IBN Sina Foundation

11226 South Wilcrest Dr., Houston, TX 77099
Main Tel: 281.977.7462
Fax: 281.977.7472

PATIENT INFORMATION /INFORMACION DEL PACIENTE

Date /Fecha: _____

Name /Nombre: _____ Age/ Edad: _____
Last/Apellido Name/ Nombre Middle Ini/ Inicial

Address/ Dirección: _____
Street/Calle City/Ciudad State/Estado Código Postal

Date Of. Birth/ Fecha de Nacimiento: _____ _Male _Female Marital Status: ____ Race: _____
Mas. Fem Estatus Matrimonial Raza

Home Phone Number/ Numero de Tel.: _____ Driver's license#: _____
Numero de Licencia

Cell Phone/ Numero de celular: _____ Occupation: _____ E-mail: _____
Ocupación El correo electrónico

Employer/ Empleador: _____ Work Number/ Numero de trabajo: _____

Name of Spouse or Parent/ Nombre de Pareja/Padre: _____

Emergency Contact/ Contacto de Emergencia: _____
Complete Name/ Nombre Completo Phone Number/ Numero de Tel.

Have you had any serious illness in the past? _ Yes/ Sí _ No Describe /Descripción: _____
¿En el pasado ha tenido enfermedades serias?

Have you had any surgeries in the past? _Yes/ Si _ No Describe/Descripción: _____
¿En el pasado ha tenido cirugías?

Indicate all medications that you are currently taking: _____
Indique todo los medicamentos que esta tomando

Indicate all medications that you are allergic to: _____
Indique los medicamentos a los que Ud. es alérgico/a

Do you smoke?/ ¿Fuma? _ Yes/ Si _ No If yes, how much?/ Y si fuma, cuanto? _____

Do you drink Alcohol?/ ¿Toma bebidas alcohólicas? _ Yes/ Si _ No Y si toma, cuanto? _____

Do you take any blood thinner medications?/ ¿Toma alguna medicación sanguíenos más delgados? _____

Breifly state the reason for your visit to the doctor today: _____
Brevemente explique el motivo de su visita

How did you hear of IBN Sina?/ ¿Cómo escucho de IBN Sina? _____

I authorize IBN Sina to provide me with treatment. I also agree to be responsible for all unpaid bills.
Yo autorizo IBN Sina que me dé tratamiento. Al igual me hago cargo de todos los pagos necesarios para mis tratamientos.

Financial Policy /Póliza Financiera

Please understand that payment is considered part of your treatment. Por favor entienda que su pago es considerado parte de su tratamiento

WE ACCEPT CASH AND MAJOR CREDIT CARDS. ACEPTAMOS EN EFECTIVO Y TARJETAS DE CREDITO MAYORES .
PAGO COMPLETO ES REQUIRIDO ANTES DE LOS SERVICIOS.

Ihave read and understand the financial policy. By signing the line below I take responsibility and accept the terms and conditions described in this form.
Yo e leído y entiendo la póliza financiera. Firmando la línea abajo, me hago responsable y acepto los términos de escribidos en esta forma.

_____
Patient's signature/Parent/Guardian Firma del Paciente/Padre/Tutor

Ibn Sina Foundation

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Ibn Sina Foundation may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Ibn Sina Foundation has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Ibn Sina Foundation will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Ibn Sina Foundation to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Ibn Sina Foundation has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting our Administrative Office: Ibn Sina Foundation, 11226 S. Wilcrest Dr. Houston, TX. 77099 or by phone at 281-977-7462.

FORM Us

IBN SINA Community Health Center

CONSENT FOR TREATMENT BY AN ADULT

Name of Patient:_____ **Date of Birth:** _____

I hereby and voluntarily consent to authorize the medical and dental staff, if available at the Clinic at this service location to provide health care services to me. The health care services may include routine physical and mental assessment, diagnostic and monitoring test and procedure, examinations and medical and/or dental treatment, if available. The health care services may include, but are not limited to, routine laboratory work, such as blood, urine and other studies, x-rays and other imaging studies, heart tracing (EKG), administration of medication, as well as procedures and treatment prescribed by the medical and/or dental staff. The health care services also may include counseling services necessary to receive appropriate services including family planning services as defined by federal regulation.

I certify that I fully understand this consent for treatment, use of midlevel providers, release of personal health information and my rights concerning these issues.

I understand that this consent is valid and remains in effect as long as I am a patient of the Clinic.

I have been given an opportunity to ask question about the services to be provided by this Clinic and I believe that I have sufficient information to give this consent.

_____ _____

Signature Patient Date

ALTERNATIVE CONTACTS AUTHORIZATION

This authorization allows our Physicians and staff to communicate only with the individual(s) you designate in the event you are not able to receive phone calls or you have an adult/guardian that helps coordinate and or pay for medical care. As a part of our patient privacy policy we will give your health information only as specified below.

- I do not authorize any one to receive information regarding my Medical Care
- I authorize my physician and the employees of this pracice to with and communicate information regarding my medical

1) Person _____ Relation _____ Phone # _____

This authorization will remain in effect unless I change it. When I am a patient of this practice it is my responsibility to complete a new form notifying any changes I will also give the practice written notice should I decide to revoke this authorization.

Signature: _____ Date: _____

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11246 South Wilcrest Drive, Suite 190B, Houston, TX 77099
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Fax: 281.495.7464

CONSENT FOR MEDICAL TREATMENT/ADMISSION TO HOSPITAL OR OUTPATIENT AREAS

Patient: _____

Consent to Treatment by Trainees

I understand that the Ibn Sina Community Medical Center is an educational institution. I realize that among those who attend patients at The Ibn Sina Community Medical Center are medical, nursing, and other health care personnel in training, ranging from first year students to medical residents and fellows. These trainees may be present during my care and may help provide that care under appropriate supervision, unless ordered otherwise by the responsible physician. Trainees also may discuss patient cases in educational teaching conferences. Trainees are required to comply with The Ibn Sina Community Medical Center Clininc's policy protecting patient confidentiality.

Consent for HIV Testing

Acquired Immune Deficiency Syndrome (AIDS) is a vial illness caused by the Human Immunodeficiency Virus (HIV) and is spread by contact with the blood or body fluid of an infected parson. As part of my hospital treatment, it may be requested that I be tested to determine if I have/had previous contact with the HIV virus. This might be done as part of a diagnostic test or for hospital infection control reasons. The test for AIDS is done on a blood specimen that will be drawn along with blood for other tests. The test sometimes gives a false positive result (the test is positive without the AIDS virus being present). Therefore, a second test is done on all positive results. It is possible in the very early stage of illness (the first few weeks after contact with an infected person) that the test cold be negative even though active infection is present. Especially for people in high-risk groups or for their intimate contacts, a single negative test cannot establish with certainty that infection is not present.

Signature: _____ Date: _____

Consent for Electronic Communication

I authorize Ibn Sina Foundation to use my Email address for direct e-mail marketing purposes and patients services. I am willing to receive coupons, special promotions, and Health Fair information, discounted or free medical and dental programs, new or updated services, patient newsletters and appointment reminders via email. I also understand that this disclosure will exclusively be used by Ibn Sina Foundation.

I understand that I am under no obligation to sign this form and that Ibn Sina may not condition my treatment or payment eligibility for health care services based on my decision to sign this authorization.

I understand that I may revoke this consent at any time by notifying Ibn Sina Foundation in writing or via e-mail. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

X_____
Authorized E-mail Address

X_____
Patient Name

X_____ X _____
Patient Signature Date