DHCHD
Dallam Hartley Counties
Hospital District

1411 Denver Avenue
Dalhart, Texas 79022
www.dhchd.org

DALHART FAMILY MEDICINE CLINIC

206 E 16TH ST, DALHART, TEXAS 79022
(806) 244-5668 FAX (806) 244-5913

PATIENT INFORMATION (CONFIDENTIAL)

Please complete entire form: Date:_____

Patient's Legal Name_____ Sex: Male / Female

First Middle Last Suffix

First Name you prefer to go by_____ Maiden/Birth Name_____

Date of Birth_____ Age_____ Soc. Sec #_____

Drivers Lic #_____ and State_____ Circle Status: Married , Single , Divorced , Widowed

Mailing Address_____ City_____ State_____ Zip_____

Physical Address_____ City_____ State_____ Zip_____

Home Phone (___)_____ Cell (___)_____ Work (___)_____ Other_____

Email Address_____ Preferred Pharmacy_____

Patient Employer_____ Phone Number_____

Parent Information (for minor)

Parent Name_____ DOB_____

Emergency Contact Information

1st Emergency Contact_____ Relationship_____

Home Phone_____ Cell_____ Work_____

Mailing Address_____

2nd Emergency Contact_____ Relationship_____

Home Phone_____ Cell_____ Work_____

Mailing Address_____

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INSURANCE (PRIMARY)

Name of Insurance_____ Name of Employer_____

Name of Insured_____ Date of Birth_____ Soc Sec #_____

Relationship to Patient_____ Phone number (if different than patient)_____

Address (if different than patient)_____

INSURANCE (SECONDARY OR SUPPLEMENTARY)

Name of Insurance_____ Name of Employer_____

Name of Insured_____ Date of Birth_____ Soc Sec #_____

Relationship to Patient_____ Phone number (if different than patient)_____

Address (if different than patient)_____

Please Check

Race:
____American Indian or Alaska Native
____Asian
____Black or African American
____Native Hawaiian or other Pacific Islander
____White
____Hispanic
____Other:_____

Tobacco Use: _____YES ____NO

Financial responsibility and assignment of benefits: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to High Country Community Rural Health Clinic Physicians and/or Medical Practice Income Plan. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to HCCRHC Physicians and/or Medical Practice Income Plan. I Certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid is correct.

I hereby give consent to this office to be diagnosed and treated by all qualified Medical staff for myself or child. I understand that I have been given the option of seeing any of the above listed upon scheduling an appointment.

NOTICE OF PRIVACY PRACTICES:

I have asked for and received a paper copy of DFMC Privacy Practices_____ (Patient/Guardian Initials)

Patient/Guardian Signature_____ Date_____

Relationship to Patient_____

Thank You for choosing Dalhart Family Medicine Clinic for your health care needs.

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206 E 16th St. Dalhart, TX, 79022
PH: (806) 244-5668 F: (806) 244-5912

Medical History

(please mark those that apply)

Angina/Chest Pain		GERD (reflux)		Osteoarthritis	
Coronary Artery Disease		Irritable Bowel Syndrome (IBS)		Rheumatoid arthritis	
Valvular Heart Disease		Crohn's Disease (IBD)		Gout	
Arrhythmias (Afib, WPW, etc)		Ulcerative Colitis (IBD)		Osteoporosis	
Hypertension		Pancreatitis		Fibromyalgia	
Hyperlipidemia		Peptic Ulcer Disease		Chronic low back pain	
Congestive Heart Failure		Gastritis		Chronic Joint Pain (please specify):	
Abdominal Aneurysm		Hemorrhoids			
History of MI		Chronic Constipation			
Peripheral Vascular Disease		Fecal Incontinence			
Syncope		Hepatitis		Hearing loss	
		Fatty Liver		Glaucoma	
Diabetes Mellitus		Abnormal Colonoscopy (please specify):		Cataracts	
Hypothyroidism				Vision loss	
Hyperthyroidism					
				Acne	
Anemia		Headaches		Eczema	
Bleeding Disorder		Stroke (CVA) or TIA		Psoriasis	
Clotting Disorder		Seizures/Epilepsy			
Thrombocytopenia		Peripheral Neuropathy			
Deep Vein Thrombosis (DVT)		Restless Leg Syndrome		Chickenpox	
Pulmonary Embolism (PE)		Dementia		HIV/AIDS	
		Parkinson's Disease		MRSA	
COPD		Multiple Sclerosis		Tuberculosis/Abnormal PPD (please specify):	
Asthma					
Sleep Apnea		Depression		Rubella	
		Anxiety		Polio	
Chronic Kidney Disease		Bipolar Disorder		Mumps	
Urinary incontinence		Anorexia		Measles	
Kidney Stones		Bulimia		Rheumatic fever	
Recurrent UTI		Schizophrenic			
Interstitial Cystitis		ADD/ADHD			
Hematuria		Autism Spectrum Disorder			
		Learning delay			
Cancer (specify type):		Other (please specify):			

Please be sure to continue to next page...

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Surgical History

	Date		Date		Date
Tonsillectomy		Cholecystectomy		Mastectomy	
Dental Surgery		Appendectomy		Lumpectomy	
Heart Cath		Splenectomy		Breast biopsy	
Coronary Stent		Colonoscopy			
CABG		Bowel resection		Skin cancer removal	
Pacemaker/Defibrillator		Hernia repair			
Valve Replacement		Gastric bypass		Cesarean Section	
Thyroidectomy		Bladder Surgery		Bilateral Tubal Ligation	
Parathyroidectomy		Kidney Surgery		Hysterectomy	
Spine Surgery (please specify):		Joint replacement (please specify):		Ovary removal	
				LEEP	
				D&C	

Other (please specify):

Family History

(please mark those that apply)

	Father	Mother	Sibling	Children	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Diabetes Mellitus								
Thyroid disease								
Hypertension								
Hyperlipidemia								
Coronary Artery Disease								
Congestive Heart Failure								
Heart attack (MI)								
Arrhythmia								
Stroke								
Dementia								
Asthma/COPD								
Bleeding disorder								
Clotting disorder								
Autoimmune disorder								
Depression								
Addiction								
Kidney Disease								

Cancer (please specify):

Other (please specify):

Please be sure to continue to next page...

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OB/GYN History

Age Periods Started: _____ Age Periods Stopped: _____

Last Menstrual Period: _____ Average length of period: _____ Average length between periods: _____

# of Pregnancies: _____ # of miscarriages: _____ # of live births: _____

Birth Control Method: _____

Last Pap Smear (date/results): _____

Last Mammogram (date/results): _____

Current Medications: (please include any over the counter medications & herbal supplements)

Medication Name	Strength	Frequency	Medication Name	Strength	Frequency

Preferred Pharmacy: _____

Allergies (medications, food, environmental, etc.)

_____

_____

_____

_____

Social History

Tobacco Use: Current: YES NO If yes, how many packs per day? _____ How long? _____

Past: YES NO when did you quit? _____ Secondhand exposure: YES NO

Alcohol Use: YES NO If yes, how much/often? _____

Substance Use: ☐ None ☐ Marijuana ☐ Opiates ☐ Cocaine ☐ Heroin ☐ Amphetamines ☐ Hallucinogens
☐ Other (please specify): _____

Preferred Language:
☐ English ☐ Spanish ☐ Other: _____

The information given in this medical history is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

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NOTICE OF FINANACIAL RESPONSIBILITY

Patient's name:_____ Date of Birth:_____

I _____(parent /guardian/ responsible party's name) have been notified by clinic staff (physician/provider) that my insurance_____ may deny payment of certain health care services. If my insurance denies payment I understand that I will be personally and fully responsible for payment of services rendered. I also understand that I can personally appeal or discuss such denial of coverage with my insurance company and that covered services may change at any time without notification due to me.

X_____ _____

Patient signature (Guardian if minor) Date

X_____ _____

Witness/Clinic Staff signature Date

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DRAFT CHOICE OF LAW AND FORUM CLAUSE

NONEMERGENCY
AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Signature of Patient Date

NO ES DE EMERGENCIA
ACUERDO CON RESPETO A LA LEY APLICABLE Y FORO:

El paciente, incluyendo el representante del paciente, y herederos o beneficiarios, y el proveedor de cuidado de la salud, incluyendo a los empleados y agentes del proveedor de atención médica, la prestación o la prestación de asistencia médica, cuidados de la salud, o servicios de seguridad o profesionales o administrativos directamente relacionados con la atención sanitaria a los pacientes de acuerdo de:

1. Que todo cuidado de la salud se regirán exclusivamente y sólo por la Ley de Texas y en ningún caso la ley de cualquier otro estado aplicará a cualquier cuidado de la salud prestada al paciente; y
2. En el caso de una disputa, cualquier demanda, acción o causa que de alguna manera se relaciona con el cuidado de la salud proporcionado al paciente sólo será llevada en un tribunal de Texas en el condado / distrito donde todo o sustancialmente todo cuidado de la salud fue prestada o proporcionada y en ningún caso cualquier demanda, acción o causa de acción nunca será llevada en cualquier otro estado. La elección de las disposiciones legales y selección de foro de este párrafo son obligatorios y no son permisivas.

Signature of Patient Date

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HIPPA Release Form

Patient Name: _____ Date of Birth: _____

☐ I authorize the release of information including the diagnosis, records: examination rendered to me and claims information.

This information may be released to:

☐ Spouse_____
☐ Child(ren)_____
☐ Other_____
☐ Information is not to be released to anyone

This release of information will remain in effect until terminated by me in writing.

Messages:

Please call:

☐ My home
☐ My work
☐ My cell number:_____

If unable to reach me:

☐ You may leave a detailed message
☐ Please leave a message asking me to return your call
☐ DO NOT leave a message

Signature: _____
Date: _____

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No-Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our "No-Show" Policy and sign at the bottom of the form. If you have any questions, please let us know.

DEFINITION OF A "NO-SHOW" APPOINTMENT

Dalhart Family Medicine Clinic/High Country Community Rural Health Clinic defines a "no-show" appointment as any scheduled appointment in which the patients either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 15 minutes late and is consequently unable to be seen

"No-Show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no shows" a scheduled appointment, it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair to the other patients who could have taken the appointment slot
- Disrespects the provider's time, other patients, and the time of the staff

To avoid a "no show" appointment, arrive 15 minutes early or give the clinic at least 24 hours' notice to cancel the appointment. The reason we ask you to arrive 15 minutes prior to your appointment time is to allow our staff to address any insurance or billing questions, update your record in our electronic medical records, and to allow the nurse time to room you and get you prepared to be seen by the provider.

Our call center will attempt to contact you the day before your scheduled appointment to confirm your visit. We must have a correct phone number to reach you. It is your responsibility to keep us updated with any number changes. If our call center is unable to confirm your appointment, please contact our office at 806-244-5668 by 9 a.m. the business day before the appointment to make changes.

CONSEQUENCES OF "NO-SHOW" APPOINTMENTS

A $25 fee will be charged for any "no-show" appointments. This policy applies to new and established patients and will be charged directly to the patient/guarantor, NOT to the patient's insurance. **All No-Show fees MUST be paid prior to the next appointment to be seen.** If you miss three appointments within a year, you may be asked to find another provider within 30 days.

I have read and understand the Dalhart Family Medicine Clinic/High Country Community Rural Health Clinic "No-Show" Policy as described above.

_____ _____

Patient Signature *Date*

DHCHD Dallam Hartley Counties Hospital District

SLEEP ASSESSMENT AND EPWORTH SCALE

(Questionnaire used to identify sleep disorder candidates)

Patient Name _____ Date of Birth _____

HT: _____ Wt: _____ Age: _____ Daytime # _____

Please list any Medical Problems within the last 5 years (hypertension, diabetes, surgery, etc.)

_____

_____

Have you suffered from Heart Attack or Stroke? _____ When? _____

If you have high blood pressure or hypertension are you taking multiple medications: Yes No

1.	Do you snore at night	yes	no	occasionally
2.	Witnessed pauses in breathing while asleep	yes	no	occasionally
3.	Do you have difficulty falling asleep	yes	no	occasionally
4.	Do you have difficulty maintaining sleep	yes	no	occasionally
5.	Experience excessive daytime tiredness	yes	no	occasionally

Do you frequently awaken with: **(please circle)**

Dry mouth Nasal Congestion Headache Heartburn Chest Pain
Excessive sweating Choking and gasping Feeling Groggy or Unrefreshed

Choose the appropriate number value to represent how likely you are to fall asleep in the following situations. Try to be as honest as possible.

0-never **1-slight chance** **2-moderate** **3-always**

Sitting and Reading	0 1 2 3
Watching T.V.	0 1 2 3
Sitting, Inactive in a public place (Movie theatre, meeting)	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Driving a vehicle for two or more hours	0 1 2 3
Lying down to Rest in the afternoon when circumstances permit	0 1 2 3

Office use only- Total: _____

X _____
Provider Signature

X _____
Nurse Signature

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Your Information. Your Rights. Our Responsibilities

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

Your Rights:
You have the right to:
- Get a copy of your health and claims records
- Make amendments your health and claims records
- Request confidential communication
- Ask us to limit information we share
- Get an accounting of those with whom we've shared your information
- Get of copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices:
You have some choices in the way that we use and share information was we:
- Answer treatment questions from your family and friends
- Provide disaster relief
- Market our services and sell your information
- Engage in fundraising activities

Our Uses and Disclosures
We may use and share your information as we:
- Help manage the health care treatment you receive
- Run your organization
- Bill for your health services
- Submit claims to payors
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation request and work with medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government request
- Respond to lawsuit and legal actions.

When it comes to your health information you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records:
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how.
- We will provide a copy or summary of your health and claims records, usually within 30 days of your request was may charge a reasonable, cost base fee.

Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.
- We may say "no" to your request, but we'll say "yes" if you tell us you would be in danger if we do not.

Request confidential communications
- You can ask us to contact you in a specific way (example: home or office) or to send mail to a different address

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• You can ask us not to bill your health plan for an episode of care, if you pay in full out of pocket for that care at the time.
• We will consider reasonable request, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we share
• You can ask us to NOT to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and may say "no" if it would affect your care.
Get a list of those whom we have shared information with
• You can ask for a list (accounting) of the times we've shred your health information for six years prior to the date you ask, who we shared it with and why.
• We will include all the disclosure except for those about treatment, payment, and health care operation, and certain other disclosures (such as nay you ask us to make). We will provide one accounting a year for free but will charge a reasonable cost based fee if you ask for another one within 12 months.
Get a copy of this privacy notice
• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.
Choose someone to act for you
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint you feel your rights are violated
• You can compliant when you feel like we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave,S.W. Washington, D.C. 20201 calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privscy/hippa/complaints./ We will not retaliate you for filling a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situation described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and the choice to tell us to:
• Share information with your family, close friends, or others involved in payment for your care including limited information in the hospital directory if you are inpatient (Must opt out in writing) Share information in a disaster relief situation. Restrict information to your health plan if your pay bill in full.
• If you are unable to tell us your preferences for example if you are unconscious, we may also go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Cases where we NEVER share your information unless you give us permission:
• Marketing purposes
• Sale of information
• Any notes relating to psychotherapy

How do we typically use or share your information?

Help manage the health care treatment you received
- Share it with professionals who are treating you.
- Example: A doctor sends us information about diagnosis and treatment plan so we can arrange additional services.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary

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- Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we bill for your health services
- Example: We share information about you with your health plan to coordinate payment for you treatment.

Prior Authorization from your health plan

- We may disclose your health information to your health plan for prior authorization of care.
- Example your company contracts with a health plan, and we prior authorize services and bill for your care.

Help with public health and safety issues

- We can share health information about you for certain situations such – Preventing disease, product recalls, reporting reactions, reporting abuse, neglect, or violence, preventing or reducing serious threat to anyone's health or safety.

Do research

- We can share your info for health research

Comply with the law

- Will share inform about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation request and work with funeral director

- We can share health information about you with organ procurement organizations
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers compensation, law enforcement, and other government request

- Workers compensation claims, law enforcement purposed or with a law enforcement official, with health oversight agencies for activates authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuit and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Inmates

- We can share health information to correctional institutions or law enforcement to provide you with healthcare, or to protect the health and safety of yourself, others or the correctional facility.

Our responsibilities

We are required by law to maintain the privacy and security of your health information. We will let out know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described unless you tell us we can in writing. If you tell us we can you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:www.hhs.gov/privacy/understanding/consumers/noticepp.html.

Changes to the terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website and will mail a copy for you.

September 23, 2013