Jack Sasiene DPM

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____

Address_____

City, State _____ Zip_____

Telephone (_____)_____

E-mail _____

SS# _____

□ Male □ Female

□ Single □ Married □ Widow □ Divorced

□ American Indian or Alaska Native □ Asian

□ Black or African American □ White

□ Native Hawaiian □ Hispanic Latino □ Other

Date of Birth _____

Occupation _____

Employer _____

Employer Address_____

City, State_____ Zip_____

Work Phone (___)_____

Cell Phone (___)_____

SPOUSE INFORMATION (if applicable)

Name_____

Home Phone (___)_____

Work Phone (___)_____

PHARMACY INFORMATION

Pharmacy Name _____

Address_____

City, State _____ Zip_____

EMERGENCY CONTACT (if other than spouse)

Name_____

Relationship_____

Telephone (____)_____

PARENT INFORMATION

COMPLETE IF PATIENT IS UNDER AGE 18

Name_____

Address_____

City, State_____ Zip _____

Telephone (___)_____

SS# _____

Occupation_____

Employer_____

Employer Address_____

City, State_____ Zip_____

Work Phone (___)_____

PHYSICIANS INFORMATION

Primary Physician_____

Office Number (___)_____

Referring Physician_____

CLS HEALTH

PATIENT CARE GUIDE

Welcome to CLS Health. Our mission is to provide you with high-quality, comprehensive healthcare services. To ensure a clear understanding of our practices and your responsibilities as a patient, we have created this comprehensive guide.
This guide covers various aspects of your care, including appointment procedures, privacy practices, financial responsibilities, and consent for treatment, among others. It provides detailed information regarding what you can expect from us and what we expect from you.
Please note that this guide is available upon request. For routine processes, we ask patients to sign the CLS Health Patient Acknowledgements & Agreements form, which summarizes the key points from this guide. By signing, you acknowledge that you have read, understand, and agree to the practices outlined therein and are aware that this care guide is available upon request.

SECTION 1: PATIENT CONSENT FOR TREATMENT

- Voluntary Consent: You consent to receive medical care as deemed necessary by the physicians, nurses, and other healthcare providers at CLS Health.

SECTION 2: FINANCIAL RESPONSIBILITY AND PAYMENT GUIDELINES

- Payment Obligations: We expect payments for services rendered by CLS Health at the time of service. This includes co-payments, deductibles, and co-insurance payments. You, as the patient or the designated guarantor, bear this responsibility.
- Referrals: If your insurance plan requires a referral, it is your responsibility to obtain it before your appointment.
- Appointment Cancellation and No-Show Policy: CLS Health may charge between $30-$200 as outlined in the CLS Health Financial & Office Policies, which you agree to by signing this form. This form can be made available to you by request.

SECTION 3: INSURANCE COVERAGE AND DIRECT PAYMENT AUTHORIZATION

- Insurance Understanding: It is your responsibility to understand the specifics of your insurance coverage, including which services are covered.
- Uncovered Services: You agree to be financially responsible for any charges for services not covered by your insurance policy.
- Insurance Benefit Payments: You authorize CLS Health to receive direct payment of any insurance benefits for services rendered to you or your dependents.

SECTION 4: INFORMATION DISCLOSURE AND ASSIGNMENT OF BENEFITS

- Medical Records Release: You consent to CLS Health sharing your medical records with specialists, consulting physicians, and other involved healthcare entities.
- Information Release for Claims Processing: You permit CLS Health to provide relevant medical and other information to insurance companies for claim processing.

SECTION 5: ACKNOWLEDGEMENT OF ADDITIONAL CHARGES FOR DIAGNOSTIC SERVICES

- You understand that services like lab tests, X-rays, and other diagnostic procedures might incur additional charges not covered by your insurance. You agree to be financially responsible for these charges.

SECTION 6: CONSENT FOR ELECTRONIC COMMUNICATIONS

- You consent to receive various communications concerning your healthcare, including but not limited to automated calls, artificial or pre-recorded messages, text messages, and promotional material on your registered mobile number.

SECTION 7: AUTHORIZATION FOR MINOR'S TREATMENT

- In cases where you can't accompany your minor child to the clinic, you give permission for designated adults (over the age of 18) to seek medical care for your child. You also authorize CLS Health to discuss and disclose details regarding your child's medical conditions, test results, appointments, insurance, and billing information with these designated individuals.

SECTION 8: OPTIONAL AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO THIRD PARTIES

- You authorize CLS Health to discuss or disclose details related to your medical condition, appointments, billing information, and insurance with additional contacts provided by you.

SECTION 9: PRIVACY PRACTICES AND DATA ACCESS BY CLS HEALTH SUBSIDIARIES

- You have received or had the opportunity to read the Notice of Privacy Practice

SECTION 10: AUTHORIZATION TO COLLECT MEDICATION HISTORY

- You authorize CLS Health to collect your medication history from various sources, including but not limited to, pharmacies, health insurers, and other healthcare providers. This information can include prescribed medications, over-the-counter drugs, dietary supplements, herbal remedies, and other treatments.

  Understanding your medication history allows us to: Avoid harmful drug interactions.
  Prevent duplicate therapies.
  Identify medication non-adherence.
  We assure you that your medication history, as part of your overall health information, is protected under federal and state law and will be used exclusively for the purpose of providing you with optimal medical care.

ACKNOWLEDGEMENT & AGREEMENTS

By signing, I acknowledge and agree to the following:

- I, as the responsible party, have entered the information in the patient registration form accurately and truthfully to the best of my knowledge.
- I have received or had the opportunity to read the CLS Health Patient Care Guide explaining my rights, responsibilities, and CLS Health's policies.
- I will seek clarification on any unclear details and can request the CLS Health Patient Care Guide at any time.
- I agree to the terms outlined in the CLS Health Patient Care Guide and acknowledge CLS Health will retain this form in my records.

Patient / Legal Guardian **Name:** _____ **Signature:** _____

Date:_____

IMAGING DISCLOSURE STATEMENT

In the case where any outside imaging is required

Listed below are imaging centers owned by CLS Health for MRI, CT, Ultra-Sound and/or X-ray services.

For your convenience, we have listed imaging service suppliers within a 25-mile radius of our office that provide: MRI, CT, Ultra-Sound and X-ray services as of September 2023:

Pulse Imaging
202 N Texas Ave Suite 500, Webster, TX 77598
281.238.2555

Alliance MRI of Clear Lake
17490 TX-3 Suite B400, Webster, TX 77598
713.351.4976

Gulf Coast MRI and Diagnostic
830 Gemini St, Houston, TX 77058
281.488.7226

KingsPoint Medical Imaging Inc
14200 Gulf Freeway, Houston, TX 77034
713.943.9933

Lakeside Open MRI and Diagnostic Center
17360 TX-3, Webster, TX 77598
281.338.5575

Below are some additional imaging centers that your physician can send you to that are within a 25-mile radius from our offices:

HCA Houston Healthcare Mainland
6801 Emmett F Lowry Expy, Texas City, TX 77591
409.938.5000

CHI St Luke's Health Brazosport
100 Medical Drive, Lake Jackson, TX 77566
979.297.4411

Alliance MRI of Angleton
2760 Brazos Pkwy Ste B, Angleton, TX 77515
979.849.5700

By signing this notice, you acknowledge that you may choose any imaging service supplier other than the ones listed above.

Patient / Legal Guardian **Name:** _____ **Signature:** _____

Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____Day _____ Year_____

ADDRESS _____

_____

CITY _____STATE_____ ZIP_____

PHONE (_____)_____ ALT. PHONE (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____ Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____Dr. Jack A. Sasiene DPM, PA_____

Address ___3200 Palmer Hwy Texas City / 201 Oak Drive South Ste 108_____

City ____Texas City / Lake Jackson_____ State ___Texas_____ Zip Code 77590 / 77566___

Phone ___(409) 948-4848 / (979) 297-7798____ Fax __(409) 948-6042 / (979) 297-7522_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Radiology Reports & Images
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)

_____Drug, Alcohol, or Substance Abuse Records

_____Genetic Information (including Genetic Test Results)

_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

SIGNATURE X_____ _____

Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____

Signature of Minor Individual **DATE**

MEDICAL HISTORY INFORMATION

CLS HEALTH

Patient Name: _____ **DOB:** _____ **Date:** _____

Explain your foot/ankle problem ☐ Right ☐ Left _____
Describe the pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other_____
When did the pain/discomfort begin? _____
What makes the pain/discomfort better? _____
What makes the pain/discomfort worse? _____

MEDICATIONS: ☐ **None** **If yes, List them below**

_____
_____
_____

ALLERGIES: ☐ **None** ☐ Penicillin ☐ Aspirin ☐ Shellfish ☐ Narcotic Agent/Codeine ☐ Anesthesia ☐ Sulfa Drugs ☐ Nickel/Metal ☐ IVP Contrast Dye ☐ Other_____

SOCIAL HISTORY:

**** Tobacco Use****	Yes / No How much ? _____ How long ? _____
**** Alcohol Use****	Yes / No Frequency ? _____
**** Recreational Drug Use ****	Yes / No

MEDICAL HISTORY ☐ **None** **If Yes, check mark below**

___Anemia
___Arthritis
___Asthma
___Bleeding Disorders
___Cancer
___Circulation Problems
___Diabetes:
Glucose _____How long? _____
___Gout
___Heart Disease
___Hepatitis Type ____
___High Blood Pressure
___High Cholesterol
___HIV/AIDS
___Major Injury/Trauma
___Kidney Disease
___Liver Disease
___Mental Retardation
___Mitral Valve Prolapse
___Multiple Sclerosis
___Nail Disorders
___Nerve Disorders
___Obesity
___Phlebitis
___Skin Problems
___Thyroid Disorders
___Stroke
___Stomach/Intest Problem
___Varicose Veins

SURGICAL HISTORY: ☐ **None** **If Yes, List them Below**

_____
_____

Occupation: _____ **Is your problem work related?** _____
Do you Exercise? ☐ No ☐ Yes **If Yes, Explain:** _____
Are you currently pregnant? ☐ No ☐ Yes **If Yes, when are you due?** _____

BY SIGNING I CONSENT THAT ALL THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT/ LEGAL GUARDIAN **SIGNATURE**_____

CLS HEALTH

REVIEW OF SYSTEMS:

Please check any of the following that you are currently experiencing or have recently experienced:

Constitutional	____ Chills ____ Fatigue ___Fever ____Weakness ____Weight loss
Head	___Dizziness ___Fainting ____Headaches
Respiratory	___Asthma ___Short of breath ___Wheezing ___COPD ___Bronchitis ___TB
Cardiovascular	___Hair loss on Legs ___Leg or Foot Ulcers ___Vascular Graft/Stents ___Heart Murmur
	___Cramps in legs or feet ___Replacement heart valve___Cold Feet ___History of heart attack
Gastrointestinal	___Liver disease ___Hepatitis ___Antacid Use ___Nausea ___Excessive thirst
	___Gall Bladder Disease
Musculoskeletal	___Joint Stiffness ___Lower Back Pain ___Joint Implants ___Restricted Motion
Psychiatric	___Depression ___Anxiety ___Memory Loss
Skin	___Eczema ___Dryness ___Athletes Foot ___Keloid Scars ___Itching ___Ugly Toenails
Neurological	___Burning ___Fainting ___Strokes ___Unsteady Balance ___Numbness ___Tingling
Endocrine	___Sweats___Thyroid
Hematologic/Lymph	___Bruises Easily ___Slow Healing Cuts ___Bleeds Easily ___Recent Chemo/Radiation
	___Blood Clots

Height: _____ **Weight:** _____ **Shoe Size:** _____

FAMILY HISTORY:

	List immediate family		List immediate family
___ Anemia	_____	___ Liver Disease	_____
___ Arthritis	_____	___ Skin issues	_____
___ Asthma	_____	___ Mental Retardation	_____
___ Cancer	_____	___ Mitral Valve Prolapse	_____
___ Diabetes	_____	___ Multiple Sclerosis	_____
___ Gout	_____	___ Nail Disorders	_____
___ Heart Disease	_____	___ Nerve Disorders	_____
___ Hepatitis	_____	___ Obesity	_____
___ High Cholesterol	_____	___ Phlebitis	_____
___ Hypertension	_____	___ Skin problems	_____
___ HIV/AIDS	_____	___ Thyroid disorder	_____
___ Major Injury	_____	___ Stroke	_____
___ Kidney Disease	_____	___ Stomach/intest problem	_____
		___Varicose Veins	_____

BY SIGNING I CONSENT THAT ALL THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT/ LEGAL GUARDIAN **SIGNATURE** _____