Stefanie McCain, MD
#19 Hospital Drive
Abilene, Texas 79606
Ph: 325-690-0620 Fax: 325-690-0622

# PATIENT INFORMATION FORM

Please provide the following information and answer the questions below. Please note: information you provide her is protected as confidential information.

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

Social Security Number: _____

Sex: Male or Female Date of Birth: _____

Marital Status: (Circle One) Single Married Partner_____ Divorced Widowed

Height: _____ Weight: _____

Address: _____
(Street Address)

_____
City State Zip

Home Phone: (_____)_____ May we leave a Message? Yes or No

Cell Phone: (_____)_____ May we text you? Yes or No

Work Phone: (_____)_____ May we call you at Work? Yes or No

Email Address: _____

**Emergency Contact**

Name: _____ Emergency Phone Number:(____)_____

Relation: _____

Primary Care Physician: _____

Phone Number: (____)_____ Fax : (____)_____

Referred By (if any): _____

How did you hear about us? _____

**Health Insurance Information (Primary Carrier)**

Insured's Name: _____

Insured's Date of Birth: _____

Insured's Social Security Number: _____

ID Number: _____ Group Number: _____

Insurance Company: _____

Insurance Company Address: _____

City, State, and Zip: _____

Insured's Employer:_____

**Secondary Insurance**

Insured's Name: _____

Insured's Date of Birth: _____

Insured's Social Security Number: _____

ID Number: _____ Group Number: _____

Insurance Company: _____

Insurance Company Address: _____

City, State, and Zip: _____

Insured's Employer:_____

**** A copy of your insurance card or cards is required**

Please list all past medical history: _____

_____

_____

Please list first-degree family past medical history: _____

_____

_____

Please list past surgical history: _____

_____

_____

_____

Please list medications and dosages you are currently taking: _____

_____

_____

_____

Please list any allergies: _____

Please list hormones you are currently taking or have previously taken: _____

_____

What are you currently using for birth control? (Please circle)

| | | |
|---|---|---|
| Birth Control Pill | Tubal Ligation | Menopause |
| Abstinence | Vasectomy | Other: _____ |
| IUD | Hysterectomy | |

Are you or your partner currently trying to get pregnant? Yes or No

Are you a current smoker? Yes or NO

Do you use Alcohol? Yes or No

Do you exercise regularly? Yes or NO

Stefanie McCain, M.D.
HIPPA FORM

Dear Patient:

Physicians have always protected the confidentiality of our patient's health information by securing medical records away from open access and refusing to reveal information. Additionally, State and Federal laws set security standards to ensure the confidentiality of this sensitive information.

The Federal government published regulations designed to protect the privacy of your health information. The "Privacy Rule" protects health information that is maintained by hospitals, health care providers and health plans. Physicians, as of April 13, 2003, must comply with the federal government's regulations privacy rule's standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription, or send a claim your healthcare provider will need to comply with the privacy rules. All health information including paper, oral or electronic are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions. We also take precautions in our office to safeguard your health information, such as training our employees and employing computer security measures.

In the reception room we have placed copies of our NOTICE OF PRIVACY PRACTICES. This notice contains very important information about how you can exercise your rights with regard to your protected health information. We request that you take the time to review the privacy practices of the office before you see the medical providers.

You may request, from the receptionist, a copy of the NOTICE OF PRIVACY PRACTICES to take with you for further review. Federal regulations require that we document that the patient has been advised of our privacy practices and offered a copy of the notice. Additionally, we must receive documentation of the patient's authorization for communication. We require that you complete the attached form to serve as the formal documentation for both the notice and consent for communication. If you have any questions regarding our privacy practices you may schedule a meeting with the privacy officer for further details and review.

Thank you for your patience and assistance.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the document.

Furthermore, **by my specific initials**, I authorize my physician and his/her staff, to contact me by the designated means noted below.

_____home phone/answering machine/voice mail _____office/workplace/voicemail

_____cell phone / text (standard text messaging costs from your carrier may apply _____fax

I authorize my physician and her staff to communicate information regarding my appointment, medical results, and billing issues to:

_____spouse_____ _____other_____

_____other_____ _____other_____

This Authorization shall remain in force until revoked in writing, attention of Privacy Officer.

_____
Signature of Patient or Personal Representative

_____
Printed Name Date

**Check In**

- Your time is important to us. The first step in keeping your appointment on time is being prepared. This includes filling out all required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Questionnaire. This will avoid delays in creating your chart and account at your visit. Please arrive at least 15 minutes prior to your scheduled time so that all paperwork may be completed BEFORE you are scheduled to see the provider.
-

**Nurse Practitioner**

- Dr. McCain has a Nurse Practitioner on staff to assist in the delivery of medical care. Stacy Hammond, FNP-C, is an advanced practice nurse who has completed a graduate level education and training in the diagnosis and management of medical conditions. She has been employed with Dr. McCain over 10 years. New patients will see Stacy for their first visit.

**Missed Appointments, Late Cancellations, Late Arrivals, and Non-Compliance**

- We require a 24 hour advance notice if you must cancel your appointment. We offer appointment reminder calls prior to your appointment which will allow you to cancel at that time. However, it is ultimately your responsibility to keep track of your appointment whether you receive a reminder call or not.
- Patients with multiple cancellations or missed appointments may be discharged from our practice.
- At times, a surgery may take longer than anticipated or a patient has been worked in for an emergency which may cause our providers to run late. You won't be rushed when you see the doctor and your patience is appreciated if we are running behind.
- Please note that noncompliance with treatment plants (including medications and / or lab work) and abusive / inappropriate behavior towards staff and / or patients will result in immediate dismissal of your care from our practice.

**Forms of Payment**

* We accept payment in the form of cash, check MasterCard, Visa, Discover.
  Checks returned to us due to insufficient funds are processed by Instacheck. In addition to charges assessed by Instacheck, we will assess a $30.00 fee for all returned checks.

**Collection Fees**

- We will send you three statements regarding your balance. The second statement is considered past due. If you should receive a third statement noted "Final", the account balance will be turned over to a collection agency. If your account is turned over to a collection agency, you will be discharged from the practice.

I have read, understand and agree to the above office and financial policies of Dr. Stefanie McCain. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing by signing this statement. My signature below states my agreement and understanding of Dr. Stefanie McCain's office and financial policies and also serves as a request and consent for treatment. I authorize and assign all benefit payments to be made directly to Dr. Stefanie McCain.

Signature of Patient/Legal Representative:_____ Date__/__/____

Name of Patient/Legal Representative:_____

Stefanie McCain, M.D.
Stacy D. Hammond, FNP-C
19 Hospital Drive
Abilene, TX 79606
Office: 325-690-0620 Fax: 325-690-0622

## Authorization to Release Medical Information

I understand that I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the office. Unless revoked, this authorization will expire in 180 days from the date signed.

I also understand that once the health information I have authorized to be disclosed reaches the noted recipient, the person or organization may re-disclose it. At this time it may no longer be protected under privacy laws. Records received by this office will not be re-disclosed without written authorization by the patient.

**Please release my healthcare information to/from:**

Stefanie McCain, M.D.
Stacy D. Hammond, FNP-C
19 Hospital Dr.
Abilene, TX 79606
Office: 325-690-0620
Fax: 325-690-0622

**Please release my healthcare to/from:**

_____
_____
_____
_____
_____

**Information to be released:**

| | | |
|---|---|---|
| Lab Result__ | Pap Smear__ | Radiology Services__ |
| Op Reports__ | Entire Records__ | History and Physical only__ |
| Discharge summary__ | HIV test__ | Other_____ |

**Purpose of disclosure:**

Personal use: ____ Transfer of Care: ____ other: _____

**Patient Authorization:**

I understand that the information in my health records may include information relating to sexually transmitted diseases, AIDS, and HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Treatment and payment may not be conditioned upon authorization. There may be a charge for copying records. **Initial**_____

**Signature:** _____ **Date**_____
**Signature of parent/guardian if needed:** _____
**Printed Name**_____ **SSN:**_____
**DOB:**_____ **Maiden or other Name:**_____