diagnostic laboratory and testing services, can potentially have emergency medical condition arising from treatment program or treatment adversely affecting.

INFORMED CONSENT & LIABILITY RELEASE - PAGE 2

C. INFORMED CONSENT TO MEDICATION:

NAMES OF MEDICATION(S) to which the consumer is consenting on this date:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

In general terms, I have discussed the above medication(s) with the consumer /parent/legal custodian/guardian. Expected results, common side effects, and possible risks were discussed and presented in a clear and reasonable manner consistent with his/her abilities of comprehension and understanding. Alternate treatments (including no treatment and its consequences) were also discussed. I also informed this person that he/she could refuse medication and/or could withdraw consent. I informed him/her that if such refusal would be unsafe to the consumer or others, the consumer may be medicated involuntarily. I have informed this person of his/her right to file a human rights complaint or to seek judicial protection of consumer's rights or privileges by law.

I hereby accept the responsibility for any harm, injury or damage that may result from medical services and treatment provided by Houston Medical Group Downtown, Inc. and entire organization.

I also agrees to immediately go to the nearest hospital medical emergency room at the time of any type of medical emergency or medical condition that believes requires the immediate medical attention which arises from any treatment, service, products, prescription drug provided by Houston Medical Group Downtown, Inc., any employee, agent, independent medical physician, or physician assistant and nurse that covering for the medical physician.

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____

WRITTEN CONSENT: THE ABOVE-NAMED PHYSICIAN EXPLAINED THE BENEFIT(S) AND THE EFFECTS OF THE ABOVE MEDICATION(S).

I UNDERSTAND AND CONSENT TO THIS MEDICATION AS ORDERED BY THE PHYSICIAN AND AGREE TO REPORT ANY CHANGES IN MY/THE CONSUMER'S

CONDITION. I ALSO UNDERSTAND THAT I MAY REFUSE TO TAKE MEDICATION WHEN IT IS OFFERED AND/OR REVOKE CONSENT AT ANY TIME. I UNDERSTAND THAT IF SUCH REFUSAL WOULD BE UNSAFE TO THE CONSUMER OR OTHERS, MEDICATION MAY BE GIVEN INVOLUNTARILY. I UNDERSTAND I HAVE THE RIGHT TO FILE

HUMAN RIGHTS COMPLAINT OR TO SEEK JUDICIAL PROTECTION OF CONSUMER'S RIGHTS OR PRIVILEGES AS PROVIDED BY LAW.

_____

Patient's Name (Print) **Date**

_____

Patient's Signature

_____

Legal Guardians Signature **Date**

CONFIDENTIALITY STATEMENT

Your health is a serious personal matter and we understand that confidentiality is of utmost importance. To ensure your complete privacy, we implemented and follow specific strict security protocols and processes. We only use the highest level of customer and web site security features to guarantee your privacy and security. It is our policy to never allow any 3rd party access to any of your personal financial or medical information. If you have a question on our security processes or protocols please contact us immediately.

Your Test Results - You and only you receive your test results unless you direct us in writing to forward your results to a medical practitioner or an additional 3rd party. Although some positive results such as HIV are required to be reported to certain government agencies, only the minimum required information will be reported.

YOUR PRIVACY IS IMPORTANT TO US AND WE USE EVERY CARE TO SECURE YOUR PRIVACY RIGHTS!

HIPAA: Health Insurance Portability and Accountability Act - This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review this carefully. In compliance with the 1996 Congressional Act to protect the privacy of patients' protected health information, we will safeguard all client/patient information and will disclose or share only minimal information necessary for the following purposes:

Treatment: Information regarding current or past health information necessary for the agency to carry out appropriate care of the clients requesting home care services which may include, but is not limited to:

History and physical, progress notes, laboratory reports, x-ray results, operative reports, consultation reports, hospital discharge reports, hospital DNR, to be obtained from any clinic, hospital, skilled nursing facility, physician office or health care agency involved in the patient/client's present and future care.

Payment: Information requested by the Insurance company, necessary for the processing of claims for payment of services.

Operations: Review of medical records by any peer review organization, accrediting body, state or regulatory body for statistical or agency evaluation purposes only. Any information disclosed will be held in strict confidence and not used for any public disclosure.

If you feel that your privacy rights have been violated you may contact us and ask for the Director or Operations. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state or federal organization address and or telephone numbers to file a complaint.

We will maintain a log for each patient we service which will list what information was released and for what purpose. The patient has the right to review this log upon request.

_____	_____	_____
Printed Name	Patient Signature	Date

ATTESTATION

By my signature below, I hereby attest and certify that the personal injury claim that I am pursuing was the result of the legitimate accident that occurred on _____.

I hereby acknowledge that I have been informed by Houston Medical Group that it is a violation of federal and State Law to falsely claim that I was injured or involved in an accident that is in any way staged or set up for the purpose of filing a fraudulent claim.

Further by my signature below, I acknowledge that nobody has come to my residence or otherwise contacted to inform me that I should or must come to this clinic for therapy due to the accident on _____, that caused my injury.

Patient Signature _____ **Date** _____

Patient Name _____ **SS#** _____

TRANSPORTATION RELEASE OF LIABILITY

I, _____ do hereby release, forever discharge and agree to hold harmless:

DOWNTOWN PERFORMANCE MEDICAL CENTER, IMAGE MEDICAL CLINIC, NORTHSIDE PAIN RELIEF CENTER, CHANNELVIEW MEDICAL CENTER, & ST. MARY BEHAVIORAL PAIN MANAGEMENT, LLP

and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property loss, damages and/or expenses, of any nature whatsoever which may be incurred by the undersigned that occur while said is receiving complementary transportation provided by this facility.

Furthermore, I hereby assume all risk of personal injury, sickness, death, damage and expense as a result of transportation provided to me, free of charge, to and/or from the clinic.

The undersigned further hereby agrees to hold harmless and indemnify said organizations(s), its directors, employees and agents, for any liability sustained by said travel organizers as the result of negligent, willful or intentional acts of said transportation recipient, including expenses incurred attendant thereto.

Further, should it become necessary for the participant to return home due to medical reasons, disciplinary action or otherwise, I (we) hereby assume all transportation costs.

Please understand that transportation is available only to those that meet our requirements which include: unable to drive due to health conditions or injury, no driver's license, does not have a vehicle or vehicle is not drivable.

We require that you will be available within 1 hour of pick up time before and after your appointment. We also require that you must complete all treatments prescribed by the doctor, unless there are contraindication to other health conditions.
*We reserve the right to refuse transportation services to anyone and at any given time if you do not meet the requirements.

Recipient Signature: _____**Date:** _____

Print Name of Recipient: _____

Witness Signature: _____**Date:** _____

Print Name of Witness: _____