



**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](mailto:info@letsjustimagineMD.com)  
[www.letsjustimagineMD.com](http://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
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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.*

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Signature of Patient (or Patient’s Representative)

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Date

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Printed Name of Patient (or Patient’s Representative)

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Representative’s Relationship to Patient (if applicable)