



Authorization for Release of Protected Health Information

Agreement and Consent

Diagnostic Group complies with HIPAA which dictates that our office must do everything possible to protect your medical information. For this reason, please indicate below the names of each family or friend who we can talk to and release your information to regarding appointments, prescriptions, test results, surgery dates and any other medical need we may have.

I will allow medical information and test results, abnormal results and appointment information released to the following people.

Name	Relationship	Phone Number

Please indicate the phone number where you can be reached or a message can be left for you during our routine business hours of Monday through Thursday, 8:00 am to 5:00 pm and Friday 8:00 am to 12:00 pm.

1. (____) ____ - ____ home cell other _____
2. (____) ____ - ____ home cell other _____

_____ **I authorize the release of my complete medical record.** I understand I have the right to revoke this authorization in writing at any time by sending written notice of revocation to person(s) authorized in paragraph above to disclose the information.

_____ ***I do not want any medical information or test results released to anyone but myself.***
(Initial)

I understand that Diagnostic Group is in compliance with HIPAA and has provided me the opportunity to review it in detail. My signature below verifies my understanding of my right. The decisions I have made on this form will be valid until revoked in writing by me.

Signature of Patient/Guardian (if appropriate)

Date

Name of Patient (Please Print)



**Medical Records and Authorization for Use of
Disclosure of Protected Health Information**

I hereby authorize _____, M.D.

_____ Address

_____ City, State, Zip

_____ Phone Number

_____ to furnish all medical information to:

Diagnostic Group

Physician's Name
288 Country Lane
Lumberton, TX 77657

The information may be used only for the purposes of medical treatment.

I fully understand that the information released may include information about drug or alcohol screens, HIV testing or diagnosis, and psychiatric or psychological testing or diagnosis.

Please print the following information:

Patient Name: _____

Address: _____

Phone # _____

SSN: _____

Date of Birth: ____/____/____

Patient Signature

Today's Date



Financial Policy

I, _____, understand that my insurance co-payment is due at the time of service. Diagnostic Group will file a claim with my medical insurance company for services rendered. I understand that after payment is received, there may be charges that are not paid and/or covered by my insurance plan. These include but are not limited to:

- Medical Insurance Deductible
- Co-Insurance or Out-of-Pocket amount
- Unauthorized Medical Visit
- Provider is Out of Network
- Services provided are not covered under my medical plan
- Medical insurance is not active

I agree to be financially responsible for all charges not covered by my medical insurance plan for services rendered by this physician of Diagnostic Group.

Patient Signature

Date



No Show Policy

We understand situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours' notice. This will allow another patient who is waiting for an appointment to be scheduled in that time slot. When cancellations are made with less than 24 hours' notice, we are unable to offer that time to other people.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered a **NO SHOW**. Patients who do this three (3) or more times in a 12 month period may be dismissed from the practice and will be denied any future appointments.

Patients will be subject to a \$35.00 fee for office appointment No Show.

The No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about no show fees should be directed to Diagnostic Group at 409.813.1677.

Please sign that you have read, understand, and agree to this No Show Policy.

Patient Name (Please Print)

Date of Birth

Signature of Patient or Patient Representative

Date



Diagnostic Group Integrated Healthcare System (DG) is part of Harbor Healthcare System, a healthcare services and management company based in Beaumont, Texas. Both DG and Harbor Healthcare System are owned by Qamar Arfeen, MD.

The purpose of this notice is to inform you that as part of your continued care, you may receive a referral for an additional medical service (or services), which, at your election, may be provided by or at one of the following other Harbor Healthcare System providers or facilities:

- Diagnostic Group Imaging – An outpatient imaging center that provides MRI, ultrasound, mammography and x-ray services
- Alliance Medical Services – A durable medical equipment provider
- Harbor Home Health – A home health provider
- Harbor Hospice – An inpatient and outpatient hospice services provider
- Beacon Hospice – An inpatient and outpatient hospice services provider

In connection with any referral for additional medical services, please note that you are not obligated to obtain these services from a Harbor Healthcare System provider or facility, and may choose to obtain any such additional medical services from any provider or facility of your choosing.

If you have any questions about the Harbor Healthcare System, its services, or locations, please call 409.813.2332

I have read and acknowledged the above.

Patient name (Please Print)

Date

Patient signature



Past Medical History

Please list the month and year for the following:

Last yearly exam: ___/___ Eye Exam: ___/___ Flu Vaccine: ___/___
Endoscopy: ___/___ Stress Test: ___/___ Sleep Study: ___/___
Mammogram: ___/___ Pap smear: ___/___ Colonoscopy: ___/___
Pneumonia Vaccine: ___/___ Bone Density: ___/___

Please list name of current specialist you may see:

Cardiologist: _____ Pain Management: _____
Pulmonologist: _____ Urologist: _____
Gastroentlogist: _____ Gynecologist: _____
Other: _____

Please list any previous surgeries:

Surgery	Year

Sleep Screening



Patient Information

Name: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Ordering Provider: _____

- Do you snore? Y / N
- Do you feel fatigued during the day? Y / N
- Do you wake up feeling like you haven't slept? Y / N
- Have you ever been told you stop breathing while asleep? Y / N
- Do you have difficulty falling asleep at bedtime? Y / N
- Do you have disrupted sleep where you wake up more than once a night? Y / N
- Do you have difficulty going back to sleep once awakened? Y / N
- How many hours of sleep do you average a night? _____

Epworth Sleepiness Scale

Use the following scale to choose the most appropriate number for each situation:

- 0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Print out this test, fill in your answers and see where you stand.

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total score (add the scores up) (This is your Epworth score)	_____