**New Patient Registration**

*Please complete these forms before we arrive for your appointment*

 **New Patient Checklist**

**The following is a list of items you need to bring with you**

 **for your first appointment:**

**1.Insurance card**

**2.Driver’s license or alternate photo ID**

**3.Medication list: Please include all prescription and over‐the‐counter medications you are currently taking**

**4. X‐ray films, CT, PET, and/or MRI scans (only if available).**

7098 Duckhorn Ln The Colony TX Phone: 469-430-8371 Fax: 585 312-2258 I mailto:cavanaughhealthcareassoc@gmail.com

**Authorization for Release of Healthcare Records**

\*Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Previous Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Facility Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Address: \_\_\_Facility Fax: \_\_\_\_\_\_\_

City, ST, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of disclosure is:

 Change of Insurance or Physician Referral Other

This request and authorization applies to: Dates and Type of information to disclose:

 Progress Notes, Discharge notes

 Laboratory data, Imaging results

 Specific Information Requested:

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: ATTN: Ebony Cavanaugh AGPCNP-BC, RN Cavanaugh Healthcare Associates PLLC

Address: 7098 Duckhorn LN City, State, Zip: The Colony TX, 75056

Phone: 469-430-8371 Fax 535-312-225

 I have read the above foregoing Authorization for Release of Information and do hereby acknowledge

 that I am familiar with and fully understand the terms and conditions of this authorization

\*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

 **Patient Authorized Agent Signature (Relationship) Date**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

 **Agency representative Signature Date**

**Patient Consent for Medical Treatment**

**By signing this agreement, I consent to receive these services and agree**

 **to the following:**

* + I consent to receive Medical services from the provider listed above and/or any associates he/she may designate to assist in providing me with care management services.
	+ I understand that I have the right to stop services at any time (effective at the end of a calendar month) with Cavanaugh Healthcare and the effect of a revocation of this agreement. I may revoke this agreement verbally by calling (469)-430-8371 or in writing to 7098 Duckhorn Ln. The Colony, TX 75075. After revocation of this agreement, I may opt to receive medical services from another healthcare provider in the month following revocation of this agreement.
	+ I understand that I will receive a written or electronic copy of my comprehensive

 care plan.

* + I authorize electronic communication of my medical information with other

 treating providers.

* + A representative of Cavanaugh Healthcare has explained potential cost-sharing obligations that may apply when receiving medical services.
	+ It is the policy of Cavanaugh Healthcare Associates to protect all clinical records against loss, defacement, tampering and use by unauthorized person. I authorize Cavanaugh HealthCare Associates to release medical information to physician or facilities of my choice, a payer source or an accrediting regulatory/consulting organization as appropriate.
	+ I authorized the release of the plan of treatment and discharge summary upon my transfer to another health care facility.
	+ PHOTO AUTHORIZATION- I hereby grant my permission for CHA to take and use my photo for medical record purpose only

|  |  |  |
| --- | --- | --- |
| Patient Name |  | Date of Birth |
| Patient Signature |  | Date |

#### Release of Information

I authorize the release of all medical information including the diagnosis (including HIV testing), records; examination rendered to me and claims information. This information may be released to the following persons: *Please check the appropriate box below*

Spouse Name

Child(ren)

Other Relationship

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by the patient or patient representative in writing.

#### Phone messages

I authorize the release of all medical information to be left in voice messages on;

## Home Phone Work Phone Cell Phone Other number

I do **NOT** authorize the release of any medical information to be left in a voice message

The best time to reach me is (*day*) between (*time*)

# PATIENT INFORMATION

### PATIENT PHYSICAN LIST

\*Patient Name \*Date of Birth

I give VIP Healthcare permission to contact past and current physicians for diagnostic test results, and discuss protected health information with, the following Physician(s):

Doctor Name Specialty

Address: Telephone:

Doctor Name

Address:

Doctor Name

Address:

Specialty Telephone:

Specialty Telephone:

Doctor Name

Address:

Specialty Telephone:

Doctor Name

Address:

**Current Medications:** *Please include prescription medications, over-the-counter drugs, vitamins and*

 *supplements*

|  |  |  |  |
| --- | --- | --- | --- |
| Name / Dose | # Tabs / Frequency | Name / Dose | # Tabs / Frequency |
| 1) |  | 6) |  |
| 2) |  | 7) |  |
| 3) |  | 8) |  |
| 4) |  | 9) |  |
| 5) |  | 10) |  |

Last Name: First Name: MI:

Address: Mailing Address:

City: State: Zip:

Date of Birth: Sex: Male Female

Marital Status:

Single Married

Divorced

Widowed

Partnered

Home Phone Cell Phone

Appointment Reminder Preference: (Please choose one)

Home or Cell

If Cell: Voice or Text

Email Address for Patient Portal Use: Driver’s License & State Issued:

Emergency Contact Name: Emergency Contact Phone:

Emergency Contact Address: Relation to You:



**EMPLOYMENT**

Employer Name:

**INSURANCE**

Retired Unemployed Disable

Primary:

Secondary

Policy/Group:

Effective Date:

*Please bring your Insurance Card to each visit*

Policy/Group: Effective Date:

**Supplemental Data Collection: Race:**

White

Asian

Hispanic American Indian

Black-African American

Native Hawaiian

Other Pacific Islander Unreported/Refused to Report Other Race

**Ethnicity:**

Hispanic Non-Hispanic Refused to Report

**Preferred Language:**

English Spanish Other