NEW PATIENT COVID HISTORY FORM

PATIENT INFORMATION:

Name: _____ DOB _____/_____/_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____

Is patient a minor _____Y _____N If so, name of responsible party:_____

Pharmacy: _____ Phone#:_____ Fax#:_____

Referred by:_____

What is the reason for your visit?_____

Have you had a COVID Test? Yes_____ No_____ If so, was result Positive_____ Negative_____

Date of Onset of symptoms: ____/____/____ Date of Test: ____/____/_____ Date of Results: _____/____/_____

Do you know your Oxygen Saturation Level? If so, what is your level? _____

SYMPTOMS: Have you had any of the following?

- Sore throat: Yes: ____ No: ____
- Sinus or nasal symptoms: Yes: ____ No: ____
- Chills: Yes: ____ No: ____
- Sweats: Yes: ____ No: ____
- Cough: Yes: ____ No: ____
- Shortness of breath: Yes: ____ No: ____
- Fatigue/Exhaustion: Yes: ____ No: ____
- Loss of Taste or Smell: Yes: ____ No: ____
- Body aches: Yes: ____ No: ____
- Diarrhea: Yes: ____ No: ____
- Fever: Yes: _____ No: _____ If so, temp.: _____ Date of onset: _____ Date of last fever: _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

_____None

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. 10.

ALLERGIES: (to medications, antibiotics) NKDA_____

Substance & Reaction:_____ Substance & Reaction:_____

Substance & Reaction:_____ Substance & Reaction:_____

_____

History of Pneumonia: Yes: ____ No: ____, if yes, date of onset: _____

History of Asthma: Yes: ____ No: ____

CARDIOVASCULAR HISTORY:

_____High blood pressure _____Diabetes

_____Low blood pressure _____Dizzy spells _____Hx of Heart Rhythm Disturbance

_____Racing heart or irregular heartbeat _____Heart murmur _____Hx of any known heart disease

_____Chest pain

_____ _____

Patient or Responsible Party Signature Date

PRIVACY

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on **April 14, 2003.**

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____ _____
Print Name Signature Date

WHO MAY WE SPEAK TO REGARDING YOUR HEALTHCARE?

_____ Speak only to me
_____ Permission to speak with spouse
_____ Permission to speak with my parent's
_____ Permission to leave voice message
_____ Permission to leave message on answering machine
_____ Permission to speak with other (please specify, grandparent, other relative) _____

_____ _____ _____
Print Name Signature Date

RELEASE OF MEDICAL RECORDS:

Your insurance company may request additional information so that your claim may be processed. We will need your signature to authorize us to send any additional information they may need to process your claim. If you choose not to sign, your claim may not be able to be processed efficiently, therefore delaying or possibly denying any reimbursement due to you.

_____ _____
Signature Date

ATTENTION MEDICARE PATIENTS!!!!!

IF YOU HAVE MEDICARE YOU MUST SIGN THIS FORM IN ORDER TO BE SEEN AT OUR OFFICE

This agreement is between Dr. Howard J. Lang, and Dr. Derek H. Lang, whose principal place of business is 789 Lonesome Dove Trail, Hurst, Texas, and (patient) _____, who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has **opted out of the Medicare program** originally effective on November 4, 2004. Physician opts out every two years.

Physician agrees to provide medical services to Patient.

In exchange for the Services, the Patient agrees to make payments to the Physician pursuant to the Fee Schedule upon completion of services provided. Patient also agrees, understands, and expressly acknowledges the following:

- Patient agrees **not to submit a claim** (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that the Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him/her.

Executed on_____, by_____and Dr. Lang, D.O.
Date Patient

Howard J. Lang, D.O.
Derek H. Lang, D.O.

_____ _____
Patient signature Physician signature

WE ARE NOT PROVIDERS WITH ANY INSURANCE GROUP

PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME TREATMENT IS RENDERED.

FOR YOUR CONVENIENCE, WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER & HEALTH SAVINGS ACCOUNT CARDS.

IF YOU HAVE MEDICAL INSURANCE THAT YOU WOULD LIKE TO FILE, YOU WILL BE GIVEN A RECEIPT UPON CHECKING OUT THAT WILL ENABLE YOU TO FILE YOUR CLAIM WITH EASE.

PLEASE REMEMBER THAT YOUR INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR PAYMENT OF ALL CHARGES AT THE TIME OF SERVICE.

PLEASE DON'T HESITATE TO ASK ANY OF OUR STAFF FURTHER QUESTIONS THAT YOU MAY HAVE. CINDY, OUR OFFICE MANAGER, IS ALSO AVAILABLE TO ASSIST YOU WITH ANY QUESTIONS OR CONCERNS YOU MAY HAVE.

Thank you,

Dr. Howard J. Lang, D.O.
Dr. Derek H. Lang, D.O.

I understand that my signature represents that I have read and understand the above policies. I agree to make payment in full at the time of my office visit(s).

_____ _____
PATIENT SIGNATURE **DATE**