Steven A. Fein, MD, FACG
Chrislyn Chaloupka, FNP-C
6243 Fairmont Parkway, Suite 203B
Pasadena, Texas 77505
Office (281) 487-0812 • Fax (713) 946-7210
Email: info@letsjustimagineMD.com
www.letsjustimagineMD.com

PATIENT INFORMATION – ***Please Print*** How did you hear about us? ______________________________

Last Name ______________________ First Name ____________________ MI _______ Date of Birth ____/____/_____

Address ____

Primary Phone# _________________ Cell Phone# ___________________ Email ______________________________

____ Male ____Female (Check One) ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Life-Partner (Check One)

Social Security# _________-_________-_________ Driver's License# ______________________________ State _______

Race *(circle one)* Caucasian Black Hispanic Native American Asian Pacific American Pacific Islander Subcontinent Asian American American Indian or Alaskan Native Native Hawaiian Black Non-Hispanic White Non-Hispanic Other Race

Ethnicity *(circle one)* Latino/Hispanic Other Not Reported/Refused

Employer____

Emergency Contact: __________________________Relationship: __________ Phone Number _____________________

Nearest Relative (not living with you)

____
Name Address & Phone Number Relationship

Primary Care Doctor: ____

Referring Provider:____
Name Phone Number

COMMUNICATION AUTHORIZATION – ***Please Complete***

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact should we need to reach you. Place a √ in the appropriate box(es).

☐ Primary Phone# ☐ Message to return call ☐ Detailed message (results, treatment) ☐ No message ☐ Voice mail ☐ Family member

☐ Alternate Phone# ☐ Message to return call ☐ Detailed message (results, treatment) ☐ No message ☐ Voice mail ☐ Family member

RELEASE OF INFORMATION POLICY – ***Please Read***

I hereby authorize Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C to use and/or disclose my personal health information which identifies me, or which can be reasonably used to identify me, to carry out my treatment, payment and other health care operations. My protected health information may be released to the following individual(s):

Name ___________________________________ DOB ___/___/____ Relationship to patient____________________

Name ___________________________________ DOB ___/___/____ Relationship to patient____________________

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM ______ *Please initial*

I have been provided the Notice of Privacy Policies for Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C, which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and other health care operations. I understand that I have the right to review such "notice" prior to signing this consent.

- I understand that I may revoke this consent at any time by notifying Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C in writing, but if I revoke my consent, such revocation will not affect any actions that Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C took before receiving my revocation.
- I understand that Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C has reserved the right to change its privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or other health care operations. I understand Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C does not have to agree to such restrictions, but that once restrictions are agreed to; Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C must adhere to such restrictions.

FINANCIAL POLICY – *Please Read* ______ *Please initial*

This is a financial policy agreement between Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C as creditor and the Patient/Debtor named on this form. In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "ours" refer to Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C.

- By executing this financial policy agreement, you are agreeing to pay for all services that are received.

ACKNOWLEDGEMENT – *Signature Required*

- I acknowledge that I have received the "Notice of Privacy Policies" for Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C.
- I hereby authorize Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C to release any information requested by the above-named insurance company or companies or their respective representatives for payment of services rendered.
- I understand that I am financially responsible to the physician for any charges incurred by myself and/or my dependents.
- I acknowledge full financial responsibility for services rendered by Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C, and authorize transfer of all unpaid amounts to me I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default of payment of charges that are my financial responsibility.

I have read and understand the "Release of Information Policy", "Assignment of Benefits", "Notice of Privacy Policies" and the "Financial Policy" established by Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C. I further acknowledge that I accept the terms outlined in each of the policies. I understand that, while this consent is voluntary, if I refuse to sign this consent, Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C, can refuse to treat me.

____ ______________________

Signature of Patient (or Patient's Representative) **Date**

____

Printed Name of Patient (or Patient's Representative)

____

Representative's Relationship to Patient (if applicable)