Clear Lake Specialties

Patient Registration Form

PATIENT INFORMATION

Patient's Name_____, _____, _____ **DOB**_____
(Last) (First) (Middle Initial)

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security _____-_____-_____ **Gender:** ☐Female ☐Male ☐Transgender

Race ☐ American Indian/ Alaskan ☐ Asian ☐Native Hawaiian/ Pacific Islander ☐ White
☐ Black/African American ☐ Other

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/ Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Hindu/Urdu ☐ Arabic ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ Other

Email Address _____

Phone Numbers: Home_____ Cell_____ Authorize to Leave message Yes----- No-----

Address_____
Street Name City, State Zip Code

PCP_____ **Referring Provider**_____
(Primary Care Physician)

Phone:_____ **Phone :**_____

EMERGENCY CONTACT INFORMATION:	**INSURANCE INFORMATION:**
Emergency Contact: Name_____	Primary Insurance_____
Number_____	Secondary Insurance: _____
Relationship to Patient_____	* **PHARMACY INFORMATION:**
Employer / School _____	*Pharmacy Name_____
Number	* Number
Do you have an Advance Directive? Yes — No—	

AUTHORIZATION TO RELEASE INFORMATION TO CARE GIVER / FAMILY MEMBER

Name_____ Relationship to Patient *:_____

Name_____ Relationship to Patient*:_____

* Authorize to Leave message Yes ----- No----

I agree that the information on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ Date_____

Clear Lake Specialties, PA

New Patient Information

Today's Date: _____ Doctor's Name: _____

Patient's Name: _____ Date of Birth: _____

Patient History

Reason for today's visit: _____

_____

_____

Medications

Please list the name, dosage, and how often you take the medication.

Please include IV antibiotics, nebulizer medications, vitamins, over the counter and prescription meds.

1) _____ 11) _____

2) _____ 12) _____

3) _____ 13) _____

4) _____ 14) _____

5) _____ 15) _____

6) _____ 16) _____

7) _____ 17) _____

8) _____ 18) _____

9) _____ 19) _____

10) _____ 20) _____

Allergies

1) Medications: _____

_____

2) Food: _____

_____

3) Other: _____

_____

Clear Lake Specialties, PA

New Patient Information

Please let us know if you have been diagnosed with any of the following:

- ☐ Anemia
- ☐ Angina Aortic Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain/injury
- ☐ Bleeding Disorders
- ☐ Blood clots in the legs or lungs
- ☐ Bronchitis
- ☐ Cancer; where?

_____

- ☐ Cirrhosis of the liver
- ☐ Compression fracture
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombus
- ☐ Depression/Nervous disorder
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Eye Problems
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Goiter/thyroid disorder
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Problems, Other
- ☐ Hepatitis
- ☐ Hernias, Hiatal or Other
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney stones
- ☐ Kidney/Bladder infection
- ☐ Migraine headaches
- ☐ Osteoporosis (thinning of bones)
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Prostate enlargement
- ☐ Prostate infection
- ☐ Psychiatric Illness
- ☐ Pulmonary Embolus
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TB Tuberculosis
- ☐ Lung Problems, Other
- ☐ Ulcers
- ☐ Urinary Problems

Women Only

- ☐ Currently on birth control pills
- ☐ Recurrent Vaginitis
- ☐ Endometriosis
- ☐ Ovarian cysts or tumors
- ☐ Pelvic Infection
- ☐ Menstrual Disorders
- ☐ Recent Miscarriages

OTHER: If there are other illnesses not listed here, please write them in the space below:

_____

_____

_____

_____

_____

Clear Lake Specialties, PA

New Patient Information

Surgeries

Please tell us if you have had any of the following surgeries and list the date of each one.

☐ Lungs/ Chest: What kind? _____ Date: _____

☐ Heart: What kind? _____ Date: _____

☐ Abdominal: What kind? _____ Date: _____

☐ Gallbladder: _____ Date: _____

☐ Appendix: _____ Date: _____

☐ Hernia: _____ Date: _____

☐ Eyes: _____ Date: _____

☐ Prostate: _____ Date: _____

☐ Hysterectomy: _____ Date: _____

☐ Mastectomy: _____ Date: _____

☐ C-Sections: _____ Date: _____

☐ Others: _____ Date: _____

_____

Hospitalizations

Have you ever been hospitalized for any reason? Please explain and list the dates

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Immunizations/ Vaccines

When was the last time you had the following vaccines:

Pneumonia: _____ Flu Shot: _____

Hep A: _____ Tdap: _____

Hep B: _____ Other: _____

Clear Lake Specialties, PA

New Patient Information

Family History

Did any blood relatives (parents, grandparents, children, brothers, or sisters) have any of the following

If yes, please list who had the illness.

☐ Asthma _____

☐ Tuberculosis _____

☐ Heart Disease _____

☐ Diabetes _____

☐ Hypertension _____

☐ Lung Disease _____

☐ Cancer _____

☐ Stroke _____

☐ Excessive Bleeding _____

☐ Thyroid _____

☐ Arthritis _____

☐ Glaucoma _____

☐ Others _____

Social History

Did you ever smoke cigarettes, cigars, or pipes?

How many packs per day _____ How many years? _____ Age quit?_____

Did you ever drink alcohol? If so, what type?

How many drinks per week_____ How many years? _____ Age quit?_____

Who do you live with? _____

Do you have any pets? What kind? _____

What jobs/occupations have you had during your lifetime? _____

_____

Were you ever exposed to excessive dust, asbestos, sand etc.? _____

_____

Have you travelled outside the US? If so, when? _____

CLS – Orthopedic Department
Karthik Jonna, MD
American Board of Orthopedic Surgery
600 N. Kobayashi Rd #208
Webster, TX 77598
Phone: 281-985-9342 | Fax: 281-393-0029

PATIENT RESPONSIBILITY FORM

PLEASE INITIAL BESIDE EACH SECTION

1. I acknowledge that my physician is my partner in health. As an adult, it is my responsibility to keep track of my medical conditions, medications, and all other physicians that are involved in my medical care. It is my responsibility to inform every physician or other health care provider that I encounter about any changes in my medications, medication dosages, any medical conditions or any evaluations in progress. (Initial) _____

2. Test results are usually reviewed and discussed in the office at a follow-up appointment. I acknowledge that if I am NOT notified of any test results obtained or referred by this office, then it is my duty to contact the office to make arrangements to receive the results. I will not assume that not receiving results means tests are normal. I also understand that certain results may warrant a formal discussion and the doctor may require a follow-up appointment in lieu of a phone conversation. (Initial) _____

3. I acknowledge that if I fail to keep an advised follow-up appointment to go over test results, monitor treatment, or evaluate symptoms, then I am responsible if this results in harm to myself, delay in diagnosis, or failure to treat or cure. (Initial) _____

4. I acknowledge that I am responsible for scheduling my own appointments. As a courtesy – the physician's office will attempt to contact me one or two days prior to remind me of an appointment, however I may not receive this message for various reasons. (Initial) ____

5. I acknowledge the importance of making sure the physician's office has my current address and all phone number contacts. If my information on file is not current, then I acknowledge that my physician's office will not be able to notify me about abnormal test results, medication recalls, changes in appointment or surgery scheduling, etc. (Initial) _____

6. I acknowledge that I am responsible to know the insurance benefits provided by my insurance carrier(s). Any questions I have regarding my insurance benefits will be directed to my insurance carrier or Human Resources department by my guarantor or myself. (Initial) _____

Print Name & Date of Birth	Signature	Date

CLS – Orthopedic Department

Karthik Jonna, MD
American Board of Orthopedic Surgery
600 N. Kobayashi Rd #208
Webster, TX 77598
Phone: 281-985-9342 | Fax: 281-393-0029

Initial	Financial & Office Policies Please initial next to each section:
	All co-pays, co-insurance, deductibles and cash payments are due at check-in on the day services are rendered. Should you have any remaining balance on your account, you will receive a billing statement.
	For your convenience we accept cash, money order, debit, and most major credit cards
	For all elective procedures we DO NOT accept checks. Payment must be made in one of the other acceptable forms of payment or your procedure may be rescheduled.
	A fee of **$50.00** will be charged to your account for any returned check.
	"No-Show for Appointment or office procedure" – failure to keep a scheduled appointment without giving our team 48 hour notice fee: **$25.00**
	"Cancellation" – Appointment cancellation with less than 24 hours' notice fee: **$50.00**
	Surgery Deposits must be paid prior to your scheduled surgery day, usually at the time our schedulers reserve a time slot for you: **$100.00**
	CLS Orthopedics requires a 5 BUSINESS DAYS notice for cancelling surgical cases. If you do not cancel your surgery 5 BUSINESS DAYS in advance, you may be subject to a **$200.00** fee.
	Completion of disability forms, FMLA, or insurance forms will be assessed a **$40.00** fee per form to cover the administrative overhead involved in completing these forms. This fee is not covered by insurance.
	Fee for completion of Prior Authorizations for medications that are not covered by your insurance company - **$30.00**. We will notify you in advance if we believe your insurance company won't cover your medication. If you wish for us to appeal the decision, the fee will cover the manpower required to attempt the appeal. **THERE IS NO GUARANTEE THAT YOUR INSURANCE COMPANY WILL APPROVE ANY APPEAL.**

Print Name & Date of Birth _____ Signature _____ Date _____

Clear Lake Specialties (CLS)

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. The collected information is stored in the CLS electronic medical record (EMR) system and becomes part of your personal medical record.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate and up to date. Your medication history might not include drugs purchased without using your health insurance. In addition, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient or Legal Guardian:

_____

Patient Name: _____ Date:

_____

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**