T. Garrett Family Health and Wellness Clinic
Brief Registration Form

Patient Name: _____ Today's Date: _____

Date of Birth: ____/_____/_____ Sex: M ◯/F ◯ Married◯/Single◯/Divorced◯/Widow ◯

Address: _____
(Street) (City/State/Zip)

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

E-Mail Address: _____

Would you be interested in having communications sent to you via your e-mail address? Yes◯/ No◯

How did you hear about our practice?_____

Emergency Contact Information:

Name: _____

Address: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Relationship: _____

Smoking history: ☐ yes ☐ No
If yes how many years? _____ How many Packs a day _____
Drug Abuse: ☐ yes ☐ NO
Alcohol Abuse ☐ yes ☐ NO If yes how much a week?_____
Social Drinker ☐ yes ☐ NO If yes how much a week? _____

Goal weight_____ Lowest Weight _____ Highest Weight_____

Height _____

What diets have you tried? _____

Do you exercise? _____ if yes how many days a week _____

Eating Habits: ☐ Healthy ☐ Diabetic ☐ Sweets ☐ High Carb ☐ Regular ☐ other

315 S. Cockrell Hill Rd. Suite 200 Duncanville, TX 75116 Office:972-572-2121
Fax: 214-580-5180 www.tgarrettclinic.com info@tgarrettclinic.com

MEDICAL HISTORY

Name: _____Date of Birth:_____

Please select if you had or currently have any of the following conditions:

☐ Migraine ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid disorder ☐ Food Allergies

☐ Heart Problem ☐ Kidney Disease ☐ Seizure Disorder ☐ Anemia ☐ Indigestion ☐ Constipation ☐ Eating Disorder ☐ Depression ☐ Asthma ☐ Cancer

☐ Sleep Disorder ☐ Chest pain ☐ Hepatitis ☐ Liver problem ☐ Gout ☐ HIV

☐ Osteoporosis ☐ Stroke ☐ Heart Attack ☐ Hearing/Vision problems ☐ Blood Clots

☐ Eczema ☐ Psoriasis ☐ Arthritis ☐ GERD ☐ COPD

Do you have any other medical conditions not listed above?

_____

_____

_____

List any medications, vitamins or natural supplements you are currently taking

Prescription Medications	Vitamins and/or Supplements

List all of your Medication and Food Allergies. Also list what type of reaction you have:

Medication or Food Allergies	Allergic Reaction

When was your last physical? (Month/Year) _____

WOMEN ONLY:
Is there a possibility you could be pregnant? _____

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I certify that the above information I have provided on this form is correct. All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from the nurse practitioner, I accept full liability from any consequences that may arise.

By signing, I understand and will follow the policy stated in this contract.

_____ _____

Signature of Patient, Parent or Guardian **Date**

Advanced Practice Nurse Consent for Medical Treatment

T. Garrett Family Practice and Wellness Clinic is owned and operated by Travicia Garrett, Board Certified Family Nurse Practitioner. Family Nurse Practitioner is the primary provider of the clinic, Travicia Garrett has a master's Degree in nursing. Off-Site Supervising physician is Dr. Teriya Richmond, MD. The Advance Practice Nurse has had the required training and skill set to take care of all age groups. Family Nurse Practitioners have passed the requirements by the state, to diagnose, monitor, educate, treat and provide prescriptions to all age groups.

I _____am aware that I will be receiving care from an Advanced Practice Nurse / Family Nurse Practitioner

Patient Signature _____ Date_____

Patients Name_____ D.O.B _____

TREATMENT CONSENT AND AUTHORIZATION

I consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments which the medical and professional staff of *T. Garrett Family Health and Wellness Clinic* may deem necessary, advisable, or appropriate. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

I have read the above information and consent that it is correct to the best of my knowledge. My signature here indicates compliance with the above policies.

_____ _____

Signature of Patient/Guardian Date

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Protected Health Information (PHI) / HIPAA

Patient Keep Copy

Patient Name (Print) _____ Date_____

HIPAA

T. Garrett Family Health and Wellness Clinic upholds the standard of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum information to only those in need of your health care information, treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this must be in writing*.
- Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). This information is critical in making appropriate medical decisions.

If you have any questions regarding this consent, please speak with one of the staff of *T. Garrett Family Health and Wellness Clinic.*

T. Garrett Family Health and Wellness Clinic is required to:

Maintain the privacy of your health information.

- Provide you with this notice as to our legal duties and privacy practices with respect to your information we collect and maintain about you.
- Abide by the terms of this practice.
- Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
- We will not use or disclose your health information without your authorization, except as described in this notice.

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUMSTANCES:

1. **Disclose Required By La**w: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety**: Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice will routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions.

All requests for medical records should be written and contain:

- **Social Security Number**
- **Date of Birth**
- **Insurance Carrier**
- **Mailing Address**
- **Written Signature**

In addition an advanced fee will be accessed for copy and mailing of all medical records information.

At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

Patient Rights

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from T. Garrett Family Health and Wellness Clinic

Indicated below are names of any Person(s) to who I would like T. Garrett Family Health and Wellness Clinic to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate "All" if appropriate).

Name	Relation (Spouse, Child, Friend, etc.	Allowed Disclosure
1.		
2.		
3.		

_____ _____

Patient Signature Date

_____ _____

Signature Legal Guardian Date

Relationship to Patient_____

FOR OFFICE USE ONLY
Date Received: _____
Received By: _____

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