Cheryl L. Howard, D.O.
Board Certified Neuromusculoskeletal Medicine
Osteopathic Manipulative Medicine & Family Practice

3100 Timmons Lane Suite 120
Houston TX 77027
(O) (713) 840-1177
(F) (713)621-2491

Patient Intake Form

Name _____ Date of Birth _____

Gender _____ Race/Ethnicity _____ Marital/Relationship Status _____

Address _____

City _____ ST _____ ZIP _____

Email Address _____ Phone# (cell) _____ (home) _____

Occupation _____ Employer _____

Referred by _____ Family Physician _____

Insurance _____ ID# _____ GRP# _____

Provider # (on back of card) _____

Responsible Party _____ DOB _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone _____

Pharmacy _____ Address _____ Phone _____ Fax _____

Authorizations (please initial)

A photocopy of this form is as valid as the original

__ I understand that Dr, Howard is a "Fee for Service" practitioner and she requires payment at the time of service and claims will be filed to my insurance company as a courtesy. The benefits quoted are not a guarantee of payment They are an estimate and subject to change when claims are processed,

__ I hereby give consent for treatment to Dr, Howard including examination and treatment deemed medically necessary

__ I authorize any physician, hospital, and/or medical care facility to release any and all information on my medical history or treatment to Dr. Cheryl Howard that is required for continuation or coordination of care per the privacy guidelines,

__ I understand there is a $75 charge for missed appointments

__ I authorize Dr. Howard to email me in regard to my medical information

__ I have reviewed and agree to abide by the office policies

REPORTS AND FORMS:

I authorize the release of medical information required by my insurance carrier or its designated review agent in order to process any insurance claim for benefits. This authorization may be revoked or changed by me in writing at any time. There may be a fee of charged for dictation, filing of long reports, or excessive photocopying. This fee will be proportionate to the amount of time charged for an office visit. I am responsible for this fee should it apply.

A copy of this authorization will be deemed as valid as the original authorization.

Signature: _____ Date: _____

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PATIENT PRIVACY

New regulations for HIPPA are out. This office, though exempt because there are no third parties in our interaction and no electronic claims are being made, will present a written patient privacy policy.

We make every effort to ensure that the privacy of you medical record is maintained. To help us do this, we ask that:

1. All requests for medical records be made in writing. For your convenience a standard medical release form is available.
2. Medical record be sent by mail, rather than fax, to a designated person.
3. You not discuss sensitive medical information with non-medical personnel, leave such information on the answering machine, or send such information via email.

For that same reason, Dr. Howard will not leave information on a message machine nor will she respond to medical questions via email.

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES:
I have been given the opportunity to review the practice's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I have been offered a copy of this document

Signature of Patient or Responsible Party _____Date _____