BROADWAY FAMILY CLINIC

3129 Kingsley Drive
Suite 340
Pearland, Texas 77584

Main: (346) 800 5148
Fax: (346) 800 5169
www.broadwaydoctor.com

Patient Information

Last Name: ________________________________ First: ______________________________ Middle Initial: ______________________

Date of Birth: _____________________ SSN (if applicable): __________________ Gender (circle): **M** **F** Other: ___________________

Contact Number: ________________________ Email: ____

Preferred Method of Communication (circle): **PHONE** **EMAIL**

Address:

____

Street Address Apt/Suite City State Zip Code County

Race (circle): **AMERICAN INDIAN** **ASIAN** **AFRICAN AMERICAN** **PACIFIC ISLANDER** **WHITE** **OTHER:** ___________________

Ethnicity (circle): **HISPANIC** **NON HISPANIC**

Marital Status (circle): **SINGLE** **MARRIED** **DIVORCED** **SEPARATED** **OTHER:** __________________________

TCPA Consent

Telephone Consumer Protection Act of 1991, 47 U.S.C. § 227 ("TCPA" or the "Act") The TCPA was enacted by Congress to combat aggressive telemarketing and fax advertising practices believed to invade consumer privacy. The TCPA also regulates the use of automated equipment to deliver non telemarketing calls or text messages to mobile phones without prior express consent. This means patients must provide express consent to receive general messages and reminders through automated calls and SMS text messages on their mobile device(s). Consent is not required if the call or text is for emergency purposes or if made directly from a doctor, nurse, or other staff member. Please note that you can revoke consent to receive these messages at any time. You are free to opt out of receiving automated phone calls and/or text messages by indicating so below.

☐ **I agree to receive notifications/reminders by phone and/or text message** ☐ **I do NOT agree**

____ _____________________________________

Initial of Patient or Representative Date

Emergency Contact

Full Name: ____ Relationship to patient: ______________________________

Contact Number: ___________________________________ Email:____

Address: ____

Street Address Apt/Suite City State Zip Code County

Preferred Pharmacy

Name of Pharmacy: _______________________ Cross Street: _______________________________________ City: ____________________

Broadway Family Clinic is enrolled in an electronic prescribing program. This program is meant to help our providers understand what medications our patients are currently using to provide the best possible treatment. By signing this consent form you are agreeing that Broadway Family Clinic may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all the above, I hereby provide informed consent to Broadway Family Clinic to enroll me in the ePrescribe program.

Initial: ___________

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Payment & Insurance

Self-Pay (skip the rest of this section) **Insurance** (Present Insurance Card **OR** fill out this section)

Subscriber Information

Subscriber Name: ____Date of Birth: ____________________ Gender (circle): **M** **F**

Address: ____

Street Address Apt/Suite City State Zip Code County

Phone Number: ____ Relationship to Patient: _______________________________________

Name of Insurance: ____Subscriber ID: _______________________ Group ID: ________________

Plan Type (circle): **HMO** **PPO** **Medicare** **Medicaid** **HSA** **EPO** **POS** **OTHER**

Claims Address (usually listed on the back of insurance card): ____

Claims Phone Number: ____ Claims Fax Number: ____

HIPAA Compliance, Notice of Privacy Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we leave a message on your answering machine at home or on your cell phone? YES ☐ NO ☐
May we discuss your medical condition with any member of your family? YES ☐ NO ☐

If YES, please name the members allowed:

Name: ____ DOB: ____________________________ Phone Number: _____________________________

If you are 18 years or older, we will not disclose any information with anyone not listed above.

____ ____

Signature of Patient or Representative Date

Record Release Authorization

Authorization for Use and Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)
Authorization. I authorize you to use and disclose the protected health information described below to a business entity known as Broadway Family Clinic.**Effective Period.** This authorization for release of information covers all past, present, and future periods of healthcare. **Extent of Authorization**. I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.)**Use**. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. **Termination**. This authorization shall be in force and effect until an event described as upon the patient choosing to switch to another primary care provider or notifying Broadway Family Clinic of termination, at which time this authorization form expires. **Revocation Rights**. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.**Benefits.** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.**Disclosure**. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ____

Signature Date

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Consent to Treatment

General Consent to Care or diagnose or Treat: I (We), the undersigned, for myself. legal surrogate, or a minor child of another person for whom I have authority to sign, hereby consent to medical care, diagnose and treatment, as ordered by a provider(s), while such medical care and treatment is provided through "ZN HealthCare Services, PLLC" d.b.a "Broadway Family Clinic" on an outpatient/office/Telehealth visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. I agree and acknowledge that Broadway Family Clinic is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient or of whom I consent. I am aware that the practice of medicine is not an exact science, nor guaranteed and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Broadway Family Clinic facilities. Telemedicine: I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws which can be found on website: www.broadwaydoctor.com. To the Patient: You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing to ZNHealthCare Services, PLLC dba Broadway Family Clinic. You have the right at any time to discontinue services. Signed Consent: I hereby give my consent to treat minor child/children, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Broadway Family Clinic. Any care deemed medically necessary may be provided without my presence: I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ______________________
Signature Date

Patient Fusion® Consent

By agreeing to the following terms and conditions, I acknowledge that I am requesting access to portions of the patient's health information and the ability to communicate with Broadway Family Clinic health care team concerning the patient's health information via the Internet using an electronic application called Patient Fusion®.

- I understand that Patient Fusion® is intended as a secure online source of confidential medical information. I must have internet access and my computer's internet browser must be either Mozilla, Firefox, Safari, or IE 6 or newer.
- I understand that Patient Fusion® is never to be used as a means of communication to Broadway Family Clinic health care providers for urgent or emergency matters. For all matters that I believe might immediately affect the patient's health or well-being, I will dial 911 without delay and/or go to the emergency department of a local hospital.
- I understand that my Broadway Family Clinic health care team may send messages about the patient via Patient Fusion®. These messages may contain information regarding the patient's health and medical care. I understand these messages need to be monitored. I agree not to hold Broadway Family Clinic liable for any loss, injury or claims of any kind resulting from Patient Fusion® messages that are not read or acted upon in a timely manner.
- I have the option of entering a valid and functional email address that may be used to notify me of the presence of Patient Fusion® messages. If I opt to provide this email address for notification of the presence of Patient Fusion® messages, I will update my email address on Patient Fusion® when my email address changes.
- I understand that the anticipated turnaround time for responses to electronic messages is one to three business days.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way. If I share my Patient Fusion® ID and password with another person, that person may be able to view the patient's health information. I agree to hold Broadway Family Clinic harmless for any loss, injury or claims of any kind resulting from my disclosure of the confidential password or confidential information on Patient Fusion®.
- I understand that Patient Fusion® contains selected, limited medical information from a patient's medical record and that Patient Fusion® does not reflect the complete contents of the medical record. I also understand that I may request a paper copy or a summary of the patient's medical record from Broadway Family Clinic.
- I understand that my activities within Patient Fusion® may be tracked by computer audit and that entries I make may become part of the electronic record.
- I understand that my use of Patient Fusion® must be appropriate and may not be used to harass, intimidate, defame, or threaten any individual or entity or for any illegal activity.
- I understand that use of Patient Fusion® is voluntary and I am not required to use Patient Fusion® or to authorize a Patient Fusion® proxy.
- I understand that my proxy access could be revoked at the request of the patient, to the extent legally permissible.

____ ______________________
Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: ______________________ **DATE:** ______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	____ +	____ +	____
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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Record Release Authorization

Effective Date: ________________________________

Authorization for Use and Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

To:

Broadway Family Clinic

3129 Kingsley Dr Suite 340

Pearland, TX 77584

Phone: (346) 800 – 5148 | **Fax:** (346) 800 -5169

1. **Authorization**. I authorize you to use and disclose the protected health information described below to a business entity known as Broadway Family Clinic.
2. **Effective Period**. This authorization for release of information covers all past, present, and future periods of healthcare.
3. **Extent of Authorization**. I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.)
4. **Use**. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. **Termination**. This authorization shall be in force and effect until an event described as upon my choosing to switch to another primary care provider or notifying Broadway Family Clinic of termination, at which time this authorization form expires.
6. **Revocation Rights**. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. **Benefits**. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. **Disclosure**. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient’s Name: ____ Patient’s DOB: ____________________

____ ____________________

Signature Date