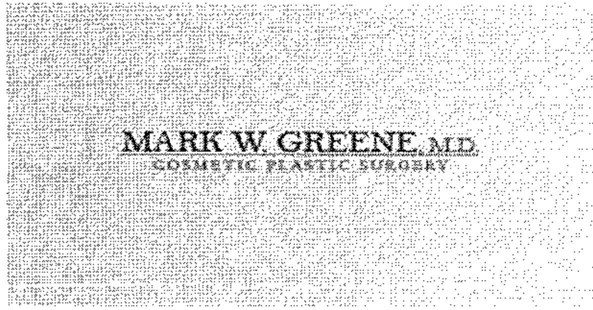

Name:____
Last name First Name Middle Name

Street Address: ____

City, State, Zip: ____

Home Phone (______)______________ Work (_____)____________ Cell Phone (______)________________

E-mail address: ____

What is the best way to contact you? Phone E-mail Regular mail May we mail to your home?____________

Marital Status: Single Married Widowed Divorced Separated Sex: Male OR Female

Date of Birth ______/______/______ Age _____ Social Security Number (optional)____________________

Employer________________________________ Occupation____________________________

Referred to office by:

☐ Patient____________________ ☐ Friend________________ ☐ Doctor ______________

☐ Website ☐ Internet Search ☐ Magazine - Texas Monthly Scene in SA NEW BEAUTY

☐ Other ____

Reason for Consulation____

I authorize my information to be released to the following people about anything pertaining to my records:

1. ____ Phone________________

2. ____ Phone________________

In case of an emergency contact______________________________ Phone________________

Responsible Party Must Sign. (Must be at least 18 yrs. of age)
I hereby consent to and authorize examination and treatment by Dr. Mark W. Greene and he may assign such assistant or staff.

Signature/Guarantor ____________________________________ Date ______________

MEDICAL HISTORY

Name ______________________ Age ________ Height ____________ Weight ____________

Prior Surgery & Year ____

____ Tubal Ligation: Yes No If yes, when ____________

Are you currently under the care of a Physician? ______ If yes, why ______________________

What Medications are you taking? ____

What vitamins or herbal medications are you currently taking or have taken in the last 3 months? ______________

____

How much alcohol do you drink weekly? ________________________________

Have you been or are you currently being treated for anxiety or depression? ________ If so, how long? ____________

Do you use or have you used illegal drugs in the last two years? ______ Have you ever attempted suicide? _________

Have you ever been involved in a medical lawsuit? No Yes ______________________

Smoking History: ☐Never smoked ☐Smoke - # of cigarettes- Daily____ Weekly ____☐Ex-smoker – how long?______

Drug Allergies ______________________ What reaction? ______________________

Have you or your family members ever had: (PLEASE STATE WHO HAD WHAT)

☐ Diabetes	☐ Rheumatic Fever	☐ Kidney Disease
☐ Heart Disease	☐ Stroke	☐ Asthma or Hay Fever
☐ Chest Pain	☐ Jaundice	☐ Tuberculosis
☐ Angina	☐ Black Stools	☐ Epilepsy
☐ Blood in Urine	☐ AIDS/HIV	☐ High Blood Pressure
☐ Hepatitis	☐ Liver Disease	☐ Emphysema
☐ Blood Transfusions	☐ Nervous Breakdown	☐ Psychiatric Care
☐ Convulsions	☐ Thyroid Disease	☐ Breast Cancer
☐ Reaction to Anesthesia	☐ Blood clotting disorders	☐ Abnormal bleeding from surgery

Cancer of any kind: ______________________ Year ____________

Have you taken any of these medications in the past six months? Yes No

Steroids Aspirin/Advil/Motrin/Ibuprofen/Aleve/Midol Blood Thinning Medication Anticoagulants HBP Medication

The information listed above is correct to the best of my knowledge:

Patient/Guardian ______________________________ Date ______________

MARK W. GREENE, M.D.

I understand that Dr. Greene is accepting me as a private pay patient. I will be responsible for paying for all services that I receive from this practice. I understand Dr. Greene's office will not file a claim for any procedures to any insurance company including Medicare/Medicaid for services provided to me.

____

Patient's Signature   Date

Medical Information Release

Please read before completing

I authorize the below named person(s) (example: your spouse, parents (if over 18), siblings or children) to receive my personal medical information, financial information and any other information provided to my doctor and his staff if requested by telephone or mail. I give this authorization freely and do not hold my physician or his staff liable if such information is used improperly by the person(s) that I have authorized or person(s) who may represent themselves as one who is authorized. I understand that I may change this authorization at any time by requesting such change. I also understand that if I do not provide the names of the people that I designate, no information will be given. (mark "NONE" if you have no person(s) designated). I understand that my physician and his staff will not release medical information, financial information (exception: insurance claims) or any other information provided to others that are not named below, unless it is in the best interest of the patient's health, emergency reasons or continuance of care.

Patient Name: ____________________ Date of Birth: ____________

Patient Signature: __________________________ Date: __________

Person(s) authorized to receive information:

(PLEASE WRITE "NONE" BELOW IF THERE IS NO ONE)

Name: ____________________ Relationship: ________________

Name: ____________________ Relationship: ________________

Name: ____________________ Relationship: ________________

Name: ____________________ Relationship: ________________

**IN EFFORT TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Acknowledgement of Receipt of Notice of Privacy Practices
(this acknowledgement will be filed in the patient's medical chart)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

By way of my signature, I provide Mark W. Greene, M.D. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Signature: ______________________________________

Name Printed: ___________________________________

Date: ____

Relationship ____________________________
(if not signed by patient)

MARK W. GREENE, M.D.
NOTICE OF PRIVACY PRACTICES

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

Mark W. Greene, M.D. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information
Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example) "On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with "Mark W. Greene, M.D." "It is our policy to provide a substitute health care provider, authorized by Mark W. Greene, M.D. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."
Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.
Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.
Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
Deceased Persons
We may disclose your health information to coroners or medical examiners.
Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.
Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Appointment Reminders
As a courtesy to our patients, we may call your home to remind you of your appointment time, or a missed appointment. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment, unless you have given prior permission.
Change of Ownership
In the event that Mark W. Greene, M.D. is sold or merged with another organization, your health information/records will become the property of the new owner.
Your Health Information Rights
* You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Mark W. Greene, M.D. is not required to agree to the restriction that you requested.
* You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
* You have the right to inspect and copy your health information.
* You have a right to request that Mark W. Greene, M.D. amend your protected health information. Please be advised, however, that Mark W. Greene, M.D. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason (s) and information about how you can disagree with the denial.
* You have a right to receive an accounting of disclosures of your protected health information made by Mark W. Greene, M.D.
* You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.
Changes to this Notice of Privacy Practices
Mark W. Greene, M.D. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Mark W. Greene, M.D. is required by law to comply with this Notice.
Mark W. Greene, M.D. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, you may contact our Privacy Officer by calling our office at 210-653-4993 or 830-896-0070.
Complaints
If you believe your privacy rights have been violated, you can either file a complaint with our Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR is as follows:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

This notice is effective as of April 14, 2003