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/have with you for your first appointment:

1. **Insurance Card(s)**

2. **Driver's license or Alternative Photo ID (State issued ID, Military ID, Veteran Affairs ID, Passport)**

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).**

* Signature and name only needed for first page. We will fill in Facility name This only in the event we need to request medical records from a facility or another medical office.

Phone: (469)-399-0380 Fax: 469-925-2831 Email: admin@cavanaugh-health-care.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 ☐VA C&P Exam ☐Consultation ☐Other: _____

This request and authorization apply to:

☐All Records at this facility. Dates: _____
☐Outpatient Records. Dates:
☐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: 9696 Skillman St, Ste 220, Dallas, TX 75243

Phone: PH: 214-523-9645 Fax 469-925-2831

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 or Guarantor Name **Relationship**

_____ _____
Patient or Guarantor 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)-399-0380, or in writing to 9696 Skillman St, Ste 220, Dallas, TX 75243. 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 if I wish to receive a copy of my records, I will pay the fee Stipulated by my state of residence.

I authorize electronic communication of my medical information with other treating providers.

- 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.
- I will allow for my credit card information to be stored electronically to collect payment for services rendered or to collect no-show fees, as applicable.

Patient or Guarantor Name	**Relationship**
Patient or Guarantor Signature	**Date**

CAVANAUGH HEALTHCARE ASSOCIATES PLLC
Dragonfly HOUSECALLS
Phone: (469)-399-0380 Fax: 469-925-2831 Email: admin@cavanaugh-health-care.com

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:

☐Spouse Name_____

☐Child(ren) Name_____

☐Other Name_____

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 ☐cell phone ☐work phone ☐other phone: _____

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

The best time to reach me is ☐Daytime or ☐Nighttime

I prefer to be contacted via:

☐ Home Phone Number in Portal

☐ Cell Phone Number in Portal

☐ Email listed in Portal

☐ US Mail via Address in Portal

Medication History

Name of Medication	Dose	How Often do you take it?	For what condition?	Who Prescribed this?

Over the Counter Medications / Supplements

Name of Medication or Supplement	Dose	How Often do you take it?

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Other Specialists or Providers

Specialist's Name	Specialty	Office Number