Allen Friends
& FAMILY CLINIC

(469) 342-6303
info@allenfamilyclinic.com
1511 W McDermott Dr Ste. 240,
Allen, TX 75013

PATIENT REGISTRATION

Please fill out all fields that apply. Thank you!

1 PATIENT INFORMATION

Full Name _____ Date of Birth _____

Age _____ Gender ☐ Male ☐ Female ☐ Other Marital Status ☐ S ☐ M ☐ W ☐ D

Address _____ City _____ State _____ Zip _____

Phone (Mobile) _____ Phone (Home) _____ Email _____

Preferred Contact Method ☐ Phone ☐ Text ☐ Email Best Time to Contact ☐ AM ☐ PM

Emergency Contact Name _____ Relationship _____ Phone _____

Student Status ☐ Yes ☐ No If Yes, School Name _____ ☐ Full-Time ☐ Part-Time

2 RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Full Name _____ Relationship to Patient _____

Phone _____ Email _____

3 INSURANCE INFORMATION

Insurance Company _____ Phone _____

Member ID / Policy # _____ Group # _____

Subscriber Name _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent

Subscriber Date of Birth _____ Subscriber Phone _____

Secondary Insurance? ☐ Yes ☐ No

If Yes, Insurance Company _____ Member ID / Policy # _____

4 AUTHORIZATION & ASSIGNMENT

I hereby authorize Allen Friends & Family Clinic and/or my insurance company to use and disclose my health information as needed to process claims and for treatment, payment, and healthcare operations.
I understand I am financially responsible for all charges not covered by insurance.

Signature _____ Date _____

5 OFFICE USE ONLY

Patient ID _____ Date Received _____ Reviewed By _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSURES OF HEALTH INFORMATION

This office may use and disclose health information about you for treatment, payment, and healthcare operations that may be necessary now or in the future. For example:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you, or collect payment from other entities such as insurance or healthcare plans, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- **Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy. However, 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 restrictions.
- **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law or national security activities.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities when we suspect abuse or neglect.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders. (Such as **voicemail messages, phone text, email, postcards, or letters**).

PATIENT RIGHTS

- **Access:** You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.
- **Amendment:** You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

MEDICAL RECORDS

We require your written release of information and payment for copies of medical record.
A reasonable fee will be charged.

Patient Name (Please Print) _____ Patient Signature _____ Date _____

ALLEN FRIENDS & FAMILY CLINIC, PLLC

Chi-Hwa Yeh, M.D.
Ph: (469) 342-6303 | Fax: (469) 342-6301
1511 W McDermott Dr Ste. 240, Allen, TX 75013

OFFICE POLICIES

Welcome to Allen Friends & Family Clinic (AFFC). We hope to work with you in providing the best medical care in our neighborhood. As medical care is a two-way street, the more information you can provide to the doctor, the better the outcome of your care. As human body is complicated, your diagnosis may change as illness evolves.

Below you will find our office policies. Please read carefully and ask us for any questions.

OFFICE HOURS

Our office hours are Monday through Friday from 8:30 A.M. to 5:30 P.M.
And **close for LUNCH**, from 12pm to 1:00pm.

APPOINTMENTS

Office visits are by appointments only, though we welcome walk-in patients. Walk-in patients are expected to wait for gaps between patients with appointments. We'll do our best to see all our patients on timely basis. However, some patients may have conditions that demand more of physician's time.
Also, patients with urgent complaints may need to be evaluated first.

NO SHOW & LATE CANCELLATION POLICY

We value your time and the time of our other patients.

- **NO SHOW (No call / No show for your appointment): $50 FEE**
- **LATE CANCELLATION / RESCHEDULE WITHIN 24 HOURS: $20 FEE**

If you need to reschedule or cancel, we kindly ask for at least 24 hours' notice.
Reschedule or cancel before 24 hours – **NO COST.**
We would love to reschedule or cancel your appointment for you!

In case you need to cancel or reschedule your appointment, please kindly call us at least 24 hours in advance so we can schedule other patients. These charges are not billable to your insurance and MUST be paid before being seen at our clinic.

TELEPHONE CALLS

Please call us during normal business hours for any non-emergent calls. If there is threat or possibility of threat to your life, vision, or limbs, please go to the hospital ER or call 911.
Messages left on our voicemail will be answered within 24 business hours, excluding weekends. Please call us again during our opening hours if no one calls you after that time. Please direct any medication refill request to your pharmacy who'll fax us the request form.

PATIENT/INSURANCE PAYMENTS

Co-pay and Deductibles are expected at the time of check-in. We accept cash, or credit cards (MasterCard, VISA, and Discover). Please bring a valid health insurance card and a photo ID. Please complete our registration form and make necessary changes in the future as needed. While we strive to ask your health insurance to cover for your visit, most of them don't cover 100%. You may get additional bills from us after settlement with your insurance even though you have paid your co-pay. Please pay the balance as soon as possible. Any unpaid balance more than 60 days will be sent to our collection agency and we may release you from the practice. Patients with outstanding balances may be refused further appointments until balances are paid in full or other payment arrangements are made. Deductibles paid in the office may appear more than the insurances allowable amount. If more than a $40.00 difference is shown you may call our office to request as a credit or refund. **Any amount less than $40.00** will automatically be forwarded to your account as a credit to your next visit.

COMMUNICATION CONSENT & INITIALS _____ Please Initial ☐

☐ **ALLOW US TO TEXT OR CALL PATIENTS WITH REMINDERS AND MESSAGES**
I consent to receive text messages and/or phone calls with appointment reminders, general information, and important updates from Allen Friends & Family Clinic.

☐ **RECORD PATIENT'S CONSENT AND APPROVAL TO TURN ON TEXT AND VOICE REMINDERS AND MESSAGES FOR THIS PATIENT**
I understand that message and data rates may apply. I can opt out at any time by contacting the clinic.

Patient Signature: _____ ♥ Date: _____

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____, acknowledge that I
(Name of Patient or Parent or Legal Guardian)

have either received a copy of this office **NOTICE OF PRIVACY PRACTICES** or that this office **NOTICE OF PRIVACY PRACTICES** was made available to me to receive.

I also give consent to the use and disclosure of my personal health information by your office for Treatment, Billing / Payment and Healthcare Operations as outlined in the **NOTICE OF PRIVACY PRACTICES.**

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature (for Minors Only) Relationship to Patient

PATIENT CONSENT TO TREAT

I hereby give my consent to Allen Friends & Family Clinic (AFFC) and authorize him or her to provide my medical treatment. I understand that AFFC will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize AFFC to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

I also hereby authorize AFFC to perform necessary tests regarding my treatment as ordered by the physician. I understand that not all tests may be covered by my insurance company or may go toward my insurance deductible. Insurance companies do not pay for everything, and in that case I understand I will be responsible for the charges for the testing. I have carefully read this form and have all my questions answered by the AFFC staff.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature (for minors): _____

Relationship to the Patient: _____

Signature of Treating Provider (if procedure was done): _____

Date: _____

ALLEN FRIENDS & FAMILY CLINIC
Medical History Form

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

PREVIOUS SURGERIES/HOSPITALIZATIONS:

Please list all **SURGERIES/ HOSPITALIZATIONS & YEAR:**

_____

_____

_____

_____

SOCIAL HISTORY:

Use of Tobacco: ☐ Never ☐ Previously ☐ Currently, if so how much daily? _____

Use of Alcohol: ☐ Never ☐ Socially ☐ Daily, if so how much? _____

Do you have any **MEDICATION ALLERGIES?** ☐ No ☐ Yes, what medication? _____

CURRENT MEDICATIONS:

Please list all medications **CURRENTLY TAKING & DOSAGES:**

_____

_____

_____

_____

FAMILY MEDICAL HISTORY:

RELATION		AGE	DISEASE/DISORDERS
Mother	_____	_____	_____
Father	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Children	_____	_____	_____

IMMUNIZATIONS:

Vaccine	Up to Date	Need to Get
TD/Tdap		
Pneumovax		
Hepatitis A/B		
MMR		
Chicken Pox		
Meningococcal		
Influenza		

MEDICAL HISTORY - Have you ever had or do you currently have any of the following:

CARDIOVASCULAR:	NEVER	PAST	CURRENTLY
Heart Attack	☐	☐	☐
Heart Murmur	☐	☐	☐
Stroke	☐	☐	☐
Palpitations	☐	☐	☐
High Blood Pressure	☐	☐	☐
Varicose Veins	☐	☐	☐
Heart Disease	☐	☐	☐
Cholesterol	☐	☐	☐
OTHER (specify):			

RESPIRATORY:	NEVER	PAST	CURRENTLY
Shortness of Breath	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Frequent nose bleed	☐	☐	☐
Tuberculosis	☐	☐	☐
OTHER (specify):			

BLOOD:	NEVER	PAST	CURRENTLY
Anemia	☐	☐	☐
Bleeding disorders	☐	☐	☐
Sickle cell disease/trait	☐	☐	☐
Leukemia	☐	☐	☐
OTHER (specify):			

NERV/JOINTS:	NEVER	PAST	CURRENTLY
Frequent Headache	☐	☐	☐
Epilepsy, seizures, convulsions	☐	☐	☐
Arthritis	☐	☐	☐
Palsy or Tremors	☐	☐	☐
Severe Head Injury	☐	☐	☐
MS	☐	☐	☐
OTHER (specify):			

DIGESTIVE:	NEVER	PAST	CURRENTLY
Blood in Stool	☐	☐	☐
Ulcer	☐	☐	☐
Appendicitis	☐	☐	☐
Colitis	☐	☐	☐
Irritable Bowel	☐	☐	☐
Frequent constipation	☐	☐	☐
Stomach pain	☐	☐	☐
Hemorrhoids	☐	☐	☐
Hernia	☐	☐	☐
Diverticulitis	☐	☐	☐
Hepatitis	☐	☐	☐
Cirrhosis	☐	☐	☐
Jaundice	☐	☐	☐
Gallstones	☐	☐	☐
OTHER (specify):			

ENDOCRINE:	NEVER	PAST	CURRENTLY
Diabetes	☐	☐	☐
Thyroid disorder	☐	☐	☐
Pancreatitis	☐	☐	☐
OTHER (specify):			

KIDNEYS:	NEVER	PAST	CURRENTLY
Blood in Urine	☐	☐	☐
Kidney stones/ disease	☐	☐	☐
Urine Infection	☐	☐	☐

MALES ONLY:	NEVER	PAST	CURRENTLY
Prostate enlargement	☐	☐	☐

GOUT:	NEVER	PAST	CURRENTLY
	☐	☐	☐

MENTAL HEALTH:	NEVER	PAST	CURRENTLY
ADD/ ADHD	☐	☐	☐
Bipolar	☐	☐	☐
Depression	☐	☐	☐
Anxiety	☐	☐	☐
OTHER (specify):			

PATIENT NAME: _____ DATE: _____

ALLEN FRIENDS & FAMILY CLINIC

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)	**Not at all** 0	**Several days** 1	**More than half the days** 2	**Nearly every day** 3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

For Office Coding

_____ + _____ + _____ + _____ = _____ (Total Score)

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐