PATIENT DEMOGRAPHIC INFORMATION

**** PLEASE PRINT ****

Patient's Name:____ S.S.#:______________________
Last Name First Name M.I.

Mailing Address:________________________________City/State/Zip: ______________________

Physical Address **(no P.O. boxes)**: ____

Pharmacy:____

E-mail:____

Home Phone (___________)_____________________ Cell Phone:(________)___________________

Sex: __ M ____ F Age: _______ Birth date: ___________ Marital Status: M S D W

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employer/School: ______________________________ Occupation: ____________________________

Employer/School Address: ___________________________________ Phone: ____________________

PARENT/GUARDIAN (if under 18)

NAME: __________________________________

DOB: ___________________________________

S S #: __________________________________

EMERGENCY CONTACT

NAME: __________________________________

PHONE NUMBER: _________________________

RELATIONSHIP TO PATIENT: ________________

INSURANCE

**** PLEASE PRESENT YOUR INSURANCE CARD WHEN YOU CHECK IN FOR EVERY VISIT ****

Policy Holder's Name: ____

Policy Holder's Date of Birth: ____

Policy Holder's SSN: ____

Policy Holder's Relationship to Patient: ____

HOW DID YOU HEAR ABOUT US?

☐ Word of Mouth ☐ Facebook ☐ Website ☐ Newspaper ☐ Other:_____________________________

Signature:____Date:__________________

KCHC
A Limestone Medical Center Clinic

Medical History Form

Name: ______________________ **DOB**:______________ **Pharmacy**: ____________________

Reason for today's visit: ____

Allergies (Medications/Food/etc.): ____

Previous Primary Care Provider: ____________________ **Last Seen PCP:** ____________

Preventative Care

Date of last Mammogram: ____________ Never☐
Date of last colorectal screening: ____________ Never☐
Date of last DEXA scan: ____________ Never☐
Date of last PSA: ____________ Never☐
Date of last Pap: ____________ Never☐

Social

Are you sexually active? _________
Do you smoke? ____________
- If yes, # per day: ____________ Stop date: __________

Do you drink alcohol?
- If yes, # per day: ____________ Type: ____________

Any Drug use? ____________
- If yes, How often? ____________ Type: ____________

Surgeries: ____

____

Current Medications: ____

____

Immunizations:

___ Flu – Date of last shot: __________ ___ Pneumonia – Date of last shot: __________
___ Tetanus – Date of last shot: __________
___ COVID → Moderna/Pfizer/J&J Dose: 1st or 2nd Date of shot(s): __________
___ COVID Booster – Date of shot: _________

Personal & Family Medical History

Mark if **you** or a **family member** has had any of the following:

	Self	Mother	Father	Sibling	Grand-parents		Self	Mother	Father	Sibling	Grand-parents
Alcohol/Drug Use						Diabetes					
Anemia						Eating Disorder					
Anxiety						Heart Disease					
Asthma						Heart Murmur					
Bleeding Disorder						High Blood Pressure					
Cancer						Kidney Disease					
Depression						Stroke					
						Thyroid Disorder					

Release of Information

I understand that:

Once Kosse Community Health Clinic (KCHC) discloses my health information by my request, it cannot guarantee that the receipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization of applicable federal and state laws governing the use and disclosure of my health information.

I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).

My records are protected and cannot be disclosed without written permission.

This authorization will remain in effect until I provide a written notice of revocation to Kosse Community Health Clinic.

Signature of Patient/Parent or Legal Guardian: ______________________________

Date: ______________________________

Email: ______________________________

If signed by a legal representative, relationship to patient: ______________________________

Witness Signature (optional): ______________________________

Patient Portal FAQs

What is the LMC/KCHC patient portal?

The Limestone Medical Center/Kosse Community Health Clinic patient portal is a convenient and secure health-management tool you can use anywhere you have access to the Internet. Through the portal you can view your clinic record summary for each visit. In the future you will be able to correspond with your health care team (coming soon!).

How old do I have to be to participate in the Limestone Medical Center/Kosse Community Health Clinic patient portal?

You must be at least 18 years old to participate in the LMC/KCHC portal.

How do I sign up for the Limestone Medical Center/Kosse Community Health Clinic patient portal?

When your registration has been completed, you will receive an email invitation to create your account. Once you receive your email invitation, click the first link you see in the email and follow the directions.

What is included in the Clinical Record Summary information?

The LMC/KCHC patient portal includes a view of the following clinical data:

- Medications
- Allergies
- Immunizations

Who can I contact if I have trouble logging in or accessing the LMC/KCHC patient portal?

Please contact the main number (254) 729-3281 at Limestone Medical Center and speak to registration to have your password reset. If additional assistance is needed, you may speak with an IT Department staff member.

How can I obtain a copy of my entire medical record?

Please call Limestone Medical Center Medical Record Department at (254) 729-3281 or Kosse Community Health Clinic at (254) 375-7001.

Patient Portal Authorization and Disclosure Form

What is the LMC/KCHC Patient Portal?

The LMC/KCHC Patient Portal is a program that allows you online access to certain parts of your electronic medical record. This service is entirely voluntary; if you wish to use this service, you must read and sign this form to authorize us to communicate with you via this mechanism.

Patient Portal Guidelines and Your Responsibilities:

- Your login information and password protect the confidentiality of your health information. Please do not share your login or password with anyone.
- Our patient portal is not for emergencies. In the event of an emergency, please call 911 or go to the nearest emergency department.
- LMC/KCHC Patient Portal is not responsible for any information that you share intentionally or unintentionally with others via email or through improper network security practices on your part. Please make every effort to safeguard your password.
- Please note that our patient portal is not a substitute for timely contact and consultation with your provider. You should never change or discontinue any course of treatment ordered by your provider without first consulting with him or her.
- You must be 18 years of age or older to use the patient portal.
- Privacy: LMC/KCHC Patient Portal has in place policies and procedures regarding access to medical records by our staff and employees.
- Security: For your security, please do not transmit any requests over an unsecured web browser.
- Please note that you can discontinue use of our patient portal at any time.
- If for any reason we decide that you have violated the terms and/or abused the use of this service, or for any other reason, we can stop your use of this service at any time. You will be notified if we cancel your access to the LMC/KCHC Patient Portal.
- Any conflicts related to this agreement will be governed by and interpreted in accordance with the laws of the State of Texas.
- If you believe someone has learned your password, you should immediately go to the website and change it.
- You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times.
- Access to the Patient Portal is a free service, but we reserve the right to change this policy if needed.
- We strive to keep all of your protected health care information completely confidential.
- If you cannot reset your password, please call and it can be reset for you.

Exclusion of warranty and limitation of liability:

LMC/KCHC Patient Portal is provided as is and your use of it is exclusively at your own risk. We make not warranties, express or implied, about the use of this portal or the materials in it, and disclaim any express or implied warranty of accuracy or quality and any implied warranty of merchantability, fitness for a particular purpose or non-infringement.

I understand that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notification to the person authorized to make the disclosure, identified above.
- My revocation will not be effective to the extent that the authorized person has relied on the authorization prior to receiving the revocation, but will be effective from that date forward.
- Failure to furnish this authorization will not affect my medical treatment nor eligibility/enrolment for health coverage nor the payment of health benefits.
- Once disclosed, the protected health information may no longer be protected by federal or state law and could be disclosed again by the recipient.

____ _______________________________

Signature of Individual or Personal Representative Date

If a personal representative is signing this form on behalf of the individual whose medical information is to be disclosed, please print the personal representatives name and describe his or her authority to act on behalf of the individual:

____

Email address: ____

A fax or photocopy of this form shall be as effective as the original

Patient Consent Form

Authorization for Care: I grant permission to the employees of Kosse Community Health Clinic, a Limestone Medical Center clinic, to examine, treat, and perform diagnostic tests and procedures that my provider deems necessary.

Authorization of Care by PA/NP: I understand that my care may be provided by a Physician Assistant or Nurse Practitioner in consultation with a physician. There may or may not be a doctor of medicine or osteopathy present in the clinic 24 hours per day, seven days a week. My signature on this form constitutes my consent to treatment by this professional.

Assignment of Benefit: Insurance Assignment: In consideration of services rendered, I hereby assign and transfer to Kosse Community Health Clinic, a Limestone Medical Center clinic, any benefits payable for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical, for the payment of services rendered.

Financial Agreement & Responsibility: I understand that, regardless of my assigned benefits, I am responsible for all charges. I understand that Kosse Community Health Clinic, a Limestone Medical Center clinic, may file a claim for benefits on my behalf but, whatever my coverage, it is a personal contract between me and my insurance company. If benefits are not paid, I will be billed for the entire balance which I must pay in full upon receipt of the statement. I understand that I am responsible for charges not covered by this assignment and / or not paid by said companies and payers.

Medicare Lifetime Authorization: By signing below, I authorize any holder of medical or other information about me to release to the Social Security Administrations and Health Care Financing Administration of the intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any medical costs not covered by Medicare.

Non-Smoking Facility: I understand this is a non-smoking facility and I will abide by this policy.

Valuables: I understand that Kosse Community Health Clinic, a Limestone Medical Center clinic, is not responsible for personal items (dental items, eye wear, jewelry, clothing, etc.) electively kept in my room or designated area while I am a patient. I further understand that patient care items left in the room following discharge will be disposed of and not replaced by Kosse Community Health Clinic, a Limestone Medical Center clinic.

HIV, HBV, and HCV Testing After an Accidental Exposure: Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, Hepatitis B virus and Hepatitis C virus in the following situations: (1) if donation of blood, blood products, organs, or tissues is contaminated; (2) if a healthcare worker is accidentally exposed to a patient's blood or bodily fluids; or (3) if a medical surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure informs that you may be tested if any of these situations occur during your hospitalization. I consent to HIV, HBV & HCV testing under any of the above situations.

Privacy Practices: Kosse Community Health Clinic, a Limestone Medical Center clinic, is required by law to maintain the privacy of a patient's protected health information (PHI). In addition, we are required by law to provide individuals with a notice of our legal duties and privacy practices, if requested, with respect to PHI.

Patient Rights and Responsibilities: I have been given the opportunity to review my rights and responsibilities as a patient. I understand my rights because they have been explained to me and my questions have been answered.

Authorization to Release Information: By signing below, I authorize Kosse Community Health Clinic, a Limestone Medical Center clinic, to release information requested by insurance companies, review agencies or other third-party payers for payment of claims arising out of this visit. **I give permission, without limitation or exclusion, for Kosse Community Health Clinic, a Limestone Medical Center clinic, and its providers to view my external prescription history for purposes of my care and treatment.** I understand that my medication history from multiple other medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan.

Signature of Patient or Patient's Representative	Relationship to Patient	Date

Staff Signature

206 N Narcissus • Kosse, TX 76653 • Phone: (254) 375-7001 • Fax: (254) 375-2233

MEDICAL RECORDS RELEASE CONSENT

Patient Name: ______________________________

Patient Address: ______________________________

City, State, Zip: ______________________________

Date of Birth: ______________________________

This authorizes to release or disclose information from the records of the above-named patient to/from:

To: Kosse Community Health Clinic	From: ____________________
Address: 206 N. Narcissus	Address: ____________________
City/State: Kosse, TX 76653	City/State: ____________________
Phone: 254-375-7001	Phone: ____________________
Fax: 254-375-2233	Fax: ____________________

The purpose of this disclosure is: ______________________________

Or circle one of the following options to be disclosed

Discharge Summary	Physician Order	Progress Notes	Birth Records	Treatment Plan
Consultation	Entire Record	Last 2 Years	X-Ray	Labs

Please fax records to: (254) 375-2233

The consent of disclosure is subject to revocation at any time except to the extent that action has been taken in reliance thereon (i.e. information already disclosed). My signature means that I have read this form and/or have had it read to me and explained in language that I can understand. I hereby release the above from any legal liability resulting from the release of this information. The consent of disclosure will expire ninety (90) days after the termination of therapy, or as otherwise specified by date, even, or condition as follows, unless previously revoked by me.

Signature of Patient: ______________________________ Date: ______________

Signature of Parent or Guardian: ______________________________ Date: ______________

Signature of Staff Member: ______________________________

TO THE RECEIVING PARTY OF THIS INFORMATION: This information has been disclosed to you from the records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 FCFR Part 2.

206 N Narcissus • Kosse, TX 76653 • Phone: (254) 375-7001 • Fax: (254) 375-2233

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: ______________________________________

I ____ authorize Kosse Community Health Clinic to release any medical information (including diagnostic information, lab results, and radiology reports) to the person(s) listed below.

I understand that if I do not list anyone below, no information will be given to anyone other than myself.

____ ____

Patient Signature (parent/guardian if patient is a minor) Patient Printed Name (parent/guardian if patient is a minor)

Relationship to Patient ☐ Self Other ☐ ______________________________________

Information can be released to:

Name: ______________________________________ Relationship: ______________________________

Phone Number: ____

Name: ______________________________________ Relationship: ______________________________

Phone Number: ____

Name: ______________________________________ Relationship: ______________________________

Phone Number: ____

____ ____

Witness Signature Witness Printed Name