Gwendolyn J. Allen MD
Family Practice

REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	Marital status: ❑Single ❑Separated ❑ Married ❑Divorced ❑Widowed

Is this your legal name? ❑ Yes❑ No If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ❑ M❑ F

check all that apply Race: ❑American Indian ❑Asian ❑African American ❑Hawaiian ❑Caucasian/White ❑Hispanic/Latino ❑Other:_______________ ❑Declined	Spoken Language: ❑ English ❑ Spanish ❑ Other:_______________

Email Address:

Street address:	Social Security no.:(Last 4 Only) XXX-XX-	Home phone no.:

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

How did you hear about us?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance? ❑ Yes❑ No

Please indicate primary ins. ❑ BCBS ❑ Aetna ❑ Cigna ❑ Tricare ❑ Humana ❑ Medicare ❑ United Healthcare ❑ CHiP's ❑ Medicaid ❑ Other__________________

Subscriber's name:	Subscriber SS#.:.(Last 4 Only) XXX-XX-	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other (please specify): ___________________

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other (please specify): ___________________

IN CASE OF EMERGENCY

Relation	Name	Home	Cell	Work

The above information is true to the best of my knowledge. I hereby give Gwendolyn J. Allen MD PA and staff permission to examine and treat my medical condition(s). I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance on my account regardless of my insurance status. I also authorize Gwendolyn J. Allen MD PA or insurance company to release any information required to process my claims. I will notify this office of any changes in my personal or insurance information immediately.

Patient/Guardian signature　　　　*Date*

PATIENT AGREEMENT

Payment is due at time services are rendered. By signing and initializing below, you agree to and understand the following policies:

GJAMD Medical Care Agreement

I authorize the physicians of GJAMD to administer medical treatment as deemed necessary. I understand that there will be a charge of $25.00 for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. I understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits otherwise payable to me to Gwendolyn J. Allen MD PA.

____
Initials

Medical Care Agreement

I authorize the physicians of GJAMD to instruct their Physician Assistant and Nurse Practitioner to assist in aspects of my medical care. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner. I acknowledge it is my responsibility to inform the staff of GJAMD if I wish not to see the Physician Assistant/Nurse Practitioner and be scheduled with my physician accordingly. I understand that I may revoke this authorization at any time.

____
Initials

Electronic Communication

By supplying my home/mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information: the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication**. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

____
Initials

GJAMD Laboratory Testing/Bloodwork

I understand that all Labwork is to be ordered by the provider. I also understand that GJAMD uses Laboratory Corporation of America Holdings(LabCorp) to process the specimens they collect. If I or my insurance company prefers another lab, it is my responsibility to inform medical staff member before the specimen is taken so I may obtain my labs at the proper facility.
I understand that lab draws are performed Tuesday and Thursday mornings from 8:00am-9:00am, and that a follow-up appointment will need to be scheduled to discuss the results of these tests.

____
Initials

GJAMD Prescription Refill Policy

I understand that there is a minimum 48-hour turnaround time on prescription refills. I will request medication refills from my pharmacy and check with the pharmacy to see if it has been completed.

I understand that if I have not been seen in the past 6 months, I will need to schedule an appointment for a prescription to be filled.

I understand that antibiotics will not be filled or approved without an appointment with a provider first.

I understand that I am to bring all prescription(s) bottles and over the counter (OTC) supplement bottles (or an updated medication list) with me to each appointment.

I understand that there is a fee for prescriptions that are not filled during an appointment with a provider. I will make every effort to check my medications, diabetic supplies, inhaler, etc. to determine my need for new prescriptions or refills **before my appointment**.

I understand that I will be required to keep regular appointments with my provider for the condition(s) I am being treated for and for the prescriptions that I take, and that I am responsible for making sure that I have enough medication to last until my next scheduled visit with my provider.

____
Initials

Third Party Forms/Applications/Letters

I understand that a fee is assessed for all forms, paperwork or letters and that it may take up to 14 days to complete these items. Fees for completion of all forms/letters etc. are required prior to completion. Fees vary according to the amount and complexity of the paperwork. The staff must review these items prior to making a determination of the fee that will be required.

____
Initials

FMLA (Family Medical Leave) forms

I understand that FMLA forms require an appointment with a provider. Fees for completion of FMLA forms will be required prior to completion and will require 14 days to complete. Fees vary according to the amount and complexity of the paperwork.

____
Initials

Signature:____ Date:________________________

NOTICE OF ASSIGNMENT OF BENEFITS TO A PROVIDER

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian now absolutely provides for the assignment of benefits to Gwendolyn J. Allen, MD, PA, authorizing this transfer of payment from the insured to the healthcare provider, Gwendolyn J. Allen, MD, PA.

I, ____, herby
(print the full name of the undersigned)

absolutely authorize Gwendolyn J. Allen, MD, PA to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurance company(ies) and that payment be sent directly to Gwendolyn J. Allen, MD, PA. I understand that it is the policy of Gwendolyn J. Allen, MD, PA to only bill my insurance company(ies) if they participate in that company's network, and if they do not, it will be my responsibility to bill my insurance company(ies) for reimbursement of my expenses.

I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied Gwendolyn J. Allen, MD, PA with the up-to-date and correct insurance identification card(s) as well as supplied Gwendolyn J. Allen, MD, PA all necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide updates to any of the information supplied within may result in denial of payment(s) to Gwendolyn J. Allen, MD, PA and resubmitted claims with corrected updated information that are still denied due to the fact that corrected information was not supplied in a timely fashion to Gwendolyn J. Allen, MD, PA and I understand that it will be my responsibility to pay Gwendolyn J. Allen, MD, PA for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney for collection or taken to court, I agree to pay any collection fees, reasonable legal fees (25% is deemed reasonable), court cost, and other expenses incurred as a result of said collection or court date, all actions have a venue of Brown County, TX, other venues notwithstanding. Further, I understand that there is a minimum $35.00 for returned checks and a late payment charge not to exceed 1.5% applies to any balance carried forward to next month's bill.

I certify that the information I have reported with regard to my insurance coverage is correct and I hereby authorize Gwendolyn J. Allen, MD, PA, the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

____ ______________________________
Signed (Patient or other Person Authorized to Act for Patient) Date Time

____
Print Name

Witnessed By:

____ ______________________________
Relationship to patient Signed(Witness) Date Time

____ ______________________________
Address Printed Name of Witness

____
City State Zip

Gwendolyn J. Allen MD

Family Practice

CONSENT FOR RELEASE OF INFORMATION

Patient Name:____Date of Birth:____________________

Cell phone#: _________________________ Email:____

Please check the sections that apply then sign at the bottom of the page:

___________ **I do not give GJAMD permission** to release information to anyone other than myself.

Or

___________ **I give GJAMD permission** to release my information that includes:

___________ Entire Medical Record

___________ Blood Tests/ X-rays

___________ Appointment Details

___________ Billing Information

With

___________ My spouse or significant other (Name ____)

___________ Other Family member (Name ____)

___________ On home answering machine or cell phone # _______________________________________

___________ On office/work voice mail# ____

I also give permission to receive all information by mail to address:

____

____

Signature:_________________________________ Date:____________________

(**A signature is required for this form to be considered valid)**

Gwendolyn J. Allen MD

Family Practice

FEMALE HEALTH HISTORY FORM

Date: ________________

Patient Name:____Date of Birth:________________________

Previous Primary Care Physician:____

Other physicians (specialists) involved in you care:____

____

Preferred pharmacy: ____

MEDICAL HISTORY:

Have you been diagnosed with any of the following?

Alcoholism ☐Yes ☐ No

Allergies ☐Yes ☐ No

Anemia ☐Yes ☐ No

Anxiety ☐Yes ☐ No

Arthritis ☐Yes ☐ No

Asthma ☐Yes ☐ No

Back Pain ☐Yes ☐ No

Blood Clots ☐Yes ☐ No

if yes, where?________________________________

Cancer ☐Yes ☐ No

If yes, what type?______________________________

Chrohn's/ulcerative colitis ☐Yes ☐ No

Depression ☐Yes ☐ No

Diabetes ☐Yes ☐ No

If yes, what type? ☐ 1 ☐ 2

Emphysema/Lung disease ☐Yes ☐ No

Endometriosis ☐Yes ☐ No

Eye disease ☐Yes ☐ No

If yes, what type?______________________________

Fractures ☐Yes ☐ No

If yes: where? ______________________________

Gout ☐Yes ☐ No

Migraines ☐Yes ☐ No

Hearing Loss/Ear problems ☐Yes ☐ No

Heart Attack ☐Yes ☐ No

Heart Disease ☐Yes ☐ No

If yes: what type? ________________________

Hepatitis ☐Yes ☐ No

If yes: what type? ☐A ☐ B ☐ C

Hernia ☐Yes ☐ No

If yes: what type?______________________________

High blood pressure ☐Yes ☐ No

High Cholesterol ☐Yes ☐ No

HIV ☐Yes ☐ No

HPV Infection ☐Yes ☐ No

Bladder Incontinence ☐Yes ☐ No

Insomnia ☐Yes ☐ No

Kidney Disease ☐Yes ☐ No

Kidney stones ☐Yes ☐ No

Osteoporosis ☐Yes ☐ No

PCOS ☐Yes ☐ No

Stomach reflux ☐Yes ☐ No

Seizures ☐Yes ☐ No

Sleep apnea ☐Yes ☐ No

STDs ☐Yes ☐ No

Stroke ☐Yes ☐ No

Stomach ulcers ☐Yes ☐ No

Thyroid disease ☐Yes ☐ No

If yes: what type?______________________________

Tuberculosis ☐Yes ☐ No

Urinary tract infections ☐Yes ☐ No

Other medical history? ______________________________

____

SURGICAL HISTORY:

Have you had any of the following? Please indicate year.

Abdominal Surgery ☐Yes ☐ No ______yr.

Appendectomy ☐Yes ☐ No ______yr.

Brain surgery ☐Yes ☐ No ______yr.

Back surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Bladder surgery ☐Yes ☐ No ______yr.

Breast Biopsy ☐Yes ☐ No ______yr.

If yes: location? ☐Right ☐ Left

Breast surgery ☐Yes ☐ No ______yr.

If yes: location? ☐Right ☐ Left

C-Section(s) ☐Yes ☐ No ______yr.

☐Yes ☐ No ______yr.

☐Yes ☐ No ______yr.

Cosmetic surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Eye surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Gallbladder removal ☐Yes ☐ No ______yr.

Heart Surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Hernia repair ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Hysterectomy ☐Yes ☐ No ______yr.

Ovarian cyst removal ☐Yes ☐ No ______yr.

Thyroid surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Tubal Ligation ☐Yes ☐ No ______yr.

Other Surgical History? ______________________________

____

OBSTETRIC/GYNECOLOGIC HISTORY:

Age at first period _______ yrs. Period cycle _______ days

Period duration _______ days

Pattern: ☐Regular ☐ Irregular Flow: ☐ Light ☐ Moderate ☐ Heavy

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times? ________

Full Term: ______ # Ectopic: _____

Preterm: _______ # Multiple (twins, etc.): ____

Miscarriages: _____ # Living Children: ______

Abortions: ______

Did you have any complication during pregnancy and/or delivery?

☐ Yes ☐ No If yes, please explain: ______________________

Are you currently sexually active? ☐ Yes ☐ No

Partner(s): ☐Male ☐ Female ☐ Both

Method of birth control:

☐ None ☐Pill ☐ Patch ☐ IUD ☐ Injection ☐ Implant ☐ Ring

☐ Tubal ligation/sterilization ☐ Diaphragm ☐ Spermicide ☐ Condom

If you are postmenopausal, when was your last normal period: _________

Are you/have you taken hormone replacement? ☐ Yes ☐ No

If yes, for how long?________________________

ALLERGIES:

Are you allergic to any medications? ☐Yes ☐ No
If yes, please list the name(s) and type of reaction

Name	Reaction

MEDICATIONS:

Do you currently take any prescription medications? ☐Yes ☐ No
If yes, please list medication name, strength, dosage, how often and prescriber below.

MEDCIATION NAME	STRENGTH	HOW OFTEN	PRESCRIBER
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	

Do you take any over-the-counter supplements or medicines? (multivitamins, sleep aids, other supplements/medicines)? ☐Yes ☐ No
If yes, please list name of supplement/medicine, amount, how often, and reason for taking below.

NAME OF SUPPLEMENT/MED	AMOUNT EXAMPLE: 500 MG, 1 TABLET	HOW OFTEN	REASON FOR TAKING:

FAMILY HISTORY:

☐Adopted/ ☐Unknown – Please complete Your Child(ren) information, if applicable, and continue to next section.

Family Member:	Name	Living?	Current Age/ Age at Death	If Deceased Cause of Death	High Blood Pressure	Heart Attack	Heart Disease	Stroke	Diabetes	Breast Cancer	Colon Cancer	Prostate Cancer	Other Cancer	Alcoholism	Allergies	Anemia	Arthritis	Asthma	Birth Defects	Blood Clotting Problem	Colitis	Seizures/Epilepsy	Genetic Disease	Glaucoma	Gout	Kidney Disease	Mental Illness	Migraines	Osteoporosis	Thyroid Disease	Tuberculosis	Ulcer	Other
Your Mother:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Mother's Mother:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Mother's Father:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Father:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Father's Mother:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Father's Father:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Brother(s):					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Your Sister(s):					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Your Child(ren):					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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SOCIAL HISTORY:

Marital status: ☐Single ☐Separated ☐ Married ☐Divorced ☐Widowed
Occupation: ______________________________________
Do you currently use tobacco products? ☐ Yes ☐ No
Go To **
Have you EVER used tobacco products? ☐ Yes ☐ No
If Yes, when did you quit? (month/year) ___________
**Type: ☐ Cigarette ☐ Cigar ☐ Hookah ☐ Chew/Dip ☐ Pipe
☐ E-cig/Vape
Packs per day: _____ for how many years? ______ Yrs.
Does anyone in your home smoke? ☐ Yes ☐ No

Alcohol use ☐ Yes ☐ No
If yes: # drinks _____ per ☐day ☐week ☐month ☐year ☐rarely
Type of alcohol __________________________________
Are other concerned by your drinking ☐ Yes ☐ No
Street Drug use ☐ Yes ☐ No
If yes: type(s) _____________________________
Do you exercise? ☐ Yes ☐ No
How Often? __________times per week
Type of exercise ___________________________

HEALTH MAINTENANCE:

If you have had any of the following, please specify date last performed:

Pap smear ☐Never _____/ _____/ _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

When: _____/ _____/ _____

How was it treated?____________________________

Mammogram _____/ _____/ _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

If yes, how long ago? ____

Colonoscopy ☐Never _____/ _____/ _____

Result: ☐ Normal ☐ Polyps ☐ Diverticula

☐ Hemorrhoids ☐ Other: ___________________

Bone density scan ☐Never _____/ _____/ _____

Result: ☐ Normal ☐ Osteopenia ☐ ☐ Osteoporosis

CT for lung cancer screening ☐Never _____/ _____/ _____

Dental Exam ☐Never _____/ _____/ _____

Eye Exam ☐Never _____/ _____/ _____

Tetanus Shot ☐Never _____/ _____/ _____

HPV series (3) ☐Never _____/ _____/ _____

Flu Shot ☐Never _____/ _____/ _____

Pneumonia Shot

Pneumovax ☐Never _____/ _____/ _____

Prevnar 13 ☐Never _____/ _____/ _____

Shingles vaccine ☐Never _____/ _____/ _____

Hepatitis A vaccine ☐Never _____/ _____/ _____

Hepatitis B vaccine series ☐Never _____/ _____/ _____

Meningitis vaccine ☐Never _____/ _____/ _____

MMR (measles, mumps, rubella) ☐Never _____/ _____/ _____

Varicella vaccine ☐Never _____/ _____/ _____

Gwendolyn J. Allen MD

Family Practice

ALLERGY SURVEY

Name: ______________________ **Age:** __________ **Date:** ______________

Do you experience any of the following? Check the box that best describes your answer.

		Never	Rarely	Sometimes	Often	Always
1.	Sneezing	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2.	Stuffy Nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3.	Runny Nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4.	Itchy Nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5.	Water Eyes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6.	Burning Eyes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7.	Itchy Eyes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8.	Itchy Ears	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9.	Ringing in the Ears	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10.	Post Nasal Drip	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11.	Hoarseness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12.	Headaches	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13.	Hives/Welts	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
14.	Rashes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15.	Cough	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
16.	Fatigue/Tiredness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17.	Wheezing	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18.	Asthma	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19.	Sinus Infections	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20.	Bronchitis	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
21.	Other:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
	Total Score:					

If you scored more than 5 points, you may benefit from being tested for allergies. We will be happy to discuss this with you during your appointment today!

1. **Have you taken any allergy or cold medicines over the past 5-7 days? ☐ Yes ☐ No**
   If yes, which ones? ______________________________
2. **Do you take medicines for blood pressure or your heart? ☐ Yes ☐ No**
   If yes, which ones? ______________________________
3. **List any other medications (prescription or OTC) you have taken over the past week:** ______________________________

For office use, only

Gwendolyn J. Allen MD
Family Practice
1604 14TH St.
Brownwood, TX 76801-5314
(325)646-5296 Fax (325) 646-5820

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:______________________________ Date of Birth ______________

Address: ______________________________

City State Zip code: ______________________________

SS#:______________________________ Patient Phone #:______________

Date of Request ______________ **Date Needed**:______________

I authorize Gwendolyn J. Allen MD to obtain protected health information from:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone # Fax #

Reason for Disclosure:
☐ Treatment/Continuing Care
☐ Insurance Coverage
☐ Personal
☐ Other ______________
☐ Transfer of Care
☐ Billing or Claims
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment

What information may be disclosed? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is REQUIRED for the release of some of these items *. If all health information is to be released, then check only the first box.

☐ **All Health Information** * ☐ History/Physical Exam * ☐ Past/Present Medications * ☐ Lab Results *
☐ Physician's Orders * ☐ Patient Allergies ☐ Operation Reports * ☐ Consultation Reports *
☐ Progress Notes * ☐ Discharge Summary * ☐ Diagnostic Test Reports * ☐ EKG/Cardiology Reports
☐ Pathology Reports * ☐ Billing Information * ☐ Radiology Reports & Images * ☐ Other ______________
☐ Mental Health Records (excluding psychotherapy notes) * ☐ Genetic Information (including Genetic Test Results) *
☐ Drug, Alcohol, or Substance Abuse Records * ☐ HIV/AIDS Test Results/Treatments *

DATES REQUESTED: ☐ ALL ☐ LAST 2 YEARS ONLY ☐ FROM ________ TO _______

Effective Time Period. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): ______________

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Gwendolyn J. Allen MD. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to the use and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by the Texas Health & Safety Code § 181.154(c) and /or §164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by recipient and may no longer be protected by federal or state privacy laws.

X______________________________ ______________
Signature of Individual or Individual's Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if Applicable) ______________________________
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ POA (Attach Legal Document) ☐ Other

A Minor individual's signature is required for the release of certain types of information. (i.e. reproductive care, sexually transmitted diseases, drug and alcohol abuse, and mental health treatment) See Texas Family Code §32.003.

X______________________________ ______________
Signature of Minor Individual Date

Gwendolyn J. Allen MD
Family Practice

ELECTRONIC PRESCIRPTION CONSENT

I voluntarily consent to provide Gwendolyn J Allen MD PA access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Gwendolyn J Allen MD PA may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this **Prescription History Consent** will be valid and remain in effect as long as I attend or receive services from Gwendolyn J Allen MD PA, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I CERTIFY THAT I HAVE READ THIS FORM OR IT HAS BEEN READ TO ME. DATE: ____________________

Print Name (Patient):____ **DOB: _______________**

Signature of Patient/Legally Authorized Representative:

____

Relationship to Patient (if Patient not signing):

____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

READER/TRANSLATOR SIGNATURE:______________________ **DATE: ____________________**

GWENDOLYN J. ALLEN, MD, PA
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.

EFFECTIVE 9/20/2013

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 GWENDOLYN J. ALLEN, MD, 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.

H. 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.

I. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, but not limited to, contacting you by phone and leaving a message on an answering machine, email communication, or website portals) 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.

J. 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.

K. 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.

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

M. 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.

N. 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.

O. 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.”

P. 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.

Q. 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.

R. 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.

S. <u>Health Oversight Activities</u>. 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.

T. <u>Legal Matters</u>. 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.

U. <u>Law Enforcement, National Security and Intelligence Activities</u>. 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.

V. <u>Coroners, Medical Examiners and Funeral Home Directors</u>. 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.

W. <u>Inmates</u>. 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.

X. <u>Marketing of Related Health Services</u>. 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.

Y. <u>Fundraising</u>. 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.

Z. <u>Electronic Disclosures of Medical Information</u>. 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:

Gwendolyn J. Allen, MD, PA
Attn: HIPAA Officer
1604 14th St.
Brownwood, TX 76801
325-646-5296

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:_______________

Gwendolyn J Allen MD Controlled Prescription Contract

Name DOB:

The purpose of this contract is to protect your access to controlled substances and to protect our ability to prescribe them to you.
The long-term use of such substances as opioids, benzodiazepines, stimulants, muscle relaxers and sleeping agents is controversial because it is not certain whether they help patients over the long term. Patients who are prescribed these drugs have the risk of developing an addictive disorder or suffering a relapse of a prior addiction. The extent of this risk is uncertain.
This includes, but is not limited to:

- **Opioids** - Vicodin Lortab, Percocet/Percodan, and OxyContin, Morphine, Duragesic, Ultram, Tussionex, Esgic-Plus, Fioricet, Tylenol 3
- **Muscle Relaxer** - Soma
- **Nonbenodiazepines** – Ambien (Zolpidem), Sonata (Zaleplon), Lunesta (Eszopiclone)
- **Benzodiazepines**- Klonopin (Clonazepam), Xanax (Alprazolam), Restoril(temazepam), Ativan(Lorazepam)

Because these drugs are of an abusive nature, it is necessary for us to observe strict rules when they are prescribed. For this reason, we require each patient who may receive a prescription for any of these medications to read and agree to the following policies:
Please initial beside each of the following polices:

_____1. All controlled substances must be prescribed by Dr. Allen. If I obtain medications from another individual, or use non-prescription illegal drugs, it will be reported to other physicians, pharmacies, medical facilities and the appropriate authorities.
If arrested or detained for any action related to intoxication, I understand that my prescription will be cancelled.

_____2. I will not allow anyone else to have, use or otherwise have access to these medications. I will keep them out of reach children.

_____3. I will inform the physician of any current, past or future personal or family member substance abuse, or current, past or future substance abuse of any member of my family.

_____4. **I will obtain all prescriptions from the same pharmacy. Should the need arise to change pharmacies; I will inform this office in advance. The pharmacy I am selecting is:**
Pharmacy Name: ____
Pharmacy Location: ____ **(ie: CVS, Brownwood, Austin Ave)**
____
Pharmacy Phone: ____

_____5. I agree that Dr. Allen has permission to discuss all necessary details with the pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

_____6. **I will take my medication as prescribed and follow the dosing instructions.** Violation of this **will result in my dismissal from the practice**.

_____7. I agree to comply with possible urine drug testing and / or pill counts at any time. This is to document the proper usage of my medications.

_____8. I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen, or if "I run out early", I understand that this medication **will not be replaced** regardless of the circumstances. **Refills of controlled substance medications: Will be made only during regular office hours, in person, once a month and during a scheduled office visit. Refills will not be made at night, weekends or during holidays.**

_____9. I am aware that attempting to obtain a controlled substance under false pretenses is illegal, and I will be terminated from treatment.

_____10. I understand that if I violate this controlled substance contract by failing to adhere to the above conditions, my prescriptions may be terminated immediately.

If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substances administration.

I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accept of these terms.
It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your condition.

Patient Signature: ____ Date: ______________________

Physician Signature: ____ Date: ______________________

Gwendolyn J. Allen MD

Family Practice

Chronic Care Management Consent Form

I agree to allow Gwendolyn J Allen MD PA to provide me with Chronic Care Management (CCM) services and to be designated my CCM provider. I also understand that other physicians may from time to time provide CCM services to me under this consent.

I understand that these services will include:

- Consultation and guidance in managing my chronic conditions so I can be as healthy as possible
- Reviewing my medications and any questions that I have
- Help with scheduling office visits and tests that my doctor ordered
- Receiving a plan of care with personal health goals
- Sharing of my care plan with other doctors that I see and the staff who are helping with my care
- Working closely with home health and other healthcare resources in my area

I understand that other doctors that I see will receive my medical information electronically through a computer system.

I understand that only one doctor can provide CCM services for me each month and that I may have to pay a monthly co-payment charge.

I understand that I can stop CCM services at the end of any month by contacting the doctor's office through telephone or the patient portal. If I decide to stop these services, I understand that I will no longer receive chronic care management from this doctor's office but this will not have any effect on my usual primary care services.

Patient or guardian signature ____

Printed name ______________________________ Date ____________

Texas Department of State Health Services

ImmTrac2 Immunization Registry
AUTHORIZATION TO RELEASE OFFICIAL IMMUNIZATION HISTORY

(Please print clearly)

Client's Name: ____________________ ____________________ ____________________
Last First Middle

Client's Date of Birth: _____/_____/_____ Client's Gender: ☐ Male ☐ Female

Address: ____________________ ____________________ ______ ______
Street City State Zip

Please indicate how and where to send this official immunization record.

Name / Organization: ____________________

Address: ____________________ ____________________ ______ ______
Street City State Zip

Phone Number: (______) ____________

Send official immunization record by: ☐ Walk-in / In person ☐ Mail to address above
☐ Fax Number: (______) ____________

Requestor Information – must complete in entirety

I, ____, authorize the Texas
Print Name of Client (or Parent, Legal Guardian, Managing Conservator for a child)
Department of State Health Services to release this client's official immunization record from the Texas Immunization Registry (ImmTrac).

Address: ____________________ ____________________ ______ ______
Street City State Zip

E-mail address (if available): ____________________ Phone Number: (______) ____________

____ ____________
Signature of Client (or Parent, Legal Guardian, or Managing Conservator for a child): Date:

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

For Office Use Only

Date Searched / Released: ____________ ☐ Record Released ☐ Record Not Found

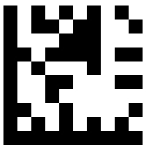
By: ____________________ ☐ Record Found, but No Immunizations Reported

If you have any questions or concerns please contact the Texas Department of State Health Services (ImmTrac Group) at (800)2529152 or via e-mail at ImmTrac@dshs.state.tx.us.

Mail To: Texas Department of State Health Services ImmTrac Group
MC-1946
P.O. Box 149347
Austin, TX 78714-9347

Fax to: ☐ (512) 776-7790
☐ (512) 776-7288

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM



(Please print clearly)

First Name ______ Middle Name ______ Last Name ______

Date of Birth (mm/dd/yyyy) ______ Telephone ( ) ______ Email address ______ Gender: ☐ Female ☐ Male

Address ______ Apartment # / Building # ______

City ______ State ______ Zip Code ______ County ______

Mother's First Name ______ Mother's Maiden Name ______

The Texas Immunization Registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): ______ Printed Name

______ Date ______ Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group • MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**