Stonebrook Family Medicine
Mona Chacko, M.D

8200 Stonebrook Parkway, Suite #100
Frisco, Texas 75034
Phone: (972) 712-1911 Fax: (972) 712-1909

PATIENT REGISTRATION

Date: _____

Patient: (Last, First, Middle) _____

DOB: _____/_____/_____ Age: _____ Gender: M_____ F_____ Preferred: _____

Street Address: _____ Apt #: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

Race: (Optional) Decline _____ White _____ Asian _____ Black/African American_____ Hispanic_____ Other_____

Email: (for patient portal use only) _____

Current Marital Status: (check one) Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Emergency Contact: _____ Relation: _____ Phone: _____

Pharmacy Name: _____ Location: (cross streets) _____

Pharmacy Phone: _____ Pharmacy Fax #: _____

Employer's Name: _____ Occupation: _____

Employer's Address: _____ Phone: _____

Spouse name: (or nearest relative) _____ DOB: _____/_____/_____

Spouse's Employer: _____ Spouse's Occupation: _____

Spouse's Work Phone: _____ Spouse's Cell Phone: _____

Dependents

The following information pertains to the ACCOUNT Guarantor or Responsible Party

Guarantor's Name: _____ DOB: _____/_____/_____

Address: _____ Relationship to Patient: _____

Driver's License #: _____ State: _____ Phone: _____ Work Phone: _____

We file your insurance as a courtesy.
<u>It is to your advantage to become familiar with your health insurance benefits</u>

Patient/Guardian Signature _____

New Patient Record

Name: _____ **Sex: M F**

Today's Date: _____

Date of Birth: ____/____/____

Medical Illnesses (Please list any chronic medical illnesses or conditions.)

_____ _____

_____ _____

Current Medication and <u>Dosage</u>
(Prescriptions, over the counter, Herbal medication)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Surgeries
(**<u>please list the year</u>**)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Allergies or Sensitivities

_____ _____

_____ _____

_____ _____

List anything you are allergic to and describe how it affects you.

Are you: Single / Married / Separated / Divorced / Widowed

Children: Girls___ Boys___ **Work History:** Are you currently employed? □ Yes □ No □ Homemaker □ Ret □ Disabled

Present type of work/employer: _____

Personal Habits	**Never**	**Sometimes**	**Often**
Regular Exercise (3 to 4x wk)			
Wear Seat Belt			
Brush Teeth (twice daily)			
Sleep Well			
Eat Balanced Meals			
Happy with Life			
Feel Lonely			
Feel Anxious/Nervous			
Use Drugs			
Smoke Cigarettes / Cigars Chew Tobacco		Cigarettes per day _____ How many years_____	
Drink Alcohol		Frequency_____ Quantity_____ Type_____	

Family Medical History

Relative	Age	Health Is Good	Poor	Deceased
Father	____	□	□	□
Mother	____	□	□	□
Brother	____	□	□	□
Sister	____	□	□	□
Spouse	____	□	□	□
Child	____	□	□	□

Cause(s) of Death: _____

_____

_____

If you (P) or a member of your family, Father (F), Mother (M), Grandmother (GM), Grandfather (GF), Brother (B), Sister (S) or Children (C), have had the following illnesses or problems list the appropriate initials:

Allergies _____
Asthma _____
Eczema, Rashes _____
Thyroid Problems _____
Lung Problems _____
Heart Diseases _____
Heart Attack_____
Cholesterol Problem _____
High Blood Pressure _____
Blood Clots_____
Stomach/Intestinal Problems _____
Ulcer_____ Crohn's_____
Liver Diseases _____
Kidney Problems _____
Diabetes _____
Cancer: Breast _____Colon_____
Prostate _____Other_____
Anemia or Blood Diseases _____
Epilepsy _____
Mental Illness _____
Depression _____
Suicide Attempt _____
Alcohol/Drug Problem _____
Arthritis _____
Osteoporosis _____
Stroke_____
Alzheimer's_____
Other

Stonebrook Family Medicine Notice of Privacy Practices

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.

Stonebrook Family Practice respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these
services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:
- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:
- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
- medical quality review by your health plan;
- accounting, legal, risk management, and insurance services;
- audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights
The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:
- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”);
- Request that you be allowed to see and get a copy of your protected health information. You may make
this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact: office manager at (972)-712-1911

Our Responsibilities
We are required to:
- Keep your protected health information private; Give you this Notice; Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our website (www.stonebrookfp.com) to download the most recent copy.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may *contact* office manager at (972)-712-1911. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to office manager at (972)-712-1911. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
- to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
- to public health or legal authorities
- to protect public health and safety
- to prevent or control disease, injury, or disability
- to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information and Additional Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.
- We provide patients the opportunity to communicate with us via electronic means (e-mail, fax, etc.). These communications are not encrypted. If you choose to communicate with us via e-mail please note that we cannot ensure the confidentiality of the information contained in e-mail messages. For example, most employers have access to employee email content so if you use your work email, your employer may be able to read the messages sent to/from our office.

Web Site

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.stonebrookfp.com

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting office manager at (972)-712-1911.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge that I have been offered a copy of the Notice of Privacy Practices. I understand that this notice is also available for my review at www.stonebrookfp.com

_____

Print Patient Name

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

A copy of this form will be retained in your medical record.

Stonebrook Family Medicine
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Frisco, Texas 75034
Phone: (972) 712-1911 Fax: (972) 712-1909

FINANCIAL POLICY

1. We will file insurance for any PPO, HMO, or other managed care plans with which we are under contract. All co-payments and/or deductibles must be paid at the time of service. It is your responsibility to make sure Dr. Mona Chacko is in your provider network and your PCP, if applicable. If we are not on contract with your insurance, payment is due at time of service.

2. Note to divorced parents: Payment is the responsibility of the parent who brings the child into the office for treatment, regardless of the terms outlined in the divorce decree. The divorce decree is a matter between the divorced parents and the courts and we cannot be placed in the middle.

3. There will be a thirty dollar ($30) fee assessed for any returned check
.
4. 24 hour notice is required for canceling an appointment or a $40.00 service fee may apply.

5. Your insurance policy is a contract between you and your insurance company. It is impossible for our office staff to know all the details of each insurance plan. It is important that you know your coverage and your policy provisions. State law requires your insurance carrier to process your claim within 45 days. If they fail to do so, you will be responsible for paying all charges within 45 days from the date of service. I understand that if there are any changes in my insurance coverage, I will notify the business office 2 days prior to my next appointment or the visit will be self-pay or rescheduled.

6. If your account is placed with a collection company for non-payment, there will be a collection service fee added to your account.

7. I understand that it is my responsibility to keep track of my medication supply. I understand that I should request refills during regular office hours and that request received will not be called into the pharmacist until the next business day.

HMO and POS Patients Only

1. **Precertification of Emergency, Hospital Care** - HMO patients with Dr. Chacko as Primary Care Physician. We must be notified within 48 hours of any hospital admission or services that you have received outside of our office. Failure to do so may result in a reduction of benefits. We will not be responsible for any reduction of benefits and we will not retroactively approve any emergency care that we were not notified of within the allotted time frame. _____
2. **Referrals**: One of the physicians at Stonebrook Family Medicine must see all patients whose insurance plan requires a referral to see a specialist. No phone referrals will be given. This is the policy of your insurance plan, not our office. Please allow three days for the referral to be processed by your insurance company. We cannot obtain retroactive referrals from your insurance company. _____

Initial the blanks above indicating you agree to payment and referral policy.

AUTHORIZATION

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to Dr. Chacko. This assignment will remain in effect until revoked by me in writing. A photocopy of this policy will have the same validity as the original.

_____ _____
Patient's signature Date

Records

Release to
Stonebrook Family Medicine

8200 Stonebrook Pkwy #100, Frisco Texas 75034
Phone: 972-712-1911/ Fax: 972-712-1909

Patient Legal Name: _____
FIRST MIDDLE LAST

Address: _____
ADDRESS

_____
CITY STATE ZIP

Date of Birth _____
MONTH DAY YEAR

PREVIOUS PHYSICIAN INFORMATION

_____
FACILITY OR COVERED ENTITY

_____ _____
CITY STATE

_____ _____
PHONE FAX

I hereby give my permission to disclose medical record information and/or protected information of the patient listed above to STONEBROOK FAMILY MEDICINE.

Records Requested:

- ☐ All records
- ☐ Labs, Xrays, and Physicals only
- ☐ Other _____

_____ I acknowledge, and hereby consent to such, that the release information may
INITIAL contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

Expiration: This authorization shall expire on the 180th day after it is signed, unless as provided otherwise upon the expiration date of event given here.

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to Stonebrook Family Medicine receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.

Copy fees/charges will comply with the Texas Health and Safety Code, Chapter 241 and all other laws and regulations applicable to release of information.

I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.
I have read the above and authorize the disclosure of the protected health information as stated.

_____
DATE SIGNATURE RELATIONSHIP TO PATIENT

Stonebrook Family Medicine

8200 Stonebrook Parkway, Suite #100
Frisco, Texas 75034
Phone: (972) 712-1911 Fax: (972) 712-

CONSENT TO RELEASE MEDICAL INFORMATION TO FAMILY

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED IN FULL

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

THE INFORMATION IS TO BE RELEASED TO

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

I, _____, give my permission for Dr. Chacko and staff to release medical information pertaining to my health.

_____ Date _____

Signature of Patient or Representative/Guardian

Stonebrook Family Medicine

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Phone: (972)712-1911 Fax: (972)712-1909

Patient Portal User Agreement

Stonebrook Family Medicine provides this site in partnership with e-MDs® for the exclusive use of its established patients. The patient portal is designed to enhance patient – physician communications. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information.

The information on the patient portal is maintained by Stonebrook Family Medicine. For questions about this site, contact Angie Cannon, office manager at 972-712-1911 or contact@stonebrookfp.com.

The patient portal does provide the following services:

- Medication re-fill request
- Communication of laboratory results from staff to patient
- Review Patient's medical summary, medication list, treatment history and visitation dates
- Schedule request, patient directed scheduling, and waiting list request
- Limited communication regarding on-going treatment.

The patient portal is not intended to provide internet based diagnostic medical services. Also following limitations apply:

- No internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and SEES the doctor.
- No Emergent communications or services. Any emergent conditions should be seen by Urgent Care, Emergency Department, or 911.
- No request for narcotic pain medication will be accepted
- Request for re-fill medication not currently being treated by physician.

The patient portal is provided as a courtesy to our valued patients. While some offices charge for this convenience on an annual basis, we are focused on providing highest level of service and health care. However, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify service offered through the patient portal.

The patient portal is provided in partnership with e-MDs, our EHR software vendor and provider. The data is stored at Stonebrook Family Medicine. The data is on HIPAA compliant VPN with high level encryption, exceeding the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent that it is possible, Stonebrook Family Medicine has undergone rigorous IT implementation and security standards exceeding industry recommendations.
Please read our HIPAA policy for information on how protected health information (PHI) is used at

Stonebrook Family Medicine. All new and established patients have signed HIPAA Acknowledgment Form and have been given a copy of our HIPAA policy. If you do not recall having signed HIPAA Acknowledgment Form, or need to reacquaint with our HIPAA policy a print copy will be provided to you for you review.

Once you have signed the Patient Portal Consent Agreement and have provided Stonebrook Family Medicine with legitimate email address that is secure, you will be given our system generated unique user identification and password. The site may be accessed in two ways:

1. Directly by going to this URL,: https://www.gotomyclinic.com/PublicPortalLive1.4/HomePage.aspx?CID=796
2. Stonebrook Family Medicine website: http://www.stonebrookfp.com and clicking on patient portal log-in tab.

Upon acceptance by our patient portal system, on the email reply, it will contain your unique user id and password along with PDF Patient User Guide. While patient portal is user friendly, limited technical support questions can be directed to contact@stonebrookfp.com.

If you have reasons to believe that breach of HIPAA exists with the patient portal and Stonebrook Family Medicine has not satisfactorily remedied the situation, you may file a complaint to Texas Medical Board at:

Texas Medical Board
P.O. Box 2018
Austin, TX 78768-2018
Phone: 1-800-201-9353 Fax: 1-512-462-9416
verifcic@tmb.state.tx.us

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communications between physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Stonebrook Family Medicine should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered with clarity.

_____

Patient Signature Print Name Date of Birth Date

EMAIL ADDRESS:_____