WHITNEY TELEMEDICINE

Virtual Health Care

Fill out this form ENTIRELY

Patient Information

Patient Last Name:_____ First Name:_____ MI_____

Mailing Address:_____ City_____ State_____ Zip_____

Physical Address (If different than Mailing)_____

Date of Birth_____ Home Phone #_____ Cell Phone #_____

Patient SS#_____ Gender: Male Female Marital Status: Married Single Divorced Widowed

Email Address:_____

Guarantor/Parent/Responsible Party Information
Anyone under 18 is a minor and MUST be accompanied by a parent/guardian.

Responsible Parties Name:_____ DOB_____

Mailing Address:_____ City_____ State_____ Zip_____

Physical Address (If different than Mailing)_____

Phone #_____ SS#_____ Gender: Male Female

Relation to Patient_____ Email Address:_____

Emergency Contact

Name:_____ Phone_____ Relation to Patient_____

Address:_____ City_____ State_____ Zip_____

Financial Agreements

I understand that if I fail to pay amounts owed to Whitney Telemedicine, the office has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

I understand that I can be charged a full fee for any appointment not canceled or for an appointment canceled with less than 24 hours notice.

There will be a $35.00 charge on ALL returned checks.

_____ _____ _____

Signature of Patient/Legal Guardian/Responsible Party Date Relationship to Patient

210 N Bosque
Whitney, Tx 76692
P: 254-707-0095
F: 254-266-0958
Whitneytelemedicine.com

WHITNEY TELEMEDICINE

Virtual Health Care

Patient Name:_____ **DOB**_____

AUTHORIZATION FOR EXAMINATION & TREATMENT: The undersigned has been informed of the examination and/or treatment considered necessary for the patient named on this record and that the treatment and procedures will be performed by Physicians and/or Physician Assistants/Nurse Practitioners of Whitney Telemedicine.

Authorization is hereby granted for such treatment and procedures and the administration of such local anesthetics, medications, or other treatment deemed necessary. I certify that I have read the above authorization and understand the same and also certify that no guarantee or assurance has been made as to the results that may be obtained.

ACKNOWLEDGEMENT OF MID-LEVEL PRACTITIONER: I hereby acknowledge that this clinic staffs a Mid-Level Practitioner (Physician's Assistant or Nurse Practitioner) to administer such treatment as is medically necessary. It is my right to choose to not be seen by the Mid-Level Practitioner.

ACKNOWLEDGEMENT OF OUTPATIENT TREATMENT: I hereby acknowledge that the medical care which may be furnished to me in the outpatient room of the Whitney Telemedicine Clinic will be limited solely to outpatient treatment. I understand that I may be released before all my medical problems are known or treated and that it will be necessary for me to make arrangements for follow-up care.

INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier to make payment directly to Whitney Telemedicine for medical expense benefits otherwise payable to me. I understand that I am financially responsible to Whitney Telemedicine for charges made by them for services rendered.

CONSENT TO PERMIT TESTING AFTER A BLOOD OR BODY FLUID EXCHANGE: In the course of clinic care and treatment, healthcare workers may be accidentally exposed to a patient's blood or body fluids (through needle sticks, blood splatter, etc). Communicable disease, including HIV virus that causes AIDS, are known to be transmitted through accidental exposures of this type. When a healthcare worker is exposed to a patient's blood or body fluids, the patient must be tested for the HIV antibody and other communicable diseases in order to determine whether an actual exposure has occurred. This information is necessary so that the healthcare worker can receive appropriate counseling and medical treatment. I understand and agree that in the event a health care worker is exposed to my blood or body fluids, my blood will be tested at no cost to me, using a special coded system, for the HIV antibody. The results of these tests may improve the course of medical treatment and will not prejudice my patient relationship with Whitney Telemedicine.

NOTICE OF POSSIBLE NON-COVERAGE: I understand that, in the opinion of Whitney Telemedicine, the services or items that have requested to be provided to me may not be covered by any insurance of the Texas Medical Assistance Program as being reasonable and necessary for my care. I understand that the Texas Department of Human Services or its health insurance agent determine the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment for the service items I requested and received if these services or items are determined not to be medically necessary for my care.

_____ _____ _____

Signature of Patient/Legal Guardian/Responsible Party Date Relationship to Patient

_____ _____ _____

Printed Name of Legal Guardian/Responsible Party Whitney Telemedicine Employee Signature Date

210 N Bosque
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P: 254-707-0095
F: 254-266-0958
Whitneytelemedicine.com

WHITNEY TELEMEDICINE

Virtual Health Care

BY SIGNING THIS FORM , YOU ARE STATING THAT YOU HAVE RECEIVED **OR** WERE NOTIFIED OF OUR **NOTICE OF PRIVACY ACTS** AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (**HIPAA**)

Patient Name:_____ **DOB**_____

_____ _____ _____

Signature of Patient/Legal Guardian/Responsible Party Date Relationship to Patient

_____ _____ _____

Printed Name of Legal Guardian/Responsible Party Whitney Telemedicine Employee Signature Date

MID LEVEL PRACTITIONER CONSENT

Whitney Telemedicine has on staff a Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) to deliver primary health care in the clinic setting,

A Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) is not a doctor. A Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) is a licensed healthcare professional who has received advanced education and training in the provision of primary health care. A Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) can diagnose, treat and monitor common acute and chronic diseases, provide health maintenance care as well as provide emergency care.

I have read the above and hereby consent to the services of a Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) for my health care needs.

Patient Name:_____ DOB_____

_____ _____ _____

Signature of Patient/Legal Guardian/Responsible Party Date Relationship to Patient

_____ _____ _____

Printed Name of Legal Guardian/Responsible Party Whitney Telemedicine Employee Signature Date

****I have the right to refuse to see the Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) and I am doing so by writing legibly REFUSED next to my signature.**

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WHITNEY TELEMEDICINE

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Patient Name:_____ **DOB**_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Whitney Telemedicine** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Whitney Telemedicine** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Whitney Telemedicine** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Whitney Telemedicine, 210 N Bosque Whitney, TX 76692.**

With this consent, **Whitney Telemedicine** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Whitney Telemedicine** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Whitney Telemedicine** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Whitney Telemedicine** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow* Whitney Telemedicine *to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Whitney Telemedicine** may decline to provide treatment to me.
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. My written revocation must be submitted to the privacy officer at:
Whitney Telemedicine 210 N Bosque Whitney, TX 76692

***Optional*: In addition, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s)/family member/friend:**

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

_____ _____ _____
Signature of Patient/Legal Guardian/Responsible Party Date Relationship to Patient

_____ _____ _____
Printed Name of Legal Guardian/Responsible Party Whitney Family Medicine Employee Signature Date

210 N Bosque
Whitney, Tx 76692
P: 254-707-0095
F: 254-266-0958
Whitneytelemedicine.com

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Virtual Health Care

Patient Name:_____ DOB:_____

ALLERGIES: None Antibiotics Foods Inhalants Insects Latex Meds Pollens Skin Transfusions X-Ray Contrast
Specify Allergies:_____
_____
_____

HABITS: Do you use (or have you used) any of the following:
Tobacco: Never Now Quit(year)_____ Type used: Cigarettes Pipe Smokeless Amount used per day: _____ How many years_____
Alcohol: Never Social/Rare Now Quit(year)_____ Type Used: Beer Wine Liquor
Amount Used per week: 12 oz beers_____ 6 oz wine_____ 2 oz shots_____ How many years_____
Drugs: Never Now Quit(year)_____ Type used: Pot Cocaine IV Pain pills Other (please specify)_____
Caffeine: (amount per day) Coffee(cups)_____ Tea(glasses) _____ Soda(12oz cans)_____
Exercise: None per week 1-2 times per week 3-5 times per week everyday
Type of exercise:_____

FAMILY HISTORY

BLOOD RELATIVES	AGE, IF LIVING	AGE AT DEATH	MAJOR ILLNESS
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Brothers #			
Sisters #			
Children #			

CURRENT MEDICATIONS: List ALL medications that you take routinely of that have been prescribed for you by a doctor (including vitamins, over-the-counter medications, eye drops, herbal medications, etc.)

MEDICATION	DOSE/STRENGTH	MEDICATION DIRECTIONS

SPECIALISTS

SPECIALIST NAME	PHONE NUMBER	CONDITION TREATING

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