Houston Endocrine Center

5039 FM 2920, Spring, TX - 77388 • Phn: (832)862-3236 • Fax: (949)862-8753

Patient Registration Form

Name _____ _____ _____
Last First Middle

Address _____ _____ ___ _____
Street City State Zip

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Home Phone _____ Work/Cell _____

Social Security # _____ - _____ - _____ Ref Physician: _____

Guarantor Information

Guarantor Name _____ _____ _____
Last First Middle

Address _____ _____ ___ _____
Street City State Zip

Guarantor Date of Birth _____ Sex ____ SS# _____ - _____ - _____

Relationship to Patient _____ Phone _____

Insurance Information

Primary Insurance _____

Policy # _____ Group # _____ Phone# _____

Secondary Insurance _____

Policy # _____ Group # _____ Phone# _____

Emergency Contact:

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

FOR ALL PATIENTS:
Assignments of insurance benefits and authorization for release of information:
(Please read carefully and sign below).

I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for the non-covered services. I also authorize the physician to release any information required to process all insurance claims.

Date: _____ Signature: _____

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Confidential Information Release Form

I, _____, do hereby authorize Dr. Zubair B Mirza and his office staff to release confidential medical/billing information concerning my health or account in my absence to the family member or associate listed below. Furthermore, I will not hold Dr. Zubair B Mirza or any member of his staff responsible for the release of my personal medical information or billing record.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Init ____ May we leave a message on your personal voicemail reminding you of appointments? YES NO (circle one)

Init ____ May we leave a message with any person that would answer the telephone at your home reminding you of an upcoming appointment? YES NO (circle one)

Init ____ I AM AWARE THAT IT IS MY RESPONSIBILITY TO KEEP MY APPOINTMENT AND THAT CANCELLATIONS MUST BE MADE AT LEAST 24 HRS IN ADVANCE OR A $25 FEE WILL BE CHARGED BEFORE I WILL BE ALLOWED TO BE SEEN BY THE DOCTOR.

_____ Signature of patient

_____ Witnessed by

_____ Date

_____ Date

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Medical Records Release

I authorize _____ to (circle one) release to:/receive from:

_____ _____ _____

Doctor or Organization Phone # Fax #

Address _____ _____ ___ _____

Street City State Zip

_____ _____

Patient's Name Date of Birth

Information/Copies to Be Released (Check All That Apply)

- ☐ Emergency Room
- ☐ Radiology Reports
- ☐ Lab Work
- ☐ H&P
- ☐ Drug/Alcohol information
- ☐ Pathology Report
- ☐ Billing records
- ☐ Consultations
- ☐ Discharge Summary
- ☐ Psychiatric Information
- ☐ All Records
- ☐ Other (please explain) _____

Purpose of Release of Information:

☐ Continued Care ☐ Attorney/Litigation ☐ Insurance ☐ Disability Service ☐ Other

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that even this authorization shall expire 1 year from the date of my signature, unless specified in writing here:

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider the release information may no longer be protected by federal and state privacy regulations. TO THE PARTY RECEIVING THIS INFORMATION; this information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, a federal regulation (42 CFR, Part 2) prohibits you from making any further disclosures of it without specific written consent of the person whom it pertains, other information is no sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 PART 2

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Printed Name of Patient or Legally Authorized Representative

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Medical History

Name: _____ Date of Birth _____

Family History: ☐Diabetes ☐High Blood Pressure ☐Stroke ☐Heart Disease ☐Arthritis ☐Cancer ☐Other: Please List:

_____

Social History: Occupation: _____

Do you smoke? Yes No (circle one) If so, How often? _____

Do you consume alcohol? Yes No (circle one) If so, How often? _____

Have you used social drugs in the past? (Marijuana, etc.) Yes No (circle one)

Past Medical History: __

☐Measles ☐Chicken Pox ☐Tuberculosis ☐Migraines ☐Diabetes
☐Glaucoma ☐Cataracts ☐Asthma ☐Heart Attack ☐Stroke
☐Hepatitis ☐Gall Stones ☐Cancer ☐Mumps ☐Kidney Disease
☐Thyroid Disease ☐Rheumatic Fever ☐Hypertension ☐Seizures/Epilepsy
☐Depression/ Anxiety ☐Sexually Transmitted Disease ☐Degenerative Joint Disease
☐Rheumatoid Arthritis/Gout ☐Emphysema/Chronic Bronchitis

Please list all surgeries _____

_____

Please list all hospitalization _____

_____

Please list all allergies _____

_____

PLEASE CHECK ALL SYMPTOMS BELOW

☐Heart burn/stomach pain	☐Excessive Weight Loss	☐Muscle weakness
☐Excessive Weight Gain	☐Nausea/ Vomiting	☐Tender points in muscle
☐Headache	☐Gastric ulcers	☐Insomnia
☐Double Vision	☐Constipation	☐Hoarseness
☐Sinus Trouble	☐Diarrhea	☐Swelling of ankles/legs
☐Hay Fever/ Allergies	☐Frequent urination	☐Easy Bruising
☐Chest Pain	☐Burning during urination	☐Blood in Sputum
☐Palpitations	☐Blood in Urine	☐Joint Pain
☐Dizziness	☐Excessive Thirst	☐Joint Swelling
☐Fainting Spells	☐Depression/Anxiety	☐Numbness
☐Weakness	☐Dryness/ Redness of Eyes	☐Skin Rash/ sores
☐Chronic Cough	☐Joint Stiffness	☐Back Pain
☐Wheezing	☐Shortness of Breath	☐Fever

List of medications _____

_____

_____

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Referral Responsibility

If your insurance plan requires a referral from your PCP to see a specialist, it is patients' responsibility to obtain referral and maintain the active status of the referral.

You will not be seen by Dr. Zubair B Mirza without a valid referral. Responsibility for payment will fall directly upon the patient for any invalid or outdated referrals.

Signature of Patient or Legally Authorized Representative	Date
Print Name of Patient or Legally Authorized Representative	Relationship to Patient

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Consent To Use and Disclose Protected Health Information

How We May Use and Disclose Your Health Information

Your protected health information will be used by Dr. Zubair B Mirza, or disclosed to other for the purposes of treatment, obtaining payment, or supporting the day to day health care operation of the practice.

The Notice of Privacy Practices

Dr. Zubair B Mirza is required to provide you a notice that describes how information about you may be used and disclosed. Additionally we must provide you information of how you may get access to this information. These policies and practices are defined in the “Notice of Privacy Practices”. PLEASE REVIEW CAREFULLY

Restrictions on the Use or Disclosure of Your Health Information

You may request a restriction on the use or disclosure of your protected health information. However, Dr. Zubair B Mirza may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional informational clarification. It is a violation of the federal privacy standard if Dr. Zubair B Mirza agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative at the office location.

You May Revoke This Consent at Anytime

You may revoke this consent at any time; however, Dr. Zubair B Mirza requires that you must revoke this consent in writing. If you choose to revoke this, consent, the revocation will not affect use and disclosure of your information before the date of your request.

Changes to Privacy Practices

Dr. Zubair B Mirza reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. Dr. Zubair B Mirza will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that you require.

Signature

I have reviewed this consent form, received the brochure entitled “Notice of Privacy Practices” and given my permission to Dr. Zubair B Mirza to use and disclose my health information in accordance with this consent and the notice provided.

Signature of Patient, Legally Authorized Representative	Date
Printed Name of Patient, Legally Authorized Representative	Relationship to Patient

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Notice of Privacy Practices

Our Legal Duty

We are required to protect the privacy of health information about you, which we call "protected health information" or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI:

- We must protect PHI that we have created or received about your past, present or future health condition, health care we provide to you or payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and /or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first:

- Posting the revised notice in our office.
- Making copies of the revised notice available upon request: and
- Posting the revised notice in our waiting area.

Use and Disclosure of Your Medical Information

1. We may use and disclose PHI about you to provide health care treatment to you. We may use and disclose PHI to provide, coordinate, or manage your healthcare and related services.
2. We may use and disclose PHI about you to obtain payment for services. Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you.
3. We may use and disclose your PHI for healthcare operations. We may use and disclose PHI in performing business activities, which we call "healthcare operations". These "healthcare operations" allow us to improve the quality of care we provide and reduce healthcare costs.
4. We may use and disclose PHI under other circumstances without your authorization. We may use and /or disclose PHI about you for a number of circumstances in which you do not have to consent, give authorization, or otherwise have an opportunity to agree or object. Those circumstances include:
    - Court Orders and Judicial Proceedings.
    - Public Health Activities.
    - Victims of Abuse, Neglect, or Domestic Violence.
    - Disaster Relief.
    - Funeral Director, Coroner, Medical Examiner.
    - Research in Limited Circumstances.
    - Law Enforcement.
5. Unless you object, we may use or disclose PHI about you in the following circumstances:

- We may share with a family member, relative, friend or other person identified by you directly related to that person's involvement in your care or payment of your care.
- We may share with a family member, personal representative or other person responsible for your care PHI necessary to notify such individuals of you location, general condition or death.
- We may share with a public or private agency PHI about you for disaster relief purposes. Even if you object, we may still share the PHI about you, if necessary, for the emergency circumstances.

6. We may contact you to provide appointment reminders. We may use and disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.
7. We may contact you with information about treatment, services, products or healthcare providers. We may use and/or disclose PHI to manage or coordinate your healthcare. This may include telling you about treatments, services, products and/or other healthcare providers.

Any Other Use or Disclosure of PHI about You Requires Your Written Authorization

YOUR INDIVIDUAL RIGHTS

1. You have the right to request restrictions on uses and disclosures of PHI about you.
2. You have the right to request different ways to communicate with you.
3. You have the right to see and copy PHI about you.
4. You have the right to request amendment of PHI about you.
5. You have the right to a listing of disclosures we have made.
6. You have the right to a copy of this notice.

You May File a Complaint about Our Privacy Practices

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us.

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services.