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#:_______/_______/________

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: __________

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

Patient Information
Adult Patient

Preferred Pharmacy information:

Local Pharmacy Name:
____

Address____________________________________Phone ___________________________

Mail Order Pharmacy Name:
____

Address____________________________________Phone ___________________________

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

American Indian/Alaskan Native

Asian

Black/African American

Nat. Hawaiian/Pacific Islander

White

Unknown

Decline

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

Hispanic or Latino

Not Hispanic or Latina

Other

Please provide e-mail address:

____

PATIENT NAME:____________________________DATE OF BIRTH:______________DATE: __________

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

PHYSICIAN ASSISTANT CONSENT FOR TREATMENT

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

_____________________________________ _________________________

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

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: _________

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

PATIENT PORTAL
MISSED APPOINTMENTS
WELLNESS EXAMS

***PATIENT PORTAL:**

Our Patient Portal has been set up to be our main/primary avenue for non-urgent communications. The portal allows our patients the freedom to send secure messages to your doctor, request medication refill, review clinic visit summaries, request appointments and request documents. You will receive an e-mail from "MYHealthRecord powered by Greenway Health." Simply follow the instructions in the e-mail and you will be ready to start interacting with us via a secure messaging system.

***MISSED APPOINTMENTS:**

There will be a fee charged to our patients who don't cancel appointments less than 24 hours prior to the appointment. The portal can be utilized to communicate with the office for appointment reschedules and cancellations.

***WELLNESS EXAMS:**

We recommend annual wellness (preventive) exams. These exams will be mandatory for our Medicare patients and insurance companies are trending toward requiring them. Annual comprehensive physical includes:

- ✓ **A health history**
- ✓ **A review of all health and lifestyle risk factors**
- ✓ **An exam of all systems including cardiovascular, respiratory, neurological, musculoskeletal, reproductive and behavioral**
- ✓ **Laboratory studies appropriate for age, risk and sex**
- ✓ **Discussion of recommended lifestyle changes**
- ✓ **For women- they can include or not include a gynecological exam and clinical breast exam**
- ✓ **Mammogram results will be sent to patients by the hospital, we will not make notification.**

____ ________________________

Patient/Parent Signature **Date**

PATIENT NAME:____________________________DATE OF BIRTH:______________DATE: __________

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.

11-1-2021

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Satir and Satir, PA including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is “de-identified.”

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Satir and Satir, PA
Attn: HIPAA Officer
4942 NE Stallings Drive
Nacogdoches, Texas 75965
936-560-9595

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

____

____

____

____

____

Patient Name: ______________________________________
(Please Print Name)

Patient Date of Birth: ________________________________

SIGNATURES:

Patient/Legal Representative: _______________________________________ Date:________________

If Legal Representative, relationship to Patient: ____

Witness (optional) : ____Date:_______________

PATIENT NAME:____________________________DATE OF BIRTH:______________DATE: __________

Satir and Satir, PA
4942 NE Stallings Drive
Nacogdoches, Texas 75965
936-560-9595

RELEASE OF INFORMATION AND MESSAGING CONSENT

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.

TELEPHONE MESSAGES

Please call my:

☐ Home number: __________________________.
You may leave a detailed message on this number: ☐ Yes ☐ No

☐ Cell number: ____________________________.
You may leave a detailed message on this number: ☐ Yes ☐ No

☐ Work number: __________________________.
You may leave a detailed message on this number: ☐ Yes ☐ No

***** All of these authorizations are good until I change them in writing.******

_________________________________ _________________________
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): ____
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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

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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? ____
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PATIENT NAME:____________________________DATE OF BIRTH:______________DATE: __________

SATIR AND SATIR, PA
4942 NE STALLINGS
NACOGDOCHES, TEXAS 75965

REVIEW OF SYSTEMS QUESTIONNAIRE

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

GENERAL	Y	N	O	RESPIRATORY	Y	N	O
Persistent or unexplained tiredness				Daily Cough?			
Gained weight (how much?)				Breathless at rest			
Lost weight (how much?)				Breathless with exertion			
Trouble Sleeping				Cough			
Excessive daytime sleepiness				Cough up sputum or phlegm			
Lots of stress				Cough up blood			
Persistent fever above 100.2				Wheezing			
Night Sweats				Excessive snoring or long paused breathing during sleep			
Chills or shakes?				Date of last chest x-ray: ________________________			
EYES	**Y**	**N**	**O**	Exposure to tuberculosis			
Change in vision				Date of last tuberculosis skin test: ____________________			
Eye injury?				If done, was it positive?			
Had glaucoma				**GASTROINTESTINAL**	**Y**	**N**	**O**
Eye pain				Heartburn			
Vision trouble other than needing glasses				Vomiting			
Double vision				Vomiting Blood			
Spots in vision				Constipation			
Wear glasses or contacts or had vision surgery				Hemorrhoids			
Date of last eye exam				Abdominal pain			
Any history of cataracts				Diarrhea			
Loss of vision				Use laxatives			
Dryness				Blood in stools			
Mucous Discharge				Chalky white stools			
Redness and/or itching				Black stools			
Sandy or Gritty Feeling				Hepatitis or jaundice in the past			
Glare/Light Sensitivity				Date of last colonoscopy: __________________________			
Excess tearing or watering				**KIDNEYS AND BLADDER**	**Y**	**N**	**O**
EAR, NOSE AND THROAT	**Y**	**N**	**O**	Pain with urination			
Changing hearing				Urinate very frequently			
Itchy nose				Get up at night to urinate			
Nose bleeds				If so, how often			
Snoring				Trouble holding urine			
Use of hearing aids				Bloody or discolored urine			
Ears ringing				**MEN ONLY**	**Y**	**N**	**O**
Sinus trouble				Impotence or difficulty with erections			
Hoarseness				Prostate trouble, difficult urination, or weak stream			
Lump in throat				Sex with other men			
Painful or difficult swallowing				Use of Viagra, Levitra or other E.D. medication			
Use of dentures				**MUSCULOSKELETAL**	**Y**	**N**	**O**
Persistent or recurring sores in mouth				Joint pains/stiff joints			
CARDIOVASCULAR	**Y**	**N**	**O**	Tendinitis or bursitis			
Chest pain, tightness or pressure				Foot swelling			
Abnormal heart rhythm or palpitations				Leg cramps while sleeping			
Heart murmur				Walk with a limp			
Leg cramps while walking				Lower back pain			
History of abnormal electrocardiogram				Upper back or neck pain			
Date of last electrocardiogram				Foot trouble			
Blue or very white fingers				Have you fallen in the past year?			
Wake up to catch breath				If yes, did you injure yourself?			
Sleep sitting up or propped up on pillows to breathe				History of compression fracture			
Date of last stress test or other heart test:				Have you ever been on a low calcium diet?			
Varicose veins				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 treatment in the neck			
NEUROLOGIC	**Y**	**N**	**O**
Headache			
Dizzy spells			
Dizzy speaking words			
Lightheadedness			
Bad memory			
Fainting or loss of consciousness			
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: