PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

SATIR AND SATIR, P.A.
4942 NE STALLINGS
NACOGDOCHES, TEXAS 75965
936-560-9595

Patient Information
Adult Patient

WELCOME TO OUR PRACTICE!

Patient Name: _____

If Patient is a minor, List Mother and Father:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____-_____ Cell: (_____) _____-_____

DOB: ____/____ /____ Age:_____ SS#:_____/_____/_____

Gender:_____ Race:_____ Marital Status: _____

Place of Employment: _____

Work Phone: (_____) _____-_____

Insured Party: _____ Insured DOB: _____

Emergency Contact Name: _____

Relationship to patient: _____

Phone Number: (_____) _____-_____ DOB: _____/_____/_____

(If different from above)
Person Responsible for payment of the account: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____-_____ Cell: (_____) _____-_____

DOB: ____/____ /____ Age:_____ SS#:_____/_____/_____

PLEASE LIST PHARMACY THAT YOU PREFER:

It is our pleasure to serve you. If you have any questions, please do not hesitate to ask. Thank you.

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

Preferred Pharmacy information:

Pharmacy Name:

_____

Address _____ Phone _____

Race – (Please circle the information below that applies to you):

American Indian/Alaskan Native
Asian
White
Nat Hawaiian/Pacific Islander
Other
Unknown
Black/African American
Decline

Ethnicity – (Please circle the information below that applies to you):

Hispanic or Latino
Not Hispanic or Latina
Other

Preferred Communication- (Please circle the information below that applies to you):

Email
Fax
Mail
Phone
Text

Please provide preferred contact telephone number:

_____

Please provide e-mail address:

_____

Please circle yes or no:

Do we have authorization to call you at work: Yes No

Is it ok to leave a message on your preferred contact number: Yes No

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

SATIR AND SATIR, P.A.
4942 NE STALLINGS
NACOGDOCHES, TEXAS 75965
936-560-9595

ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Satir and Satir, P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Satir and Satir, P.A. to: 1) release any information necessary to insurance carriers regarding my illness and treatments; 2) to process insurance claims generated in the course of examination or treatment; and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Satir and Satir, P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

SATIR AND SATIR, P.A.
4942 NE STALLINGS
NACOGDOCHES, TEXAS 75965
936-560-9595

PATIENT FINANCIAL POLICY SHEET

In order to reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment (for the patient due portion of the service) is due at the time of service. For your convenience we accept VISA and MasterCard. Payment for co-pays will be taken at the time of check-in.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized deductible and co-payment at the time of service. It is the policy of our office to collect this deductible and co-payment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim. However, each insurance company has its own version of "usual and customary" and the patient will be responsible for payment of this amount.

- In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor Date

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

HIPAA Notice of Privacy Practices

Satir and Satir, P.A.
4942 NE Stallings
Nacogdoches, Texas 75965
936-560-9595

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures **Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices: I understand that these policies are in place and will not change unless notified in writing.

Print Name:_____

Signature: _____

Date: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

HIPAA Notice of Privacy Practices

Satir and Satir, P.A.
4800 NE Stallings, Suite 115
Nacogdoches, Texas 75965
936-560-9595

RELEASE INFORMATION:

1. The following people have my permission to talk to Satir and Satir and/or pick up my medical records (list names):

_____

Or, ☐ Information is not to be released to anyone.

2. The following people have my permission to pick up my prescriptions/samples:

_____

Or, ☐ Prescriptions/samples are not to be released to anyone.

3. The following people are authorized to bring my child for medical care. (I understand that vaccinations or therapeutic shots will not be given unless a parent accompanies my child):

_____

Or, ☐ No one can bring my child to an appointment other than a parent.

These authorizations are good until I change them in writing.

TELEPHONE MESSAGES

Please call ☐ my home_____ ☐ my work_____

☐ my cell number _____

If unable to reach me:

☐ You may leave a detailed message on ☐ my home ☐ my work ☐ my cell
☐ Please leave a message asking me to return your call.

_____ _____
Patient/Parent Signature Date

_____ _____
Witness Name Date

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

PATIENT INFORMATION FORM

VICKI HEARNE SATIR, M.D. **CENGIZ SATIR, M.D.**
FAMILY MEDICINE

~~~~~~

WELCOME TO OUR FAMILY PRACTICE!

Medication Allergies (please list): _____

_____

Other allergies (latex, iodine, etc. please list): _____

_____

PATIENT HISTORY

Have you ever, or do you currently suffer from any of the problems listed? If yes, please circle.

Anemia
Animal Allergies
Anxiety
Arthritis
Asthma/Wheezing
Blood in Stool
Breathing Problems
Cancer/List Type:
_____
Chest Pain
Chicken Pox
Chronic Back Pain
Constipation
Cough
Depression
Diabetes
Difficulty Swallowing
Diverticulosis
Ear Problems
Eye Problems
Fatigue
Fractures/List:
_____
Gallbladder Problems
Gout
Hay Fever/Allergies
Headache/Type:
Tension
Migraine
Heart Problems/Type:
Heart Attack
Heart Failure
Hemorrhoids
High Blood Pressure
HIV/Aids
Jaundice/Hepatitis
Kidney Problems
Menstrual Problems
Osteoporosis
Palpitations
Rheumatic Fever
Seizures
Sexual Disease
Sexual Problems
Skin Problems
Stomach Pain
Stomach Ulcers
Stones/Blood in Urine
Stroke
Throat Problems
Thyroid Problems
Urinary Problems/Type:
Leakage of urine
Decrease in flow
Weight Loss

Other (please list): _____
~~~~~~

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

FEMALES ONLY/(MALES SKIP TO THE NEXT SECTION):

Number of Pregnancies: ____Abortions: ___Miscarriages: ___ Living Children: ___

Date of Last Pap Smear: _____ Normal / Abnormal (circle one)

Mammogram: _____ Normal / Abnormal (circle one)

Menopause symptoms? Yes / No If so, which ones? (circle) Hot flashes, Abnormal period, decreased / increased bleeding, Other: _____

Do you have questions regarding (circle): breast lumps nipple discharge

~~~~~~

All patients- List names of all prescription medications and dosages you are now taking:

All Patients- List names of all non-prescription medications (over the counter) you are now taking:

FAMILY HISTORY:

Please circle if any blood relative has had the following:

Diabetes Heart Attack Stroke Migraine Headaches High Blood Pressure

Cancer (list type):_____

Other familial medical problems (list): _____

_____

SURGICAL HISTORY

Please circle if you have had surgery for any of the following:

Gallbladder Appendix Uterus Ovaries Back Prostate

Other surgeries (please list): _____

_____

DO YOU:

Smoke cigarettes? Yes / No If yes, how much? _____ Packs per day for _____years

Use tobacco? Yes/ No If yes, how much/often? _____

Drink Alcohol? Yes / No If yes, what kind? _____ How often? _____

Ever Use Drugs? Yes / No If yes, what kind? _____

How did you hear about our practice? _____
~~~~~~

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

SATIR AND SATIR, PA
4800 NE STALLINGS, SUITE 115
NACOGDOCHES, TEXAS 75965
936-560-9595

REVIEW OF SYSTEMS QUESTIONNAIRE

PLEASE CHECK THE APPROPRIATE BOX ---- Y= YES N= NO O= OCCASSIONALLY

GENERAL	Y	N	O
Persistent or unexplained tiredness			
Gained weight (how much?)			
Lost weight (how much?)			
Trouble Sleeping			
Excessive daytime sleepiness			
Lots of stress			
Persistent fever above 100.2			
Night Sweats			
Chills or shakes?			
EYES	**Y**	**N**	**O**
Change in vision			
Eye injury?			
Had glaucoma			
Eye pain			
Vision trouble other than needing glasses			
Double vision			
Spots in vision			
Wear glasses or contacts or had vision surgery			
Date of last eye exam			
Any history of cataracts			
Loss of vision			
Dryness			
Mucous Discharge			
Redness and/or itching			
Sandy or Gritty Feeling			
Glare/Light Sensitivity			
Excess tearing or watering			
EAR, NOSE AND THROAT	**Y**	**N**	**O**
Changing hearing			
Itchy nose			
Nose bleeds			
Snoring			
Use of hearing aids			
Ears ringing			
Sinus trouble			
Hoarseness			
Lump in throat			
Painful or difficult swallowing			
Use of dentures			
Persistent or recurring sores in mouth			
CARDIOVASCULAR	**Y**	**N**	**O**
Chest pain, tightness or pressure			
Abnormal heart rhythm or palpitations			
Heart murmur			
Leg cramps while walking			
History of abnormal electrocardiogram			
Date of last electrocardiogram			
Blue or very white fingers			
Wake up to catch breath			
Sleep sitting up or propper up on pillows to breathe			
Date of last stress test or other heart test:			
Varicose veins			

RESPIRATORY	Y	N	O
Daily Cough?			
Breathless at rest			
Breathless with exertion			
Cough			
Cough up sputum or phlegm			
Cough up blood			
Wheezing			
Excessive snoring or long paused breathing during sleep			
Date of last chest x-ray: _____			
Exposure to tuberculosis			
Date of last tuberculosis skin test: _____			
If done, was it positive?			
GASTROINTESTINAL	**Y**	**N**	**O**
Heartburn			
Vomiting			
Vomiting Blood			
Constipation			
Hemorrhoids			
Abdominal pain			
Diarrhea			
Use laxatives			
Blood in stools			
Chalky white stools			
Black stools			
Hepatitis or jaundice in the past			
Date of last colonoscopy: _____			
KIDNEYS AND BLADDER	**Y**	**N**	**O**
Pain with urination			
Urinate very frequently			
Get up at night to urinate			
If so, how often			
Trouble holding urine			
Bloody or discolored urine			
MEN ONLY	**Y**	**N**	**O**
Impotence or difficulty with erections			
Prostate trouble, difficult urination, or weak stream			
Sex with other men			
Use of Viagra, Levitra or other E.D. medication			
MUSCULOSKELETAL	**Y**	**N**	**O**
Joint pains/stiff joints			
Tendinitis or bursitis			
Foot swelling			
Leg cramps while sleeping			
Walk with a limp			
Lower back pain			
Upper back or neck pain			
Foot trouble			
Have you fallen in the past year?			
If yes, did you injure yourself?			
History of compression fracture			
Have you ever been on a low calcium diet?			
Date of your last bone density scan: _____			

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

SKIN	Y	N	O
Unusual or changing moles?			
Changing spots on the skin			
Skin lesions			
Unexplained itching of the skin			
Rash			
Skin warts			
Persistent sores on the skin?			
Do you see a dermatologist?			
BLOOD AND LYMPH NODES	**Y**	**N**	**O**
Anemia in the past			
Blood transfusion anytime in the past			
Date of blood transfusion: _____			
Easy bruising			
Free bleeding			
Swollen lymph glands			
Bleeding from the mouth or frequent nose bleeds			
ALLERGIC AND IMMUNE SYSTEM	**Y**	**N**	**O**
Seasonal runny nose			
Hives			
Removal of spleen			
Use of steroids in the past			
ENDOCRINE/GLANDULAR	**Y**	**N**	**O**
Don't tolerate heat			
Don't tolerate cold			
Unusual hair growth			
Unusual hair loss			
Excessive thirst or excessive liquid drinking			
Radiation treatement in the neck			
NEUROLOGIC	**Y**	**N**	**O**
Headache			
Dizzy spells			
Dizzy speaking words			
Lightheadedness			
Bad memory			
Fainting or loss of conciousness			
Seizures			
Numbness and tingling			
Unsteady walking			
Slurred speech			
Weakness in one part of your body			
Tremor or shakiness			
EMOTIONAL HEALTH	**Y**	**N**	**O**
Blue mood or sadness or feel "down"			
Depression			
Anxiousness			
Change in personality including anger or temper			
Crying spells			
Suicidal thoughts			
Thoughts of harming others			
Early-morning awakening			
Hearing voices that others don't hear			
Trouble with concentration			
OTHER HEALTH ISSUES NOT LISTED:			

WOMEN ONLY	Y	N	O
If you see a Gynecologist, please write his/her name here			
Breast lumps or breast tissue changes			
Nipple discharge			
Date of last mammogram: _____			
Have you had an abnormal mammogram in the past?			
Hot flashes			
Change in periods			
Pain, cramping or excessive bleeding with periods			
Excessive premenstrual mood symptoms			
Date of last pap smear: _____			
Have you had an abnormal Pap smear in the past?			
Date of last period _____			
Painful sex or other difficulties with sex			
Abnormal vaginal discharge or dryness			
Did you have menopause or a hysterectomy before the age of 40			
# of pregnancies:			
# of live births:			
# of miscarriages:			

PATIENT NOTE:

Office Visit for Medical Issue:

Please note that each office visit will be problem focused- You may address one problem per visit. If you have multiple issues, pick the issue that is top priority. In the case of multiple issues- we can set you an appointment in the future that is time appropriate.

List the problem to be addressed today:

_____

Office Visit for Wellness:

No medical issues will be discussed. The purpose of the wellness exam is to evaluate you. Any medical issues that need attention will be scheduled to be addressed at a separate visit. If you are scheduled for wellness and have a pressing medical issue, we can convert the visit to a medical visit and reschedule your wellness exam.

DO NOT WRITE IN THIS SPACE- PHYSICIAN NOTES:

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER:_____

ADDRESS: _____

_____

I REQUEST AND AUTHORIZE (Doctor Name/Address/Phone Number):
_____

TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO

_____.

THIS REQUEST AND AUTHORIZATION APPLIES TO:

*ALL HOSPITAL RECORDS (INCLUDING NURSE RECORDS & PROGRESS NOTES)

*TRANSCRIBED HOSPITAL RECORDS	*CLINICIAN OFFICE CHART NOTES
*MEDICAL RECORDS NEEDED FOR CONTINUITY	*DENTAL RECORDS
*MOST RECENT FIVE-YEAR HISTORY	*PHYSICAL THERAPY RECORDS
*LABORATORY REPORTS	*EMERGENCY & URGENCY CARE NOTES
*PATHOLOGY REPORTS	*BILLING STATEMENTS
*X-RAYS, MRI'S AND CT SCANS	*ALL REPORTS
*DIAGNOSTIC IMAGING REPORTS	*OTHER: _____

THIS INFORMATION IS BEING REQUESTED FOR THE PURPOSE OF: _____

_____

PLEASE RELEASE RECORDS FOR THE DATES OF: _____

I UNDERSTAND THAT MY EXPRESS CONSENT IS REQUIRED TO RELEASE ANY HEALTH INFORMATION RELATING TO TESTING/DIAGNOSIS AND/OR TREATMENT FOR HIV (AIDS VIRUS), SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC DISORDERS/MENTAL HEALTH OR DRUG AND/OR ALCOHOL USE. IF YOU HAVE BEEN TESTED, DIAGNOSED OR TREATED FOR HIV (AIDS VIRUS), SECUALLY TRANSMITTED DISEASES, PSYCHIATRIC DISORDERS/MENTAL HEALTH, OR DRUG AND/OR ALCOHOL USE, YOU ARE SPECIFICALLY AUTHORIZED TO RELEASE ALL HEALTH CARE INFORMATION RELATING TO SUCH DIAGNOSIS, TESTING OR TREATMENT.

_____ _____
SIGNATURE OF PATIENT/PATIENT'S AUTHORIZED REPRESENTATIVE DATE

_____
RELATIONSHIP TO PATIENT: PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE

THIS AUTHORIZATION IS VALID FOR 90 DAYS AFTER THE DATE IT IS SIGNED.
A PHOTOSTATIC COPY IS AS VALID AS AN ORIGINAL.
THIS AUTHORIZATION IS REVOCABLE AT ANY TIME.