WELCOME TO EAST HOUSTON PHYSICIANS GROUP, P.A.
OFFICE OF RONALD W. KILLAM, MD
PATIENT REGISTRATION

Date: _____ **Patient Name:** _____

Male _____ **Female** _____ **Preferred Language:** _____ **Ethnicity** _____

Address: _____ **City/State/Zip:** _____

DOB: _____ **SSN:** _____ **Race:** _____

Home Phone: _____ **Cell/Alternate:** _____

Employer: _____ **Work Phone:** _____

Emergency Contact Name: _____

Relation: _____ **Emergency Contact #:** _____

If under 18

Mother/Legal Guardian: _____ **DOB:** _____

Employer: _____ **Work Phone:** _____

Father/Legal Guardian: _____ **DOB:** _____

Employer: _____ **Position:** _____

Work Phone#: _____

ATTENTION ALL NEW PATIENTS

PLEASE READ THIS ENTIRE PACKET
DR. KILLAM IS AN INTERNAL MEDICINE PHYSICIAN, NOT A PAIN MANAGEMENT PHYSICIAN.
IF YOUR VISIT IS REGARDING MEDICATION FOR PAIN, PLEASE BE AWARE THIS OFFICE IS NOT ACCEPTING NEW PATIENTS FOR THESE SERVICES.
PLEASE FEEL FREE TO RETURN THIS INFORMATION TO THE FRONT DESK PRIOR TO YOUR VISIT AND THERE WILL BE NO CHARGE.
IF A DECISION TO BE SEEN IS MADE AND DURING TRIAGE YOU DISCLOSE THAT YOU ARE SEEKING PAIN MANAGEMENT, A CHARGE WILL BE INCURRED AND PAYMENT WILL BE EXPECTED WHETHER OR NOT PRESCRIPTIONS ARE GIVEN.

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

PLEASE INTIAL AND SIGN BELOW:

_____I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO DR. RONALD KILLAM FOR SERVICES RENDERED BY HIM IN PERSON OR UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY INSURANCE.

_____ I HEREBY AUTHORIZE DR. RONALD KILLAM TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS.

_____I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I AUTHORIZE RELEASE OF ALL RECORDS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

_____I UNDERSTAND COPAYMENT IS DUE AT THE TIME OF THE VISIT. THIS IS EXPLAINED IN MY INSURANCE INFORMATION. ULTIMATELY MY COPAY IS MY RESPONSIBILITY, IF I LEAVE WITHOUT PAYING; TECHNICALLY I AM IN VIOLATION OF MY CONTRACT. AND I UNDERSTAND DOING SO MAY RESULT IN ADDITIONAL CHARGES.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN: _____

EHPG HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

East Houston Physicians Group P.A.

Credit Card Authorization

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your electronic health file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, or if a check is returned unpaid, you will be charged a fee of $25.

I, _____, hereby authorize East Houston Physicians Group P.A. to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Appointments that I have cancelled with less than 24 hours notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

____ Visa ____ MasterCard ____ Discover ____ American Express

Card # _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3 digit code on back of card by signature line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

By signing below I am authorizing East Houston Physicians Group P.A. to bill my credit card at the usual fee for professional services. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy.

Signature: _____ Date: _____

Print Name: _____

East Houston Physicians Group, P.A.
Dr. Ronald W. Killam, MD
13111 E Freeway Suite 303
Houston, TX 77015
Phone: (713) 330-0766
Fax: (877) 862-8370

Nurse Practitioner and Physician Assistant Consent for Treatment

East Houston Physicians Group, P.A. has on staff Nurse Practitioners and Physician Assistants to assist in the delivery of primary medical care. A Nurse Practitioner is not a doctor. A Nurse Practitioner (NP) is a registered nurse who has completed specific advanced nursing education (generally a master's degree or doctoral degree) and training. They can diagnose, treat, and monitor common acute and chronic diseases, as well as provide health maintenance care. In addition, the NP may treat minor lacerations and other minor injuries. A Physician Assistant is not a doctor. A Physician Assistant (PA) is a healthcare professional trained and licensed to practice medicine with limited supervision of a physician. A Physician Assistant is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of health care services that are traditionally performed by a physician. Physician Assistants conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventative health care, and write prescriptions. In addition, the PA may treat minor lacerations and other minor injuries, as well as perform surgical procedures. I have read the above, and hereby consent to the services of a Nurse Practitioner or Physician Assistant for my healthcare needs.

I understand that at any time I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician.

Patient Name: _____

Date of Birth: _____

Patient/ Guardian Signature: _____

Date: _____

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PRIVACY POLICY

Your Rights Under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:
Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restrictions does not extend to uses or disclosures permitted or required under following sections of the federal privacy regulations: 164.502(a)2(2)(i) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In cases, you do not have the right to request restriction. You may also ask us to communicate with you by other means, and if the method of communication is reasonable, we must grant the alternate communication request.

Obtain a copy of this notice of information practices. You have the right to a hard copy upon your request.

Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
Psychotherapy notes, information complied in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings, PHI that is subject to CLIA to the extent that giving you access would be prohibited by law, information obtained from someone other than a health care provider under promise of confidentiality and the requested access would be reasonably likely to reveal the course of information, and information that is copyright protected. In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access.

You have the right to request amendment/correction of your health information. We do not have to grant the request if the following conditions exist: We did not create the record, and/ or the record is accurate and complete.
Obtain an accounting of non-routine uses and disclosures, those other than for treatment, payment, and health care operations.

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Our Responsibilities under Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures.
Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
Abide by the terms of this notice. Train our personnel concerning privacy and confidentiality.
Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto. Mitigate any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.
Other uses and disclosures not described in this notice will be made only with your authorization.

ACKNOWLEDGMENT OF REVIEW OF PRIVACY PRACTICES AND CONSENT

I HAVE REVIEWED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. WITH MY CONSENT, RONALD W. KILLAM, M.D., MAY USE AND DISCLOSE PROCTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS ON MY BEHALF.

I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT IF I SO REQUEST.

SIGNATURE OF PATIENT/GUARDIAN: _____

NAME OF PATIENT/GUARDIAN: _____

DATE:_____

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Additional Policies of East Houston Physicians Group, P.A.

Cancellation Policy:

We, at East Houston Physicians Group, P.A. would like to thank you for choosing us as your medical care provider. We want make sure your experience with us is a positive one, and make every effort to assure you receive the best care possible.

Since, Dr. Killam splits his time between his practice and the hospital, please inform the front desk person when setting your appointment if you prefer to see Dr. Killam. Dr. Killam has hand selected physicians to care for his patients alongside him as well as in his absence. Our physicians will be available to care for our patients Monday-Friday every week. Due to scheduling, and his commitment to providing each patient the time and care they need with each visit, there will be patients wanting to expedite the process of their appointments.

Therefore, it is necessary for the patients to notify this office within 24 working hours of the intent to cancel or reschedule an appointment date. A $25.00 charge will be assessed to clients who do not cancel or reschedule within the critical notification time frame for a non-emergency reason. All patients will be required to make this payment prior to their next office visits.

Please know that every effort is made by this office to verify appointments by phone with patients the business day before their visit.

Pain Contract:

1. No refills will be authorized early and no refills will be requested over the phone.
2. Medicine will be taken as prescribed.
3. No prescriptions narcotics may be obtained by any other doctor.
4. No diversion of medication, i.e. selling to, giving to or buying from any person.
5. No discussing your pain management program with anyone else, including family members who may be patients of Dr. Killam as well.

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Additional Policies of East Houston Physicians Group, P.A.

Controlled Substances Policy:

ALL of our patients that receive controlled substances from our office are subject to a mandatory urine drug screen prior to them receiving their medications. East Houston Physicians Group, P.A. has a **ZERO** tolerance policy when it comes to illicit drugs. This means if you are receiving controlled substances from our office and you test positive for illicit drugs you will be released from medical care under Dr. Ronald W. Killam MD.

Refund Policy:

Payment is due when services are rendered and this includes any administrative fees. East Houston Physicians Group, P.A. will provide a credit and/ or a refund if an overcharge has occurred once insurance company has processed and paid any outstanding claims. Any credit will be used towards any past due balances and/or any future visits. Refund payments will be in form of a check and will be mailed to the address on file. There will be no transferring of credit or payment to spouse, any family members or friends.

Insurance companies do not cover administrative fees. This fee is due prior to filling out any paperwork. Administrative fees will not be refunded or credited.

Should you have any questions or concerns in regards to these policies, please speak with our office staff. By signing this agreement, you are acknowledging that you have complete understanding of these office policies. If the office becomes aware of any violation of the stipulations of these policies and agreements of this contract you will be terminated as a patient without warning.

Patient/Guardian Signature:_____

Patient/ Guardian Name: _____

Date:_____

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Authorization To Release Medical Information

Date: _____

Patients Name: _____ DOB: _____

I understand that my consent is required to release any healthcare information relating to testing, diagnosis, and treatment to anyone other than myself. I hereby authorize release of my medical information to persons listed below.

Name:_____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

_____ I do not give my permission to release any of my medical information to anyone but myself

_____ You have my permission to leave a message on my answering machine regarding my healthcare relating to testing, diagnosis and treatment.

I am authorizing to release my medical information to the persons listed above. I further understand that I may revoke this consent at any time, except to the extent that the information has already been released.

Patient/ Guardian Signature: _____

Relation: _____Date: _____

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Authorization To Release Medical Records

Patient Name: _____

DOB: _____ **SSN:**_____

Last Doctors Information

Name/Clinic: _____

Address: _____

Phone: _____ **Fax:** _____

I understand that my consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV/AIDS, Sexually transmitted diseases, Psychiatric Disorders/Mental Health, or drugs and/or Alcohol use. You are specifically authorized to release all healthcare information relating to such diagnosis and testing.

Please Send The Following (but not limited to) to Dr. Ronald W. Killam

- **Progress Notes**
- **History & Physical**
- **Psychotherapy Notes**
- **Radiology Reports (MRI, CT, X-RAY, ETC...)**
- **Cardiology Reports (EKG, STRESS TEST, ETC...)**
- **Lab Results**
- **Medication List**
- **Gastrointestinal Reports**
- **Infectious Disease Report**

I understand that the information released is for the purpose stated above, any other use of this information without written consent from the patient is prohibited by Federal Law. I further understand that I may revoke this consent in written form at any time except to the extent that the information had already been release in reliance of this form.

Patient/Guardian Signature: _____

Relationship: _____**Date:** _____