iMD Health Care & Imaging
Quality Care with Compassion

MEDICAL HISTORY INFORMATION

First Name:_____Last Name:_____DOB :_____

Are you allergic to any medications? _____

Pharmacy Name:_____ Pharmacy Address or number:_____

List all current medications & dosage you are taking(example: birth control pills, thyroid, hormones, etc)

Name of Medication	Dose	Directions

Add the date you received your vaccine or test and add an R for any tests or vaccines you refused. For Tests please indicate if normal or abnormal.

Last Menstrual Period:_____ Last Pap Smear:_____ Last Mammogram:_____

Last Colonoscopy:_____ Last Osteoporosis screening:_____ Are you Depressed:_____

Any falls in the past year:_____ if yes any injuries:_____ If diabetic, last eye visit:_____

If diabetic, last podiatrist visit:_____

Past Medical History:_____

Surgical History and Hospitalizations:_____

Family History:_____

Alcohol use - ❑Never ❑Occasionally ❑Daily

Tobacco use- ❑Never ❑Previously, but quit ❑ Packs Per Day_____ for _____ years

Last Flu shot:_____ Last Pneumonia Shot:_____ Last Tetanus shot:_____ Last HPV shot:_____

Last Shingles Shot:_____ Last HIV Screening:_____ Last Hep C screening:_____

I certify that the above information is accurate to the best of my knowledge and hereby authorize any medical information to be released to iMD Healthcare, 19144 McKay Dr, ste 150, Humble, TX 77338

Print Name_____ Signature_____Date:_____

iMD
Health Care & Imaging
Quality Care with Compassion

19411 McKay Drive, Suite 150 Humble, Tx 77338
Tel:281-459-9181
Fax:281-459-9813

Name of Patient_____

Age_____ **Date of Birth**____/____/____ **Sex** : Female/Male

Address_____ **City**_____ **State** _____**Zip**_____ **Home Phone #(____)**_____ Social Security Number_____-_____-_____

Occupation_____ E-Mail:_____

Pharmacy Name:_____**Pharmacy Address**_____

Pharmacy Phone_____

With whom may we share information about your account?

Name_____ Relationship_____ Phone #(____)_____

With whom may we share medical records?

Name_____ Relationship_____

Phone #(_____)_____

Referred by: ___Friend/Relative, if so Name_____: __Phone Book_____

Newspaper Ad: ___Billboard: ___Another physician, if so name_____Hospital: ___Other

_____

IN CASE OF AN EMERGENCY WHO MAY WE NOTIFY

Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____ Home Phone #(___)_____ Cell Phone # (___)_____ Work Phone #(___)_____Ext:___

WHO IS RESPONSIBLE FOR PAYMENT

Name_____Relationship to Patient_____

Address_____City_____State_____Zip_____ Home Phone #(___)_____ Cell Phone #(___)_____ Work Phone #(___)_____Ext:___

E-Mail _____

Do you have Medicare: ❑ Yes ❑ No

PRIMARY INSURANCE NAME:_____ID:_____ Group:_____

ADDRESS: _____CITY: _____ STATE:_____ZIP: _____

INS CO. PHONE: _____ Guarantor : _____

RELATIONSHIP: ❑ Self ❑Spouse ❑Child ❑Other_____

SECONDARY INSURANCE NAME:_____ID:_____ Group:_____

ADDRESS: _____CITY: _____ STATE:_____ZIP: _____

INS CO. PHONE: _____ Guarantor : _____

RELATIONSHIP: ❑ Self ❑Spouse ❑Child ❑Other_____

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Authorization for Medical Treatment

I,_____, a patient at iMD Health Care and Imaging hereby authorize Dr. Humara Gull as my Physician, and such associates, Medical /Technical Assistants, and other health care providers as deemed necessary on the basis of findings during the course of the visit. I certify that I have read the above authorization and understand the same, and also certify that no guarantee or assurance has been made as the results that may be obtained. Financial Responsibility I/We hereby assume financial responsibility for the payment of all charges for services rendered to the above patient. I/We hereby assign and authorize payment directly to Humara Gull, M.D. iMD Health Care and Imaging of all clinic benefits an guarantee to pay any balance at the time or request. I/We understand that all insurance benefits are assigned to the clinic until the claim is totally paid. I/We understand that insurance does not relieve obligations for this account. By this signature, I acknowledge and agree to the conditions stipulated in “Authorization to Release Medical Records Information”.

_____
Name of Patient

_____ _____
Signature of Patient /Parent (if minor) Date

_____ _____
Witness Date

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Consent to Release Protected Health Information for Treatment, Payment or Healthcare Operations

I understand that my health care provider created health history and related financial information on myself or ……..that may be used for:

- Continuing care and treatment
- Communicating with other healthcare professionals who are involved in my care
- Deriving information used in billing for my care
- Responding to insurers' requests for information about my care.

My signature below authorizes the above uses of my records and also signifies that I was given a copy of the clinic's privacy policy which provides a more complete description of the ways my medical record might change from time to time and that I can obtain another copy of the notice at the front desk any time. I know that I can request restrictions on the way my health care information is used, but I also understand that the clinic is not required to abide by my restrictions. I also understand that I can revoke this consent at any time in writing, but that this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

Please restrict the use of my records as follows:

_____
_____
_____

Signed: _____ Date:_____
Patient / or Legal Guardian

Name: _____

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Payment Policy

Thank you for choosing us as your medical provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card and we are unable to verify your coverage, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits & knowing your primary provider is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services**. Please be aware that some – and perhaps all of the services you receive may be non-covered or not considered reasonable and necessary by Medicaid or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit y our claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to contact us regarding payment on your account. Partial payments will be accepted upon authorization. Please be aware that if a balance remains unpaid, we may refer your account to collection and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat your child on an emergency basis.

Our practice is committed to providing the best treatment to our patients.
Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy.
Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient, Parent or Legal Guardian Date

iMD
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Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW CAREFULLY

This notice takes effect on May 15, 2012 and remains in effect until updated. The privacy of your personal information is important to us and we are committed to protecting it. This notice will tell you the ways we may use and share medical information about you. We also inform you of your rights and duties we have regarding the use and disclosure of medical information.

INFORMATION WE COLLECT: We collect information about you from the following sources:
• Information you give us on patient information database forms
• Information you give us on patient history forms
• Information you give to our receptionists, billing staff, nurses, physician assistants and physicians
• Information you release to us from other doctors, hospitals and laboratories
• Information from consumer reporting agencies
• Information reported to us by hospitals, labs, imaging depts. And specialists after we order tests on you or refer you to specialists

CONFIDENTIALITY, SECURITY AND INTEGRITY OF YOUR PERSONAL INFORMATION

We maintain physical, electronic and procedural safeguards to protect information we collect about you. We restrict access to your information to only those individuals who need it in order to provide services to you. Each employee, at hiring, is counseled about confidentiality of patient's personal information with periodic reviews. Employees who violate these confidentiality requirements are subject to our disciplinary process. Where nonaffiliated third parties have access to your information, they must adhere to our privacy policy.

You have the right to keep the information in your records. You also have the right to request corrections or amendments to your records and the right to request limits on disclosures (your physician may not always agree to these requests). You also have the right to request an accounting of disclosures for purposes other than treatment, payment or health care operations. Our privacy policy may change from time to time to keep up with legal requirements. You may request an updated version by contacting the office. A current version will be posted in the waiting room.

If you feel your privacy rights have been violated or you have questions or complaints about your records at iMD Health Care and Imaging, please write to iMD Health Care and Imaging,19411 McKay Drive, Suite 150 Humble, TX 77338. I HAVE READ THE ABOVE PRIVACY POLICY AND AGREE TO ALLOW iMD Health Care and ImagingTO COLLECT AND DISCLOSE INFORMATION ABOUT ME AS OUTLINED ABOVE.

_____
Patient ,Parent's or Legal Guardian's Name (First, Middle, Last)

Signature_____ Date_____

IMD Healthcare And Imaging PLLC
19411 MCKAY DR STE 150
HUMBLE TX 773385715
Ph: 281-459-9181 Fax:281-459-9813

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Total Score: _____

Interpretation

- ☐ Minimal Depression
- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Moderately severe depression
- ☐ Severe Depression

Interpretation of Total Score for Depression Severity

1-4 Minimal depression

5-9 Mild depression

10-14 Moderate depression

15-19 Moderately severe depression

20-27 Severe depression