New Wave Physicians Group, PLLC
21301 Kuykendahl Rd Ste J, Spring, TX 77379

PH: 713-429-0881/ FAX: 832-698-9568
Dr. Amie Sun-Wright Dr. Tam Truong Dr. Timothy Carder Anna Nguyen, PA

PATIENT REGISTRATION FORM

Today's Date_____ Doctor_____

Name_____ SSN_____ Date of Birth_____
first middle last (mm/dd/yyyy)

Mailing Address_____ City_____ State_____ Zip_____

Home Phone_____ Cellular Phone_____ Work Phone_____

Email_____

Employer_____ Occupation_____

Race: ☐ *Caucasian* ☐ *African American* ☐ *Asian* Ethnicity_____

☐ *American Indian or Alaska Native* ☐ *Pacific Islander or Native Hawaiian*

Language_____

Gender: ☐ *Male* ☐ *Female* ☐ *Non-Binary* ☐ *Other* Marital Status: ☐ *Single* ☐ *Partnered* ☐ *Married* ☐ *Divorced* ☐ *Widowed*

Spouse Name_____ Spouse Date of Birth_____
(if applicable) first middle last (mm/dd/yyyy)

Emergency Contact_____ Emergency Contact Phone_____
first middle last

How did you hear of NWPG: ☐ *internet search* ☐ *social media* ☐ *print/Ad.* ☐ *referred by*_____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION

Name_____ SSN_____ Date of Birth_____

Relationship to patient_____ Contact Phone_____

Mailing Address_____

Employer_____ Work Phone_____

NOTICE TO PATIENTS REFERRED TO IMAGING SERVICES

By my signature below, I understand that Federal and Texas law requires physicians to disclose financial or ownership interests in referring entities. As there are suppliers available to offer similar services to any referring entity, you are free to use other suppliers of these services, if you prefer.

CONSENT FOR COMMUNICATION VIA EMAIL/TEXT/PHONE

New Wave Physicians Group is dedicated to keeping your medical records information confidential. I understand that this office is not responsible for information loss or delay or for breaches in confidentiality that are caused by technical factors beyond this office's control. By my signature below, I agree that New Wave Physicians Group may send medical related correspondence to me via email, text or phone and they may respond back to me using the phone and email address listed in my patient registration form

APPOINTMENT CANCELLATIONS/NO SHOWS

By my signature below, I acknowledge that I may be charged a **fee of $50** (not covered by insurance) for missing my appointment, arriving more than 20 minutes late, or cancelling my appointment without 24 hours' notice unless written proof of extenuating services is provided

ASSIGMENT OF INSURANCE BENEFITS AND AUTHORIZATION FOR RELEASE OF INFOMATION

By my signature below, I requested that payment of authorized Medicare or other insurance benefits be made on my behalf to New Wave Physicians Group for any service furnished to me by one of the providers associated with the practice. I authorize any holder of medical information about me to release to the health care financing administration (HCFA), its agents and/or my Medigap or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing

_____ _____

Signature Witness (if applicable)

_____

Date

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HIPPA 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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians' practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For Example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, Employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conducting or arranging other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization.

These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

PATIENT COPY

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Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate, and respectful health care, regardless of race, creed, age, sex, or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment, and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency.
- Be free from mental, physical, and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plans.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment, or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g., allergies, past and present illnesses, medications, and hospitalizations.
- Providing staff with correct and complete name, address, telephone, and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e., herbal, or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ Address:_____

Date of Birth:_____ Phone Number:_____

I authorize _____ to release medical information to **New Wave Physicians Group**
{Facility}

Fax:_____ Phone:_____

☐ Progress Notes	☐ Colonoscopy Reports	☐ Cardiology (EKG/ECHO/Stress)
☐ Lab Reports	☐ Imaging Reports	☐ Hospital/Surgical Records
☐ Immunization/Vaccine	☐ Care Plans	☐ Therapy (PT/Rehab/Home)
☐ Consult Records	☐ Eye Exam/Retina Scan	☐ DEXA Reports

"I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information."

This authorization covers patient care rendered from _____ to _____
{mm/dd/yyyy} {mm/dd/yyyy}

Purpose of Disclosure:

☐ Medical Care ☐ Insurance ☐ Attorney ☐ Other (specify)_____

This authorization shall be valid for thirty (30) days from the date of signature below unless revoked in writing by the patient prior to that expiration.

☐ Yes
☐ No The patient or authorized representative agrees that a photocopy or facsimile of this authorization is considered valid.

Patient Signature_____ Date_____

Patient or Authorized Representative_____ Date_____

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Acknowledgment of Review of Notice of Privacy Practices

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physicians' practice has taken action in reliance on the use or disclosure indicated in the authorization.

The following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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.

_____ _____

Patient Printed Name Date of Birth

_____ _____

Patient's/Guardian Signature Date

_____

Relationship

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Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to New Wave Physicians Group unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with aids, in the following situations:

1. To screen blood, blood products, organs, or tissues to determine suitability for donation or
2. If another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to New Wave Physicians Group infectious disease protocol) or
3. If a medical or surgical procedure is to be performed which could exposure health care workers to the patient's blood or body fluids.

This disclosure is to inform you that you may be tested, at the expense of New Wave Physicians Group. If any of these situations occur during your treatment period.

_____ _____

Patient printed name Date of Birth

_____ _____

Patient's/Guardian Signature Relationship

_____

Date

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CONTROLLED SUBSTANCES

Please be advised that effective January 1, 2022, only limited quantities of pain medications for acute pain will be prescribed. All patients being prescribed said medications will be asked to sign a pain management agreement. Failure to agree and comply with said terms on agreement will result in denial of such medications. Patients that require additionally and/or long-term management of their pain symptoms will possibly be referred to pain management for additional evaluation and treatment.

_____ _____
Patient printed name Date of Birth

_____ _____
Patient/Guardian Signature Relationship

_____
Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rules give individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I consent for my PHI to be given through the following: (**Check All That Apply**)

Home Telephone

☐ Leave a message with detailed information.

☐ Only leave a message with call back details.

Cell Phone

☐ Leave a message with detailed information.

☐ Only leave a message with call back details.

Work Telephone

☐ Leave a message with detailed information.

☐ Only leave a message with call back details.

Written Correspondence

☐ Mail to my home address on file.

☐ Email to address on file.

By my signature below, I give my authorization to discuss my protected health information (PHI), including results of laboratory tests, radiology, imaging results, and/or other test results to the following designated representatives with the doctor and staff at New Wave Physicians Group if needed.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ DO NOT SHARE MY PROTECTED HEALTH INFORMATION WITH ANYONE OTHER THAN MYSELF

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

This authorization shall be valid for one (1) year from the date of the signature, unless revoked in writing by the patient prior to the expiration. As a patient, you have a right to revoke this authorization at any time, except to the extent that has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, New Wave Physicians Group must receive the revocation in writing. The revocation must include 1) The patients name, address and date of birth. 2) Patients desire to revoke the authorization. 3) The date of revocation. 4) The patients signature. All revocation must be sent in writing to the attention of: New Wave Physicians Group office at: 21301 Kuykendahl Rd. Ste. J, Spring, TX, 77379.

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No Show Policy

Each time a patient misses an appointment without proper notice, another patient is prevented from receiving care.

We reserve the right to charge for these recurrences.

Due to high patient demand and limited availability of appointments, we have a No-Show Fee that requires cancellation with at least 24 hours' notice. We do not double book appointments; your appointment time is reserved exclusively for you.

Any appointment that is a No Show will be subject to a $50.00 No Show Fee. This fee will be billed directly to you, not your insurance company.

By signing below, I acknowledge that I have read and understand this policy.

_____

Patient Name (Printed) Date

_____

Patient Signature Date

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HEALTH HISTORY FORM

NAME: _____

ALLERGIES

ALLERGY	REACTION

PAST SURGICAL AND HOSPITALIZATION HISTORY

DATE	EVENT DESCRIPTION	REASON FOR EVENT

PAST MEDICAL HISTORY

	YOU		FAMILY		RELATIONSHIP
	Y	N	Y	N	
Alcoholism					
Allergies					
Anemia					
Angina (chest pain)					
Anxiety					
Arthritis					
Asthma					
Atrial fibrillation					
Auto immune disorder					
Bipolar disorder					
Blood clots					
BPH (enlarged prostate)					
CAD (heart disease)					
Cancer- type					
Charcot-Marie-Tooth disease					
Chronic ulcer					
Color blindness					
COPD					
Crohn's					
CVA (stroke)					
Cystic Fibrosis					
Depression					
Diabetes- type					
Gallbladder disease					
GERD (reflux)					
GI Disorder					

PAST MEDICAL HISTORY

	YOU		FAMILY		RELATIONSHIP
	Y	N	Y	N	
Glaucoma					
Gout					
Hemophilia					
Hemorrhoids					
Hepatitis					
High Blood Pressure					
High Cholesterol					
Human Papilloma virus (HPV)					
IBS (irritable bowel disease)					
Kidney disease					
Liver disease					
Lupus					
Lymphedema					
Meningitis					
MI (heart attack)					
Migraine headaches					
Mitral Valve Prolapse					
Multiple Sclerosis					
Osteoarthritis					
Parkinson's Disease					
Peptic ulcer disease					
Polio					
Polycystic Kidney					
PCOS (polycystic ovary)					
Seizure disorder					
Shingles					

HEALTH HISTORY FORM

NAME: _____

MEDICATION LIST

NAME	STRENGTH	INSTRUCTIONS

SOCIAL HISTORY

Do you smoke?	☐ Y ☐ N	Packs per day _____	Interest in quitting?	☐ Y ☐ N
Did you stop smoking?	☐ Y ☐ N	When did you quit? _____		
Do you consume alcohol?	☐ Y ☐ N	Type: beer ☐ wine ☐ liquor ☐	How much per week?_____	
Do you consume caffeine?	☐ Y ☐ N		How much per week?_____	
Recreational Drugs	☐ Y ☐ N			

IMMUNIZATIONS (INDICATE YEAR OF LAST VACCINE)

TETANUS _____ Recommended every 10 years
PNEUMONIA _____ Recommended every 5 years for age 50 and older but no more than 2 per lifetime

HEPATITIS A _____ HEPATITIS B _____

INFLUENZA _____ MENINGOCOCCAL _____ SHINGLES _____

PREVENTATIVE SCREENINGS (INDICATE YEAR OF LAST EXAM)

Colonoscopy _____	Mammography _____	Carotid Doppler. _____
Cologuard _____	Pap smear. _____	Bone Density (DEXA _____
Eye Exam _____	Stress Test. _____	TB test _____
EKG _____	Rectal Exam (DRE _____	PSA _____

_____ _____

Patient/Guardian Signature Date