PLEASE FILL OUT ALL PAGES. THANK YOU.

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last)*_____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Address _____City_____State ____Zip_____

Phone Number: Home _____ Cell_____ Work_____

Email_____ If Student,School Name_____ Full-Time / Part-Time

Emergency Contact _____ Relationship to Patient _____

Phone Number _____

Responsible Party (insurance card holder)

Name _____ Relationship to Patient _____

Address_____

Phone Number _____

Emergency Contact _____ Phone Number _____

Insurance Information

Insurance Company _____ Phone Number _____

Address _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone Number _____

Employer Address_____

Insured's Social Security # _____ Date of Birth _____ Male / Female

I hereby assign, transfer, and set over to Allen Friends & Family Clinic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature_____ Date _____

ALLEN FRIENDS & FAMILY CLINIC, PLLC
Chi-Hwa Yeh, M.D.
1314 W McDermott Dr, Ste 158, Allen, TX
Ph: 469-342-6303
Fax: 469-342-6301

Office Policies:

Welcome to Allen Friends & Family Clinic (AFFC). We hope to work with you in providing the best medical care in our neighborhood. As medical care is a two-way street, the more information you can provide to the doctor, the better the outcome of your care. As human body is complicated, your diagnosis may change as illness evolves.

Below you will find our office policies. Please read carefully and ask us for any questions.

Office Hours:

Our office hours are Monday through Friday from 8:30 A.M. to 5:30 P.M. And **close for LUNCH**, from 12pm to 1:00pm.

Appointments:

Office visits are by appointments only, though we welcome walk-in patients. Walk-in patients are expected to wait for gaps between patients with appointments. We'll do our best to see all our patients on timely basis. However, some patients may have conditions that demand more of physician's time. Also, patients with urgent complaints may need to be evaluated first.
In case you need to cancel or reschedule your appointment, please kindly call us at least 24 hours in advance so we can schedule other patients. If we don't receive adequate notice from you and/or you simply don't show up, there will be a $25 NO SHOW CHARGE per missed appointment. This charge is not billable to your insurance and MUST be paid before being seen at our clinic.

Telephone Calls:

Please call us during normal business hours for any non-emergent calls. If there is threat or possibility of threat to your life, vision, or limbs, please go to the hospital ER or call 911.
Messages left on our voicemail will be answered within 24 business hours, excluding weekends. Please call us again during our opening hours if no one calls you after that time. Please direct any medication refill request to your pharmacy who'll fax us the request form.

Patient/Insurance Payments:

Co-pay and Deductibles are expected at the time of check-in. We accept cash, or credit cards (MasterCard, VISA, and Discover). Please bring a valid health insurance card and a photo ID. Please complete our registration form and make necessary changes in the future as needed. While we strive to ask your health insurance to cover for your visit, most of them don't cover 100%. You may get additional bills from us after settlement with your insurance even though you have paid your co-pay. Please pay the balance as soon as possible. Any unpaid balance more than 60 days will be sent to our collection agency and we may release you from the practice. Patients with outstanding balances may be refused further appointments until balances are paid in full or other payment arrangements are made. Deductibles paid in the office may appear more than the insurances allowable amount. If more than a $40.00 difference is shown you may call our office to request as a credit or refund. Any amount less than $40.00 will automatically be forwarded to your account as a credit to your next visit.

Medical Records:

We require your written release of information and payment for copies of medical record. The fee for the entire record is $25 and $10 for condensed version.

Patient Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSURES OF HEALTH INFORMATION

This office may use and disclose health information about you for treatment, payment, and healthcare operations that may be necessary now or in the future. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, or collect payment from other entities such as insurance or healthcare plans, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for <u>any purpose</u>. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy. However, you should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restrictions.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders. (Such as voicemail messages, email, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

Allen Friends
& FAMILY CLINIC

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES
AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I,_____, acknowledge that I
(Name of Patient or Parent or Legal Guardian)
have either received a copy of this office NOTICE OF PRIVACY PRACTICES or that this office NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I also give consent to the use and disclosure of my personal health information by your office for Treatment, Billing / Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Signature (for Minors Only) Relationship to Patient

PATIENT CONSENT TO TREAT

I hereby give my consent to Allen Friends & Family Clinic (AFFC) and authorize him or her to provide my medical treatment. I understand that AFFC will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize AFFC to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

I also hereby authorize AFFC to perform necessary tests regarding my treatment as ordered by the physician. I understand that not all tests may be covered by my insurance company or may go toward my insurance deductible. Insurance companies do not pay for everything, and in that case I understand I will be responsible for the charges for the testing. I have carefully read this form and have all my questions answered by the AFFC staff.

Patient Name _____

Patient Signature _____ Date _____

Parent or Legal Guardian Signature (for minor) _____

Relationship to the Patient _____

Signature of Treating Provider (if procedure was done)_____

Date _____

ALLEN FRIENDS & FAMILY CLINIC

Medical History Form

Name_____ **Date of Birth** _____

PREVIOUS SURGERIES/HOSPITALIZATIONS:

Please list all **SURGERIES/ HOSPITALIZATIONS & YEAR**:

_____

_____

_____

_____

SOCIAL HISTORY:

Use of Tobacco: { } Never { } Previously { } Currently, if so how much daily? _____
Use of Alcohol: {] Never { } Socially { } Daily, if so how much? _____

Do you have any **MEDICATION ALLERGIES**? If yes, what medication? _____

CURRENT MEDICATIONS:

Please list all medications **CURRENTLY TAKING & DOSAGES**:

_____

_____

_____

_____

FAMILY MEDICAL HISTORY:

AGE DISEASE/DISORDERS

Mother _____
Father _____
Brother _____
Sister _____
Children_____

IMMUNIZATIONS:

	Up to Date	Need to Get
TD/Tdap		
Pneumovax		
Hepatitis A/ B		
MMR		
Chicken Pox		
Meningococcal		
Influenza		

MEDICAL HISTORY - Have you ever had or do you currently have any of the following:

CARDIOVASCULAR:	NEVER	PAST	CURRENTLY
Heart Attack			
Heart Murmur			
Stroke			
Palpitations			
High Blood Pressure			
Varicose Veins			
Heart Disease			
Cholesterol			
OTHER (specify):			
RESPIRATORY:	**NEVER**	**PAST**	**CURRENTLY**
Shortness of Breath			
Asthma			
Emphysema			
Pneumonia			
Frequent nose bleed			
Tuberculosis			
OTHER (specify):			
BLOOD:	**NEVER**	**PAST**	**CURRENTLY**
Anemia			
Bleeding disorders			
Sickle cell disease/trait			
Leukemia			
OTHER (specify):			
NERV/JOINTS:	**NEVER**	**PAST**	**CURRENTLY**
Frequent Headache			
Epilepsy, seizures, convulsions			
Arthritis			
Palsy or Tremors			
Severe Head Injury			
MS			
OTHER (specify):			

DIGESTIVE:	NEVER	PAST	CURRENTLY
Blood in Stool			
Ulcer			
Appendicitis			
Colitis			
Irritable Bowel			
Frequent constipation			
Stomach pain			
Hemorrhoids			
Hernia			
Diverticulitis			
Hepatitis			
Cirrhosis			
Jaundice			
Gallstones			
OTHER (specify):			
ENDOCRINE:	**NEVER**	**PAST**	**CURRENTLY**
Diabetes			
Thyroid disorder			
Pancreatitis			
OTHER (specify):			
KIDNEYS:	**NEVER**	**PAST**	**CURRENTLY**
Blood in Urine			
Kidney stones/ disease			
Urine Infection			
MALES ONLY: Prostate enlargement			
GOUT:			
MENTAL HEALTH:	**NEVER**	**PAST**	**CURRENTLY**
ADD/ ADHD			
Bipolar			
Depression			
Anxiety			
OTHER (specify):			

PATIENT NAME: _____ DATE: _____

ALLEN FRIENDS & FAMILY CLINIC

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Patient Name: _____

Date of Birth : _____ **Date of Service:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

For Office Coding _____ + _____ + _____ + _____

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
[ ]	[ ]	[ ]	[ ]