Dr. Joseph Guinn
Fort Worth Vascular & Surgical Associates PA
412 South Henderson St
Fort Worth, TX 76104

PATIENT INFORMATION

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

JOSEPH E. GUINN MD

412 S. HENDERSON ST. FORT WORTH, TX 76104
PH: 817-332-7544 FAX: 817-338-9441

I, _____ _____, do hereby
(PLEASE PRINT) NAME DATE OF BIRTH

Authorize Joseph E. Guinn MD the use and/or disclosure of my protected health information (PHI). I request to have information released to Joseph E. Guinn MD for continuing medical record.

I understand that the release of medical records may involve making available to myself or to others information of a personal nature. Issues with regard to personal use of cigarettes, alcohol, and other drugs, as well as possible exposure to infectious disease may be part of the medical record.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. I hereby acknowledge that this consent is truly voluntary and valid until revoked, and that I may revoke this consent at any time, in writing, except to the extent that action based on this consent has been taken.

_____ _____
Signature of Patient or Legal Guardian Date Signature of Witness Date

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 this document.

_____
Signature of Patient or Personal Representative

_____
Print Name

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES PATIENT THE RIGHT TO REQUEST ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME. THIS INFORMATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- ☐ HOME TELEPHONE _____
- ☐ O.K. TO LEAVE MESSAGE WITH DETAILED INFORMATION
- ☐ LEAVE NAME/DOCTOR WITH CALL BACK NUMBER ONLY
- ☐ WORK TELEPHONE _____
- ☐ LEAVE DETAILED MESSAGE ON WORK VOICE MAIL
- ☐ LEAVE MESSAGE WITH NAME/DOCTOR & CALL BACK NUMBER ONLY
- ☐ WHEN UNABLE TO CONTACT ME BY PHONE, A WRITTEN COMMUNICATION MAY BE SENT TO MY HOME ADDRESS
- ☐ OTHER _____

_____

PATIENT SIGNATURE DATE

_____

PRINT NAME BIRTHDATE

_____

SOCIAL SECURITY #

HEALTHCARE PROVIDERS MUST KEEP RECORDS OF PHI DISCLOSURES. INFORMATION PROVIDED WILL BE DOCUMENTED ON THE TEST RESULT, PROGRESS NOTE OR PATIENT COMMUNICATION IN QUESTION.

RELEASE OF PATIENT INFORMATION

I CONSENT AND AUTHORIZE THE RELEASE OF ANY NORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

- ❑ MYSELF
- ❑ VOICE MAIL_____
- ❑ MY SPOUSE: _____
- ❑ MY CHILD(REN): _____
- ❑ MY PARENT(S): _____
- ❑ OTHER: _____

I CONSENT AND AUTHORIZE THE RELEASE OF ANY ABNORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

- ❑ MYSELF
- ❑ VOICE MAIL_____
- ❑ MY SPOUSE: _____
- ❑ MY CHILD(REN): _____
- ❑ MY PARENT(S): _____
- ❑ OTHER: _____

PRINTED NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

SIGNATURE: _____

DATE: _____

Name: _____ D.O.B_____ Date: _____

Pharmacy Name: _____ PH: _____ Fax: _____

Pharmacy Address: _____City, State, Zip: _____

MEDICATION LIST

NAME OF MEDICATION	DOSAGE	QUANTITY	FREQUENCY

ALLERGIES: _____

_____