CAVANAUGH HEALTHCARE ASSOCIATES PLLC

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).

CAVANAUGH HEALTHCARE ASSOCIATES PLLC

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

Authorization for Release of Healthcare Records

*Patient's Name:_____ Date of Birth:_____
Last Name First Name

*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**

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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

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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*)

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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 Specialty

Address: Telephone:

Doctor Name Specialty

Address: Telephone:

Doctor Name Specialty

Address: 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)	

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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: Retired ◯ Unemployed ◯ Disable ◯

INSURANCE

Primary: Policy/Group: Effective Date:

Secondary Policy/Group: Effective Date:

Please bring your Insurance Card to each visit

Supplemental Data Collection: Race:

☐ White ☐ Hispanic ☐ Black-African American

☐ Asian ☐ American Indian ☐ Native Hawaiian

☐ Other Pacific Islander ☐ Unreported/Refused to Report ☐ Other Race

Ethnicity:

☐ Hispanic ☐ Non-Hispanic ☐ Refused to Report

Preferred Language:

☐ English ☐ Spanish ☐ Other

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