VANGUARD
INPATIENT PHYSICIANS
Leading Continuum of Care

4645 Sweetwater Blvd, Suite 200, Sugar Land, TX 77479 |4650 FM-1960 Rd West, Suite 101, Houston, TX 77069

Phone: 281-565-1112 Fax: 281-565-1102

Patient Information

FULL NAME: _____ ☐ FEMALE ☐ MALE
FIRST NAME MI LAST NAME

DATE OF BIRTH _____

SOCIAL SECURITY # _____ ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

HOME PHONE # _____ CELL PHONE # _____

WORK PHONE # _____ **PRIMARY PHONE**: ☐ HOME ☐ CELL ☐ WORK

EMAIL ADDRESS _____

HOME ADDRESS _____ APT # _____

CITY_____ STATE_____ ZIP CODE_____

BILLING ADDRESS _____ APT # _____

CITY_____ STATE_____ ZIP CODE_____

EMERGENCY CONTACT INFORMATION:

NAME_____

RELATIONSHIP _____

HOME PHONE # _____ CELL PHONE # _____

WORK PHONE # _____ **PRIMARY PHONE**: ☐ HOME ☐ CELL ☐ WORK

EMAIL ADDRESS _____

MEDICARE ID # _____

PLEASE COMPLETE SECONDARY INSURANCE INFORMATION OR IF MEDICARE IS NOT PRIMARY:

NAME OF INSURANCE _____ ☐ PPO ☐ HMO

POLICY # _____

GROUP # _____

CUSTOMER SERVICE PHONE # _____

ADDRESS FOR INSURANCE _____ CITY_____ STATE_____ ZIP _____

NAME OF INSURANCE POLICYHOLDER _____ RELATIONSHIP _____

☐ I do not have any secondary insurance. I will pay any copays or deductibles Medicare does not cover.

MEDICARE AND INSURANCE ASSIGNMENT AND RELEASE

I request that payment of authorized Medicare benefits be made on my behalf to: Vanguard Inpatient Physician Associates for any services furnished to me by a physician or nurse practitioner. I authorize any holder of medical information about me to release to the Heath Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services.

I understand my signature request payment be made and authorizes release of medical information necessary to pay the claim. If any secondary insurance is indicated, my signature authorizes releasing of the information to the insurer or agency shown.

_____ _____

Signature of Patient/Guardian or Power of Attorney Date

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DO YOU HAVE A MEDICAL POWER OF ATTORNEY? ☐ YES ☐ NO
FULL NAME OF POA/MPOA _____ PHONE # _____
REALTIONSHIP TO PATIENT _____
If yes, please provide the office with a copy of the POA/MPOA paperwork.

DO YOU HAVE AN OUT-OF-HOSPITAL DO NOT RESUSCITATE (DNR) OR ADVANCED DIRECTIVE? ☐ YES ☐ NO
If yes, please provide the office with a copy of the DNR/DNI/ADVANCED DIRECTIVE paperwork.

LIST YEAR OF YOUR MOST RECENT IMMUNIZATION:
PNEUMONIA _____
FLU _____
TETANUS _____
SHINGLES _____
COVID-19 _____

LIST THE MOST RECENT YEAR THESE TEST WERE DONE:
MAMMOGRAM _____
COLONOSCOPY_____
PAP SMEAR _____
BONE DENSITY SCAN _____

Pharmacy

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Number: _____

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CURRENT MEDICATIONS LIST

(PLEASE INCLUE ANY OVER-THE-COUNTER MEDICATIONS, VITAMINS, ETC.)

NAME OF MEDICATION	DOSAGE	DIRECTIONS
(EXAMPLE: LASIX)	(EXAMPLE: 20MG)	(EXAMPLE: one in morning and one before bed)

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Patient History

REASON FOR INITIAL VISIT:

_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING MEDICAL DIAGNOSIS OR CONDITIONS:

CANCER..... ☐ ..... WHERE? _____ ..... YEAR? _____

DENTURES..... ☐ UPPER ☐ LOWER

HEARING AID..... ☐ LEFT ☐ RIGHT

ASTHMA..... ☐

SHORTNESS OF BREATH.... ☐

CONSTIPATION..... ☐

DIARRHEA..... ☐

ACID REFLUX..... ☐

URINARY INCONTINENCE... ☐

KIDNEY FAILURE..... ☐

ARTHRITIS..... ☐ .....WHERE?_____

NUMBNESS..... ☐ .....WHERE?_____

SWELLING..... ☐ .....WHERE?_____

DEPRESSION..... ☐

MEMORY LOSS..... ☐

SEIZURES..... ☐

STROKE..... ☐

GLAUCOMA..... ☐

MACULAR DEGENERATION ☐

HEART ATTACK..... ☐

HEART FAILURE..... ☐

HIGH BLOOD PRESSURE..... ☐

HIGH CHOLESTEROL..... ☐

DIABETES..... ☐

If diabetic, how many times per day do you check your blood sugar?_____

PLEASE LIST ANY OTHER DIAGNOSIS OR CONDITIONS:

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES PLEASE LIST:

PLEASE PROVIDE LIST OF SURGERIES WITH DATE IF ANY:

DATE_____ SURGERY_____

DATE_____ SURGERY_____

DATE_____ SURGERY_____

DATE_____ SURGERY_____

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FAMILY HISTORY

PLEASE INDICATE YES WITH A CHECK MARK IF ANY OF THE FOLLOWING FAMILY MEMBERS HAVE HAD:

	FATHER	MOTHER	BROTHER(S)	SISTER(S)
DEMENTIA				
DIABETES				
STROKE				
HEART DISEASE				
CANCER, IF SO WHERE?				
AGE DECEASED				

SOCIAL HISTORY

PAST OCCUPATION: _____ NUMBER OF CHILDREN_____

CIGARETTE SMOKING: ☐ NEVER
☐ I CURRENTLY SMOKE
☐ I SMOKED IN THE PAST, BUT QUIT IN: WHAT YEAR?_____
HOW MANY YEARS HAVE/HAD YOU SMOKED?_____
HOW MANY PACKS PER DAY DO/DID YOU SMOKE? _____

ALCOHOL USE: ☐ NEVER
☐ SOCIAL ONLY
☐ I CURRENLY USE ALCOHOL
HOW MANY YEARS HAVE/HAD YOU DRANK? _____
HOW MANY DRINKS PER DAY DO/DID YOU DRINK? _____

FUNCTIONAL STATUS

PLEASE CHECK YOUR CURRENT MOBILITY STATUS:
BED BOUND.....☐
USES WHEELCHAIR.....☐
USES WALKER.....☐
USES CANE.....☐

PLEASE CHECK IF YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES:
TRANSPORATION? ☐ SHOPPING? ☐
TAKING MEDICATIONS? ☐ EATING? ☐
BATHING? ☐ DRESSING? ☐
TOILETING? ☐ COOKING? ☐

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NOTICE AND AUTHORIZATION OF PRIVACY PRACTICES

Healthcare providers are required by federal and state laws to maintain the privacy of "Protected Health Information" (PHI) and to provide you with notice about your rights and our legal duties and privacy practices with respect to your PHI. We must abide by the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain causes by applicable state laws that may be more stringent than the federal standards. This Notice is effective as of April 14, 2003. PHI is information about you, including demographic information that can be reasonably used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of related health care services to you or the payment for that care. This Notice tells you about the ways in which we may collect, use and disclose your PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. Your rights concerning your PHI are also discussed in this Notice. Once you sign Vanguard Inpatient Physician Associates consent/authorization form, we may use and disclose your medical information to treat you, to obtain payment, and to operate the practice. The practice may use or disclose your protected health information only with your written authorization. You may revoke authorization in writing at any time, except to the extent of PHI already disclosed. The practice may use or disclose protected health information about you for other purposes and without your consent if the law requires us to disclose information to government authorities.

You have the following rights regarding your protected health information, and the practice must act on your request within 60 days:

- You may request restrictions on certain uses and disclosures of protected health information, but we are not required to agree to a requested restriction.
- You may request that you receive confidential communication of protected health information.
- You may request to inspect and copy your own projected health information.
- You may request that your information be amended.
- You may request a paper copy of this notice.

The law requires the practice to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices. The law requires the practice to abide by the terms of this notice and to provide individuals with notice revisions. You may complain to the practice or to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. A complaint can be filed with this practice by writing to: Vanguard Inpatient Physicians 16605 Southwest Freeway, Suite 175, Sugar Land Tx, 77479.

I have read the Notice of Privacy Practices from Vanguard Inpatient Physicians. I understand that my Protected Health Information may be used by Vanguard Inpatient Physicians for the purposes of: Payment, Operations, and Treatment. I also understand that this information may be released to "Business Associates" for the same purposes. I also understand that I have the right to refuse to sign this authorization form. I understand that if I refuse to authorize the release of my health information, Vanguard Inpatient Physicians my not refuse to treat me.

I understand that in order to provide the most effective medical diagnosis and treatment, it may be necessary for my attending physician to discuss my medical condition with certain family members or caregivers. My signature below gives my permission for my physician to discuss my medical condition with the following family members or caregivers if such communication is deemed necessary.

Name :_____

Home #: _____

Work #:_____

Cell #:_____

Relationship to Patient: _____

Name:_____

Home #:_____

Work #:_____

Cell #: _____

Relationship to Patient:_____

_____ _____

Signature of Patient/Guardian or Power of Attorney

Date

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General Patient Consent

Consent to Treat

I hereby voluntarily consent to all healthcare services ordered/provided by Vanguard Inpatient Physicians providers at the Vanguard Inpatient Physicians service locations.

The health care service may include, without limitation, routine physical and mental assessment, diagnostic and monitoring tests, and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and test; x-rays and other imaging studies., administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I consent to examinations, treatments, procedures, and blood test ordered by the healthcare provider, which may include blood test for diseases such as hepatitis and HIV AIDS.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until the center changes its services and ask me to complete a new consent form.

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
1. I understand that Resident Physicians may be involved in treatment, and I consent thereto.
2. I understand that midlevel providers (Physicians Assistants and Advanced Practice Registered Nurses) may be involved in treatment, and I consent thereto.
3. I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such.
4. I hereby voluntarily give my consent to treatment at Vanguard Inpatient Physicians.

Consent to Bill Insurance and Collect Payment

I understand and agree that health, dental or behavioral health insurance coverage is an agreement between the insurance carrier and myself. I understand that Vanguard Inpatient Physicians will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized will be paid directly to Vanguard Inpatient Physicians. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I authorized Vanguard Inpatient Physicians to furnish information to insurance carriers concerning my illness and treatments.

I acknowledge my responsibility to pay for that care according to the fees established.

HIPAA Acknowledgement of Privacy Practices

I have received a copy of Vanguard Inpatient Physicians "Notice and Authorization of Privacy Practices." This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability (HIPPA) Act.

_____ _____

Signature of Patient/Guardian or Power of Attorney Date