



Mark Brickey, MD
Heather Bartlett, DNP, FNP-BC

Patient Consent and Release Forms

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY

The patient agrees to general medical treatment by Sage Health Internal Primary Care (Sage Health IPC) and understands and consents to the review and use of his/her medical records by our office. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed that the patient is responsible for all fees, including the remainder of deductibles, regardless of insurance coverage. It is customary to pay for services when rendered, unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Sage Health Internal Primary Care to furnish information concerning my medical condition and treatment thereof to my insurance carriers. I also assign insurance benefits to be paid on my behalf to Sage Health IPC by any and all insurance companies that cover the expenses I incur as a result of any diagnostic services or treatment provided to me by Sage Health IPC. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked by me, in writing.

AUTOMATED CALLS: I consent to receive automated phone calls regarding appointments, including patient portal communication. ___ YES ___ NO

MEDICATION HISTORY: I consent that my medication history may be downloaded from Sure Scripts to properly manage my care. ___ YES ___ NO

VACCINE HISTORY: I consent that my vaccines may be downloaded from IMMTRAC through the Texas Department of Health Services (DSHS). ___ YES ___ NO

Signature

Date of Birth

Date

Sage Health Internal Primary Care
2821 E President George Bush Hwy, Suite 510, Richardson, TX 75082
Phone 972-664-0404 Fax 972-664-9797

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Information Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with this important information. For a complete guide of the privacy practices of our office regarding your health information rights, please review the notebook in the waiting room. If you would like a copy to retain for yourself, please request this from our front desk staff.

By signing below, I acknowledge that I have been presented with the Notice of Privacy Practices, Office Protocol, and the Financial Policy, and that I will abide by the stated policies and understand I am fully responsible for any fees or charges incurred.

Signature

Date of Birth

Signature of Patient or Legal Representative

Date

AUTHORIZATION FOR MEDICAL RECORDS

I hereby authorize: _____

Phone: _____ Fax: _____

to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name	Date of Birth	Social Security Number
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Description of information to be released:

Purpose of the use and/or disclosure: **CONTINUATION/CO-ORDINATION OF CARE**

The health information described herein shall be released to:

Sage Health Internal Primary Care
2821 E President George Bush Hwy, Suite 510
Richardson, TX 75082
Phone 972-664-0404 Fax 972-664-9797

I further understand that I may revoke this authorization at any time by notifying you in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient

Date



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Patient Registration Form

Name: _____
(Last) (First) (Middle)

Name you prefer to be called: _____

Date of Birth ____/____/____ Social Security Number _____ Sex: M or F

Marital Status _____ Dominant Hand _____ Language Preferred _____

E-mail Address: _____

Phone: Work _____ Home _____ Cell _____

Mailing Address _____

City, State, Zip (+4) _____

Emergency Contact Name _____ Phone Number _____

Emergency Contact/Relationship to Patient _____

Whom shall we thank for referring you to our office? _____

INSURED PARTY INFORMATION (if different from patient information)

Insured Party Name: _____

Date of Birth ____/____/____ Social Security Number _____ Sex: M or F

PREFERRED PHARMACY:

Pharmacy Name: _____ Phone Number _____

Address _____

Sage Health Internal Primary Care
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Phone 972-664-0404 Fax 972-664-9797

DISCLOSURE AUTHORIZATION

As stipulated by the HIPAA privacy rule, patients have the right to control how and to whom their protected medical information is given. Please instruct below how you would like the staff at Sage Health Internal Primary Care to contact you.

I wish to be contacted in the following manner:

- OK to leave message with detailed information at home
- OK to leave message with call back number only at home

- OK to leave message with detailed information at work
- OK to leave message with call back number only at work

- OK to mail to my home address

WHOM TO CONTACT

In order to further protect your privacy, we will only disclose and/or discuss your healthcare information to members of your family, or others close to you, if you authorize us to do so.

Therefore, if you permit Sage Health Internal Primary Care to disclose information related to your medical condition(s) please list their information below:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Printed Patient Name Date of Birth

Signature of Patient or Legal Representative Date

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Sage Health Internal Primary Care

Medical Questionnaire

Name _____ Date _____

Past Medical History:

Check (✓) conditions you have or have had in the past.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine Headaches | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | |

Past Surgical History: _____

Hospitalization Other Than Surgery: _____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs/Supplements, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies to Medications, X-Ray Dyes, or Other Substances No Yes
(If yes, please list name of medicine and type of reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: Has any member of your family (including parents, grandparents and siblings) ever had the following?
Illness **Which family member?** **Age when diagnosed**

Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addiction	_____	_____
Bleeding diseases	_____	_____
Other	_____	_____

Immunization history — Have you had?

COVID Vaccine(s)	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____	Pneumonia Immunization	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____
Flu Vaccine (most recent)	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____	Tetanus Immunization	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____
Shingles Vaccine	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____	RSV Vaccine	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____
			HSV Vaccine	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____

Review of Systems: Check (✓) symptoms you currently have or have had in the past year.

<p>General</p> <p>Chills Depression/Nervousness Dizziness/Fainting Fever Forgetfulness Headache Insomnia/loss of sleep Weight gain/loss Numbness Sweats</p> <p>Muscle/Joint/Bone</p> <p>Pain, weakness, numbness in: Arms Back Feet Hands</p> <p><input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders</p> <p>Genito-Urinary</p> <p><input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood</p> <p>Cardiovascular</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> High/Low blood pressure <input type="checkbox"/> Irregular/Rapid heart beat <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins</p> <p>Eye, Ear, Nose, Throat</p> <p><input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing</p>	<p><input type="checkbox"/> Double vision <input type="checkbox"/> Earache/Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes/Halos</p> <p>Skin</p> <p><input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching/Rash <input type="checkbox"/> Change in moles <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal</p> <p>MEN only</p> <p><input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis</p> <p>Date of last colonoscopy _____</p> <p>Date of last PSA _____</p>	<p>WOMEN only</p> <p><input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Abnormal Vaginal Discharge <input type="checkbox"/> Bleeding lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Heavy menstrual bleeding <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____</p> <p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Date of last mammogram _____</p> <p>Date of last bone density _____</p> <p>Date of last colonoscopy _____</p> <p>Pregnancies _____ Birth _____ Miscarriage _____</p>
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Prevention

Do you wear seat belts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, why not? _____
Do you wear a bike helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type, duration and number of times per week? _____
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much per week? _____
Do you drink coffee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many cups per day? _____
Do you drink tea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you use drugs?(marijuana, cocaine, IV drug use)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Do you wish to be tested for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you have a "living will"?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a donor card?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Signatures

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please print name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient