DALLAS SARCOMA ASSOCIATES

PATIENT REGISTRATION FORM/HIPAA CONSENT

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)____________________(First)____________________(MI) __________

Date of Birth____________________ Preferred Name (if different from above): ____________________

Address: ____

City, State, Zip: ____________________Cell #:____________________ Home or Other #:____________________

Primary Physician First and Last Name ____________________ Primary Physician Phone #:____________________

Patient E-Mail Address:____________________How did you hear about us? ____________________

Gender: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Gender category not listed ____________________

☐ Choose not to disclose

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Choose not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Korean ☐ French Arabic ☐ Other not listed ____________________

Patient Social Security Number:______-______-________

Pharmacy Name: ____________________Phone number: ____________________

Address: ____

RESPONSIBLE PARTY INFORMATION- COMPLETE BELOW IF NOT SELF (Information used for patient balance statements)

Responsible Party: ☐ Parent ☐ Guardian ☐ Other ______________ ☐ Check here if address and telephone information is same as patient

Responsible Party Name: (Last)____________________(First)____________________(MI) ________

Date of Birth: ________________ Phone Number: ____________________ Gender: ☐ Female ☐ Male

Address:____ City, State, Zip: ____________________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)____________________ (First) ____________________

Phone number:____________________Emergency contact relationship to patient:____________________

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:____________________**Date:** ____________________

Printed name of patient or personal representative:____________________**Relationship to patient:** ____________________

Notice of Privacy Practice/Clinics

__________ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

_______ **(Patient/Representative initials)** Some messages relevant to your visit may be sent regardless of explicit consent, including instructions or communications directly related to your care. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. For other types of communications, I consent to receiving, by telephone call, text message, or voicemail transmission, communications by or on behalf of the practice/clinic at the email, telephone number or text address I have provided in my patient record. I also consent to receiving such communications to any email, text address or telephone number forwarded or transferred from that address or telephone number. Other healthcare communications may include, but are not limited to, healthcare communications to family or designated representatives regarding my treatment or condition, reminder messages to me regarding appointments for medical care, communications regarding insurance or billing or requests for feedback about my visit via satisfaction surveys and/or public-facing reviews. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system for the selection or dialing of telephone numbers or the playing of prerecorded messages and may be made by the practice/clinic or someone calling on their behalf even if my phone number is listed on any federal or state "do not call" registry. To the extent these instructions and other communications could be deemed telephonic sales calls, solicitations or advertisements, I consent to receiving them. I understand that I am not required to consent directly or indirectly to communications in order to receive healthcare services.

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship. My consent to access the location's Electronic Health Record's Patient Portal shall be considered separate and apart from the consent in this form *(section: Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications).*

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Financial Agreement

I acknowledge, that as a courtesy, Dallas Sarcoma Associates (practice), may bill my insurance company for services provided to me. I agree to pay for services not covered or covered charges not paid in full including but not limited to, any copayment, co-insurance and/or deductible, or charges not covered by insurance. **Third Party Collection.** I acknowledge the practice may use the services of a third-party business associate or affiliated entity a Central Billing Office (CBO) for medical account billing and servicing. **Assignment of Benefits**. I hereby assign to the practice any insurance or third party benefits available for healthcare services provided to me. I understand the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Dallas Sarcoma Associates by the Medicare or Medicaid program.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Signature of patient or personal representative:______________________________ Date: ______________________________

Printed name of patient or personal representative:______________________________ Relationship to patient: ______________________

DSA DALLAS SARCOMA ASSOCIATES

NEW PATIENT ASSESSMENT

Please CIRCLE your answers and explain as needed

Name: ______________________ DOB: ______________________ Height:_____ Weight: ______

Referring Provider: ______________________ Primary Care Provider: ______________________

Chief Complaint: Why have you come to see us today?

Pain **Mass/Tumor** **Infection** **Wound** **Doctor's Order** **Other**: ______________________

In which body part? ______________________ **Left** **Right**

When did you notice the problem? ______________________

How did you first notice it? (Injury, illness, etc) ______________________

Do you have other symptoms? **Drainage** **Redness** **Swelling** **Stiffness** **Weakness** **Fever** **Numbness**

How does it feel? **Aching** **Throbbing** **Sharp** **Dull** **Stabbing** **Burning** **Tingling** ____________

Rate your pain (1-10), with 10 being a trip to the ER: ______________________

Are your symptoms getting: **Better** **Worse** **Same**

When does it hurt? **Day** **Night** **Standing** **Walking** **Stairs** **In/Out of Chairs** **Constant** **Occasional**

Other: ______________________

Medications: (Please include all over the counter and herbal medications.)

Medication	Dose	When Medication Began

❖ If medications exceed above area, please provide an attachment of all medications.

Allergies:

Surgery/Hospitalizations:	Date

Past Medical History: Please circle conditions you have/had:

Anemia
Anxiety
Arthritis
Bleeding Disorder
Blood Clots
Cancer
Diabetes
Endocarditis
Fibromyalgia
GERD (Acid Reflux)
Gout

Heart Attack
Heart Problem
Hepatitis
Hernia
High Blood Pressure
Kidney Disease
Leg or Foot Ulcer
Liver Disease
Lung Disease
Osteoporosis
Pacemaker

Poor Circulation
Pulmonary Embolism
Rheumatoid Arthritis
Seizures/Epilepsy
Stroke
Thyroid Problems
Tuberculosis
Ulcers
Urinary Tract Infections
Other: ____________________
____

Childhood Diseases: **Measles** **Mumps** **Scarlet Fever** **Other**: ______________________________

If you are diabetic please list your last A1C, date drawn and managing provider. __________________________

Have you ever been diagnosed with Hepatitis C, and if so, when? ____

(If yes, then you should not drink alcohol as it is associated with varying degrees of risk to your health.)

Females: Are you now, or do you think you could be pregnant? **Yes** **No**

Family Medical History: What illnesses have there been in your family?

	Major Illnesses, or had the same problem as you do now	Living: Y N	Age of Death
Father			
Mother			
Sibling (M F)			
Sibling (M F)			
Child (M F)			
Child (M F)			
Grandparent (M F)			
Grandparent (M F)			

Siblings: Brothers: _________ Sisters: _________ Healthy? _________

Children: Sons: ___________ Daughters: ______ Healthy? _________

Immunizations:

Have you had the flu shot this flu season? **No** **Yes** If yes, when: _________________________
Have you had the pneumococcal vaccine? **No** **Yes** If yes, when: _________________________

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Social History:

Alcohol: How often do you drink? **Daily** **Weekly** **Occasionally** **Never**

Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. This may include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week (or >3 drinks per occasion) for women and seniors and >14 standard drinks per week (or >4 drinks per occasion for men >65 years old.

Tobacco: Do you currently smoke? **No** **Yes** How many packs per day? ______ How many years? ______

Have you quit? **No** **Yes** If yes, when? ______________________________

The U.S. Surgeon General has said, "Smoking cessation (stopping smoking) represents the single most important step that smokers can take to enhance the length and quality of their lives."

Exercise: **Often** **Sometimes** **Never**

Are you: **Single** **Married** **Widowed** **Divorced** **Other**: ____________________

Where do you live now? **Home Alone** **with Family** **Nursing Home** **Assisted Living** **Rehab/TAC**

Drugs: Have you, or do you currently, use illegal drugs? **No** **Yes** **Quit (when)**: ____________________

Diet: **Diabetic** **Low Salt** **Low Carb** **Other**: ______________________________

Occupation: ______________________________ **Working** **Retired** **Temp. Disability** **Perm. Disability**

Review of systems: What else is troubling you TODAY? (Circle all that apply)

GENERAL:	**Fever** **Chills** **Weight Loss/Gain** **Feel Sick** **Night Sweats**
SKIN:	**Multiple Birthmarks** **Rashes** **Wounds** **Itching**
HEAD:	**Cavities** **Visual Changes** **Ulcers**
CHEST:	**Shortness of Breath** **Wheezing** **Cough** **Chest Pain** **Palpitations**
DIGESTION:	**Nausea** **Vomiting** **Constipation** **Diarrhea**
URINE:	**Frequent Infections** **Bloody** **Frequent Urination** **Urgency**
REPRODUCTION:	**Discharge** **VD/STD** **Irregular Periods**
BODY:	**Swollen Joints** **Cramps** **Soreness** **Fractures**
NERVES:	**Weakness** **Fainting** **Numbness** **Tingling** **Shooting Pains**
MIND:	**Depression** **Anxiety** **Mood Swings**
BLOOD:	**Bruising** **Past Transfusions Performed** **Currently Taking Blood Thinners**
GLANDS:	**Excessive Thirst/Hunger** **Excessive Sweat** **Swollen Glands** **Hyperactive**

"I attest that the above information is true and correct to the best of my knowledge."

Patient name: ______________________________ Date of Birth: ____________________

Patient signature: ______________________________ Date: ____________________

Provider signature: ______________________________ Date: ____________________

Name________________________ DOB________________________

Over the past 2 weeks, how often have you been bothered by any of the following problems:

Little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day
- ☐ Declined to specify

Feeling down, depressed, or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day
- ☐ Declined to specify

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

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Name: ____________________________________ DOB: ____________________________

Please Note: This screening is required by federal mandate to be completed annually.

Date: ________________________

Increased Fall Risk Factors (check all that apply)

____ 3 or more predisposing conditions or Diagnosis on Problem List

____ History of falls within 3 months

____ Incontinence (uncontrolled bladder)

____ Visual Impairment (difficulty with vision)

____ Difficulty ambulating (walks with cane or walker)

____ Environmental hazard (stairs/loose rug in home, etc.)

____ Polypharmacy (takes 3 or more medications that adversely affects muscle function, coordination)

____ Pain affecting level of function, pain impacts activities of daily living

____ Cognitive impairment

____ No fall risk factors

History of falls in the past year: **No** **Yes** If yes, how many: _________

Were you injured during the fall: **No** **Yes**