Hac Nguyen MD – Family Practices
16736 Champion Forest Drive
Spring, Texas 77379
Phone: 832-559-7950
hacnguyenmd.com

NEW PATIENT FORMS (INSURANCE AND SELFPAY): BOTOX, JUVEDERM, WEIGTH MANAGEMENT, TESTOSTERONE INJECTIONS, PRP INJECTIONS.

Patient Name:_____ DOB: _____

Address: _____

Phone Number: _____ Home Number: _____

E-mail:_____ Sex: Male / Female

In Case Of Emergency Notify:_____

Dr. Nguyen is your selected primary care physician? YES / NO

INSURANCE NAME'S: _____

INSURANCE IDENTIFICATION NUMBER: _____

SELFPAY PAYMENT AGREEMENT

The patient is responsible for payment of services that are not covered by the insurance plan. These services include non-covered office services and procedures performed by Dr. Nguyen. Please pay your copay, co-insurance, deductible and office fee on the same day of service. Please sign acknowledging that you have read and understand this payment agreement.

Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE INFORAMTION

I authorize Hac Nguyen, MD – Family Practice to furnish medical information to my insurance carrier. I hereby assign all insurance benefits for services rendered to me or my dependent payable to Hac Nguyen, MD – Family Practice. I understand that I am fully responsible for any fees not covered by my insurance.

Signature: _____ **Date:** _____

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HYSTORY AND PHYSICAL

Drug Allergies: _____

Hospitalization / Surgeries: _____

Current Medications: _____

_____

WOMEN ONLY:

○ Pregnant	○ Yes	○ No
○ Planning Pregnancy	○ Yes	○ No
○ Hysterectomy	○ Yes	○ No
○ Menopause	○ Yes	○ No

PAST MEDICAL HISTORY

○ **Allergies**	○ **Depression / Anxiety**	○ **Anemia**
○ **Asthma**	○ **Hypothyroid**	○ **High Cholesterol**
○ **Eczema/Psoriasis**	○ **Hyperthyroid**	○ **Hepatitis**
○ **Stomach Ulcer**	○ **Heart Palpitations**	○ **Herpes**
○ **Reflux**	○ **Heart Murmur**	○ **Lupus**
○ **Pancreatitis**	○ **Heart Disease**	○ **Kidney Disease**
○ **Prostate Disease**	○ **Emphysema**	○ **Arthritis**
○ **IBS**	○ **High Blood Pressure**	○ **Gout**
○ **Sexual/ Menstrual Dysfunction**	○ **Peripheral Vascular Disease**	○ **Seizure / Epilepsy**
○ **ADHD**	○ **HIV Positive**	○ **Diabetes**

FAMILY HISTORY

	Father	Mother	Mother's Parents	Father's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disorder						
Thyroid Disorder						
Mental Illness						

HABITS: Alcohol: Yes / No

Smoke: Yes / No Packs Daily_____ How Long _____ When Stopped _____

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AUTHORIZE FOR REALEASE OF PROTECTED HEALTH INFORMATION

This is an authorization requesting Hac Nguyen, MD Family Practices to release individual health information protected by the Health Insurance Portability Act of 1996 (HIPPA), or by state law protecting the privacy of health information. I hereby authorize the use and disclosure of the individually identifiable health information as described below.

The request for release of information is being made for the patient identified below.

_____ _____

Patient's Name Date of Birth

_____ _____

Mailing Address Home/Cell Number

Specific description of information that may be used / disclosed:

- Billing / Payments
- Office Visit Office
- Labs
- X-Rays / EKG
- All Records
- Other information (must provide specific description).

_____

Persons / Organizations authorized to receive the information:

Family Members (Name and relationship):_____

Other (Name and relationship):_____

I understand that I may revoke this authorization at any time by sending a written notice of my revocation to the address listed below. I also understands that without any written authorization, Hac Nguyen, MD Family Practices may not use or disclose my health information for any reason except those described in Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date, even, or circumstance. This authorization on:_____[Insert applicable date. If no expiration is stated, this authorization will be deemed to expire one year from the date of execution.]

_____ _____

Patient Signature Date

You are entitled to a copy of this authorization after you sign it. Any revocation or change to this authorization or any questions regarding it legal effect, should be addressed to: Hac Nguyen, MD family practices.

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ACKNOWLEDEMENT OF REVIEW OF HIPPA PRIVACY PRACTICES

I have reviewed this office'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.

Signature of patient or personal representative _____ Date _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. (Please, review carefully).

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and proving treatment. For example, results of laboratory test procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payments: Your health information may be used to seek payments from your health plan, from other sources of coverage such as an automobile insurance; or from credit card companies that you may use to pay for services. For example; your health's plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day to day activities and management of Dr. Nguyen Family Practices PLLC. For example; information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission to support government audits and inspections to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example; we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require

Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specified written authorization. If you change after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of you decision.

Information about Treatment: Your health information may be used to send information on the treatment and management of you medical condition that you may find to be of interest.

You have certain rights under the federal privacy standards, Individual Rights.

These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and request a copy of your health information.

As permitted by federal regulation, we required that request to inspect or request a copy of protected health information is submitted in writing. You may obtain a form to request access to your records by contacting our clinic. Your request will be reviewed and will be generally being approved unless there are legal or medical reasons to deny the request.

- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Hac Nguyen, M.D Family Practice PLLC. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practice. These changes in our policies and practices may be required by changes in the federal and state regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to protected health information that we maintain.

Complains / Contact Person

If you would like to submit a comment or complaint about our privacy policies, you can do so by sending a letter outlining your concerns to:

Dr. Hac Nguyen Family Practice

16736 Champion Forest DR

Spring, TX 77379

If you believe your privacy rights have been violated, you should bring the matter to attention by sending a letter describing the cause of your concerns to the same address. You will not be penalized or otherwise retaliated against for filling a complaint.

To file a complaints involving covered entities located in Texas send to the address below:

U.S. Department of Health & Human Services

HIPPA Complain:

7500 Security Blvd C5-24-04

Baltimore, MD 21244