Eman Mina, M.D.

18626 Hardy Oak Blvd. Ste. 230 San Antonio, TX 78258
Office: (210) 497-7700 Fax: (210)402-6815

Today's Date:_____

Patient Name: Last First MI	Date of Birth: Social Security Number:
Address: Street	Cell Phone: Home Phone:
City State Zip	
Emergency Contact Name:	Pharmacy Name and Location:
Emergency Contact Number:	Pharmacy Phone Number:

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____

Name of Policy Holder: _____ SSN: _____*** Date of Birth**:_____

Relationship to Patient: _____

Group Name/Group Number: _____ ID Number: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____

Name of Policy Holder: _____ SSN: _____*** Date of Birth**:_____

Relationship to Patient: _____

Group Name/Group Number: _____ ID Number: _____

I assign and request payment of any medical benefits for services rendered directly to the physician. This is a direct assignment of my rights and benefits under this policy. I authorize Eman Mina, MD to release any information necessary to process my insurance claim. I also authorize the Physician to initiate a complaint to the insurance company on my behalf. I agree with the above statements:

_____

Patient Signature Date

CURRENT SYMPTOMS

Symptoms	YES	NO	N/A	Symptoms	YES	NO	N/A
Chills				Nausea			
Fatigue				Vomiting			
Fever				Burning Urination			
Blurred Vision				Bloody Urine			
Eye Drainage				Urinary Incontinence			
Glasses or Contacts				Joint Pain			
Double Vision				Back Pain			
Ear Pain				Muscle Stiffness			
Nasal Congestion				Jaundice			
Sore Throat				Rash			
Shortness of breath				Headaches			
Chest Pain				Weakness of the Limbs			
Palpitations				Easy Bruising			
Dizziness				Excessive Bleeding			
Chronic Cough				Increase Thirst			
Wheezing				Seasonal Allergies			
Acid Reflux				Anxiety or Stress			
Constipation				Depression			
Diarrhea				Sleep Disturbance and Insomnia			

How is your sleeping pattern: ☐ Good ☐ Fair ☐ Poor

How would you describe your appetite: ☐ Good ☐ Fair ☐ Poor

How often do you exercise: _____

HISTORY

Allergic to any Medications (Please List):

_____

_____

Have you had any surgeries? (Please List)

_____

_____

Do you have any of the following illnesses? (Place a check mark by all that apply)

- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Emphysema
- ☐ High Cholesterol
- ☐ Stomach
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Nervous Breakdown
- ☐ Head Injury
- ☐ Epilepsy
- ☐ Other:_____

Current Medication	Dosage	Amount taken Daily	Physician

Marital Status: _____ Children (Y/N, how many) _____

Religion: _____ Do you actively practice: _____

Education: _____ Employment: _____

Do you use tobacco products (Y/N, how much daily): _____

Do you consume alcohol (Y/N, how often): _____

FAMILY HISTORY

Do you have any family history of the following illnesses? If yes, please indicate relationship and any specifics about the illness you feel the doctors need to know.

Relationship:

- ☐ Cancer Type: _____ _____
- ☐ Diabetes _____
- ☐ Hypertension _____
- ☐ Alcoholism _____
- ☐ Heart Disease _____
- ☐ Depression _____
- ☐ Other _____

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Authorization to Release Medical Records

Patient Name: _____
Last First M.I.

DOB: _____/_____/_____ SSN: _____

Address:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Other Phone: (_____)_____

To: _____Phone:_____

To: _____Phone:_____

To: _____Phone:_____

I hereby authorize the release of my medical records. These records are requested for the purpose of review / examination and I further authorize you to provide copies there of as may be requested.

Medical Records **MRI** **CT** **EMG** **X-Ray**

Other _____

I would appreciate having these records faxed:

To: **Eman Mina M.D.** **Fax: (210) 402-6815**

I understand that I may revoke this consent at any time except that action has been taken in reliance there on.

Thank you so much for your attention to this matter.

_____
Signature Date

MEDICATION AGREEMENT

I, _____, understand that if any medications are taken other than those that have been prescribed for me by Dr. Eman Mina, then Dr. Mina will no longer be able to prescribe medications to me. I also understand that I am to follow the daily dosage requirements that were established for me by Dr. Mina, with the understanding that an early refill cannot be provided. For all prescriptions, our office will need **72 business hours** notice prior to refill date. Repeated calls will delay your request.

Patient Signature: _____ Date:_____

PICTURE AGREEMENT

I, _____, authorize the office of Dr. Eman Mina to take and store my picture on the electronic medical records system. I understand this picture will be used solely for the purpose of identification.

Patient Signature: _____ Date:_____

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OFFICE POLICY

1. Office hours are 9:00 am to 4:00 pm Monday trough Thursday
2. After hours voice mails is available to receive EMERGENCY CALLS ONLY.
3. Appointments must be scheduled to see the doctor
4. If you must cancel or reschedule your appointment, please notify our office at least 48 hours in advance. There will be a $50 no show fee if notification is not received within the 48 hours. This will enable us to accommodate any patients who are waiting to be seen by the doctor. Should you miss three appointments without proper notice, please note that our office will be unable to reschedule you for an appointment.
5. To speak to the doctor or an assistant please leave all of the information with the receptionist.
6. We return calls after clinic hours and in the order in which there were received. Any non-emergency call received after 4 pm will be handled the next business day.
   NUMEROUS CALLS TO THIS OFFICE WILL NOT PROMPT A FASTER RESPONSE.

7. Non-triplicate Medication refills: have your pharmacy fax us with your request Monday-Thursday between 9 am – 4 pm. **You must allow us 72 business hours from receipt of the request to get the prescription approved. No medication refills will be done on the weekends or holidays. REPEAT CALLS TO THE OFFICE WILL NOT EXPEDITE YOUR REQUEST.**
8. Triplicate medication will not be called in. Please call our office 48 hours in advance to pick the prescription up from our office**.**
9. Everyone will receive equal treatment and we will try to follow the schedule as closely as possible. Your patience is appreciated.
10. **Verbal of physical abuse to any of our staff will NOT be tolerated; if that occurs, you will be released.**
11. All disability insurance forms will be processed 10 business days after they are received in this office. There will be a $25 fee collected for this service.

_____

Signature Date

Eman Mina, MD
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 carefully. If you have any questions about this Notice please contact the Office Manager.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of the Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at the time. Upon our request, we will provide you with any revised Notice of Privacy Practices. You may contact our office and request that a revised copy be sent to you in the mail, ask for one at the time of your next appointment.

1. **Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose information to other physicians who may be treating you when we have the necessary permission from you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose information from time to time to another physician or health provider (e.g., a specialist or laboratory) who, at the request of your use or disclosure of all or part of our protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this care, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician is required by law to treat you and your physician has attempted to obtain consent but is unable to, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, which you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures that may be made without your consent, authorization or opportunity to object: We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Eman Mina, MD
Notice of Privacy Practices

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for purpose of a determination by the Department of Veteran Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

2. **Your Rights:** Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information: This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under Federal Law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have this decision reviewed.

3. **Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office manager, we will not retaliate against you for filing a complaint.

I hereby certify that I have received and read the above Notice of Privacy Practices and to the best of my ability understand them fully.

_____ _____

Signature Date