CovenantHealth Medical Group

A. PATIENT INFORMATION

PATIENT: _____ SSN: _____
LAST FIRST MIDDLE

DRIVER'S LICENSE NUMBER: _____ STATE: _____ BIRTH DATE: _____

GENDER: ☐ M ☐ F MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

ETHNICITY: ☐ HISPANIC, LATINO, OR SPANISH ORIGIN ☐ NOT HISPANIC, LATINO, OR SPANISH ORIGIN

RACE: ☐ ASIAN ☐ BLACK/AFRICAN-AMERICAN ☐ CAUCASIAN/WHITE ☐ HISPANIC ☐ NATIVE AMERICAN/ALASKAN NATIVE
☐ NATIVE HAWAIIAN/PACIFIC ISLAND ☐ OTHER ☐ REFUSE

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: ( ) _____ ☐ HOME ☐ WORK ☐ CELL REMINDER CALL: ☐ YES ☐ NO

CELL PHONE: ( ) _____ (ALSO REQUIRED FOR APPT REMINDER TEXT)

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ OTHER

EMPLOYER: _____ PATIENT'S WORK PHONE: ( ) _____

PATIENT'S ADDITIONAL PHONE: ( ) _____ E-MAIL: _____

EMERGENCY CONTACT NAME: _____ PHONE:( )_____

EMERGENCY CONTACT RELATIONSHIP: _____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS: ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____ OB/GYN IF APPLICABLE: _____

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ SIGN LANGUAGE ☐ OTHER: _____

B. GUARANTOR INFORMATION (IF PATIENT IS UNDER 18)

GUARANTOR NAME: _____ RELATIONSHIP OF PATIENT TO GUARANTOR: ☐ CHILD ☐ OTHER: _____

DRIVER'S LICENSE NUMBER: _____ STATE: _____

GUARANTOR MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GUARANTOR PHONE: ( ) _____ GUARANTOR SSN: _____ GUARANTOR DOB: _____

GUARANTOR EMPLOYER: _____ GUARANTOR WORK PHONE: ( ) _____

C. PRIMARY INSURANCE INFORMATION
(IF PROVIDING CURRENT INSURANCE CARD, SKIP C & D)

NAME OF COMPANY: _____

MEMBER NUMBER/CERTIFICATE NUMBER: _____ GROUP/PLAN: _____

POLICY EFFECTIVE DATE: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER/INSURED: ☐ CHILD* ☐ OTHER* ☐ SELF ☐ SPOUSE*
(*IF PATIENT IS NOT THE SUBSCRIBER, PLEASE COMPLETE THE INFORMATION BELOW)

SUBSCRIBER NAME: _____ BIRTH DATE: _____

SUBSCRIBER'S EMPLOYER: _____

D. SECONDARY INSURANCE INFORMATION

NAME OF COMPANY: _____

MEMBER NUMBER/CERTIFICATE NUMBER: _____ GROUP/PLAN: _____

POLICY EFFECTIVE DATE: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER/INSURED: ☐ CHILD* ☐ OTHER* ☐ SELF ☐ SPOUSE*
(*IF PATIENT IS NOT THE SUBSCRIBER, PLEASE COMPLETE THE INFORMATION BELOW)

SUBSCRIBER NAME: _____ BIRTH DATE: _____

SUBSCRIBER'S EMPLOYER: _____

CovenantHealth
Medical Group

Patient Financial Responsibility

We are committed to providing you with the best possible medical care. If you have special needs; we are here to work with you and the following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express and Quick Pay opportunities.

2. Our office participates with a variety of insurance plans. It is your responsibility to:

   - Bring your insurance card to every visit.
   - Be prepared to pay your co-payment at each visit by cash, check, or credit card.
   - For medical care not covered under your insurance, payment in full is due at the time of the visit.
   - You are responsible for any outstanding balances owed to the Covenant Medical Group for services provided to you or any family member for which you are responsible.

3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service.

4. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you may be financially responsible.

5. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.

6. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (number is on the insurance card).
   If your insurance company determines services provided are not covered, the responsible party owes the payment

7. If you fail to make payment in full for the services, your outstanding balance will be sent to a collections agency who is authorized to contact you via the number's you have provided. If you consistently refuse to pay for services rendered, CMG may choose to cease providing services to you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be asked prior to services provided. Please sign that you have read and agree to the above mentioned financial information which assigns Covenant Medical Group, and/or any physician who has treated you, all rights, title, and interest in any payment due you for services provided in the policy or policies of insurance including Medicare or Medicaid. I authorize any holder of medical or other information about me to be released to Social Security Administration or its intermediaries/carriers any information needed for this claim. I authorize contact on any phone number I have provided. I agree to pay for charges which may be greater than the amount paid by the insurance company or companies.

_____

Signature of Patient or Responsible Party Date

_____

Signature of Co-Responsible Party Date

CovenantHealth
Medical Group

CONSENT TO TREATMENT

I (the patient/guardian/legal representative to the patient acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians, nurse practitioners, physician's assistants and staff of Covenant Medical Group.

PHARMACY/MEDICATION HISTORY: I authorize Covenant Medical Group to obtain all of my medication history, in any format, to provide my medical care.

This consent is valid from this date forward.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Covenant Medical Group's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

ADVANCED DIRECTIVE LIVING WILL

Do you have an advanced directive/living will? ☐ Yes ☐ No

If you answered No, would you like more information on Advanced Directives? ☐ Yes ☐ No

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE PUT A ✓ IN EACH SECTION):

☐ Home Telephone _____
- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ Please **do not** leave a message

☐ Work Telephone _____
- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ Please **do not** leave a message

☐ Mobile Telephone _____
- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ Please **do not** leave a message

☐ Fax Number: _____
- ☐ Please **do not** fax any information to me

☐ Written Communication
- ☐ Mail to my home address
- ☐ Mail to my work/office address
- ☐ Please **do not** mail

☐ Electronic Communication
- ☐ Email _____
- ☐ Text # _____

☐ The following people may have access to my medical information:
- ☐ Spouse/Significant Other: _____
- ☐ Child: _____
- ☐ Child: _____
- ☐ Child: _____
- ☐ Other: _____
- ☐ Nobody should have access

TELEPHONE CONSUMER PROTECTION ACT

By providing us with a telephone number for a cellular or other wireless device, you agree that in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s)) or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you at the above listed telephone number(s) which could result in charges to you. You expressly consent that methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with this account and is not a condition of purchasing property, goods, or services. You are not required to sign this consent as a condition of treatment.

Initials Here to Accept: _____ Initials Here to Decline: _____

Patient/Patient Representative Signature _____ Relationship to Patient _____ Date/Time _____

Witness Signature _____ Reason Patient is Unable to Sign _____ Date/Time _____

CovenantHealth
Medical Group

ADDITIONAL CONSENT REGARDING SERVICES PERFORMED IN TEXAS

I understand that the physicians and other clinical staff employed by Covenant Medical Group ("CMG") are licensed by the state of Texas, and that the medical services provided to me by CMG and its affiliated health care providers will be rendered in Texas. As such, I agree that the relationship between myself and CMG (inclusive of its affiliated physicians and other health care providers) for care provided in Texas will be governed by Texas laws without regard for conflicts of laws principles. I also agree that any lawsuit or other dispute arising from or related to medical care I receive from CMG and/or its affiliated physicians or other health care providers will be brought only in an appropriate court located in Lubbock County, Texas.

The above authorized information will apply to all Covenant Medical Group providers and remains in effect until additional notice or changes are made by the patient.

Relationship to Patient: ☐ Self ☐ Child ☐ Parent/Guardian ☐ Spouse ☐ Other: _____

Printed Name	Birthdate	Signature	Date

Printed Name of Witness	Signature of Witness	Date

COVENANT MEDICAL GROUP

Patient name: _____

Referring doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

Have you tried any medication/treatment for this problem/pain? _____

Allergies – Please list ALL types (drug, seasonal, pets, food)

_____

_____

Current Medications – Please list or bring a copy of ALL medications you are currently taking including any over the counter medications

Drug Name:	Dosage:	Directions:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name _____ Phone # _____

Address _____

Have you had a flu shot in the last 12 months? Y or N Date _____

Have you had a pneumonia shot in the last 12 months? Y or N Date _____

For office use only:

_____

_____

_____

COVENANT MEDICAL GROUP-UROLOGY

SOCIAL HISTORY

Alcohol (amount _____) YES or NO

Currently smoke (____pack/day_____ # years) YES or NO

Former smoker (year quit _____)

Coffee drinker (amount _____)

Soda drinker (amount _____)

Tea drinker (amount_____)

Recreational drugs _____

FAMILY HISTORY (please list relation) **Relation**

High Blood Pressure_____

Cancer (type) _____

Diabetes _____

Heart Disease _____

Kidney stones/Disease _____

Urinary Tract Infections _____

Stroke _____

Other _____

Marital Status: _____ if married, # of years_____ # children_____

Occupation_____

COVENANT MEDICAL GROUP

Past and present medical history (check all items either YES or NO (now) or YES (past)

(Please give an explanation in the area provided below)

	NO	YES (now)	YES (past)		NO	YES (now)	YES (past)
Alcoholism				Mental disorder			
Cancer (explain)				Gastrointestinal disease (explain)			
Epilepsy				Heart murmur			
Glaucoma				Heart attack			
Hepatitis (circle) A B C				Heart fluttering			
Kidney stones				Heart disease			
Kidney disease				High blood pressure			
Bladder problems				Low blood pressure			
Venereal disease				Vascular disease			
Bladder infections				Neurological disorder			
Menstrual disorder				Respiratory disease (explain)			
Thyroid disease				Blood clots			
Muscle disease (explain)				Rheumatic fever			
Tuberculosis				AIDS/HIV			
Anemia				Stroke			
Hemophilia				Pelvic/Vaginal infections			
Diabetes insulin/non-insulin				Other (specify)			

Explanation: _____

_____

_____

_____

Surgical History (list type of surgery and date)

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Female Urologic Symptoms/History

Have you ever had any of the following symptoms in the past 6 months, or since your last visit? Please check all that apply.

____ **Frequent Urination**

____ **Urgent need to urinate**

____ **Difficulty starting urinary stream**

____ **Slowing of urinary stream**

____ **Intermittent urinary stream**

____ **Feeling bladder doesn't empty completely**

____ **Urine leaks with laughter, cough, or strain/other_____**

____ **Getting up at night to urinate____times per night**

____ **Bladder Dropping**

____ **Blood in urine**

____ **Pelvic Pain**

____ **Painful intercourse**

____ **Vaginal discharge**

____ **Vaginal bleeding (non menstrual)**

____**Vaginal dryness**

____ **Problems with bowel movements**

Number of vaginal deliveries____Number of Caesarian deliveries___

Other comments_____