MANI K MD PA

Primary Care Provider

Welcome to MANI K MD PA!

Thank you for putting your trust in MANI K MD PA for your healthcare needs. We would like to take this opportunity to welcome you to our practice and look forward to providing you with personalized, comprehensive health care.

Having the most current information is essential in meeting your healthcare needs. We would appreciate your assistance by completing all applicable forms as accurately and up to date as possible. In addition, should any changes to your contact or financial information occur we advise each patient to notify our office as soon as possible.

An important part of each visit with your doctor is reviewing all medications you are currently taking from ALL providers - both primary care and specialists. Please bring a list of current medications with you to every visit.

MANI K MD PA is recognized as a Patient Centered Medical Office which reflects our commitment to providing the highest quality care for our patients. We provide proactive care to promote wellness and prevent illness and will be communicating with you by telephone, mail, text message and, patient portal. Please be sure to provide your email address on the *Patient Information Form* to register for the patient portal.

The goal of a Primary Care Physician is to advocate and support activities which contribute to your health and wellness. Our mission is to provide patient care that is long term based upon a strong commitment to service excellence. Trust can be established and maintained only when there is a mutual respect in your interactions with anyone in our office, including your provider and office staff.

There is a zero-tolerance policy for derogatory or disrespectful language and inappropriate conduct when interacting with one another.

Should you have any questions or comments, please do not hesitate to contact me directly at **281-420-3565.**

Best Regards,
Sepi K. Moghaddam
Office Manager

Mani Khoshnejad, MD
2223 Rollingbrook Drive | Suite 125 | Baytown, TX 77521
P| 281-420-3565 F| 281- 427-7808

MANI K MD PA
Primary Care Provider

Patient Information Form (Please Print)

	Referred By:	**Have you been a patient of MANI K MD PA in the past?** ☐ **Yes** ☐ **No**

PATIENT

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

Last	**First**	**MI**	**Date of Birth** / **Age**
Address	**City**	**State**	**Zip**
Sex: ☐ Male ☐Female	**Social Security #**		
Street Address (if different from mailing)	**City**	**State**	**Zip**
Phone (Home)	**Name of Employer**	**Employer's Phone #**	
Phone (Mobile)	**Employer's Address**		

Preferred Method of Contact? ☐ Home Phone ☐ Mobile Phone
May we send appointment and treatment reminders via text and voicemail? ☐Yes ☐ No

Email:

Spouse's Name	**Date of Birth**

ADDITIONAL INFORMATION

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific ☐Black ☐White ☐Hispanic ☐Other ☐Decline to Answer

Ethnicity: ☐Hispanic ☐Non-Hispanic | What Language do you prefer? ☐English ☐Spanish

Name of your Pharmacy	**Address**	
City	**State**	**Zip** / **Phone #**

RESPONSIBLE PARTY

☐ Self
☐ Spouse
☐ Guardian
☐ Other

Last	**First**	**MI**	**Phone Number:**
Address			
City		**State**	**Zip**

EMERGENCY CONTACT

Name	**Relation**
Address	**Phone #**

INSURANCE INFORMATION

Primary Insurance		**Address**		
Policy #	**Group #**	**City**	**State**	**Zip**
Name of Policy Holder		**Date of Birth**		
Secondary Insurance		**Address**		
Policy #	**Group #**	**City**	**State**	**Zip**
Name of Policy Holder		**Date of Birth**		

Patient Initials: _____

MANI K MD PA
Primary Care Provider

PATIENT INFORMATION FORM

Patient's Name: _____ Today's Date: _____/_____/_____

ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

Medication or Other (Environmental)	Reaction

FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

Condition	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister	Additional Sibling(s)
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

Relationship	Cause of death	Age at death	Relationship	Cause of death	Age at death

YOUR HEALTH HISTORY

(Check if you have had any of the following)

	Abnormal Heart Rhythm		Chronic Pain		Heartburn/GERD		Obesity
	Allergies (any)		Chronic Kidney Disease		Heart Murmur		Osteoporosis
	Anemia		Depression		Hepatitis		Peripheral Vascular Disease
	Anxiety/Stress		Diabetes		High Blood Pressure		Seizures/Epilepsy
	Asthma		Emphysema/COPD		High Cholesterol		Sleep Apnea
	Arthritis		Gallbladder Disease		HIV/AIDS		Stomach Ulcers
	Atrial Fibrillation		Gout		Irritable Bowel Syndrome		Stroke
	Colitis or Crohn's Disease		Headaches/Migraines		Kidney Failure		Thyroid Disease
	Cancer		Heart Attack/Failure		Kidney Stones		

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

Test	Date	Results	Physician	Vaccine Type	Date
Colonoscopy				Tetanus (Td)	
Cholesterol Screening				Pneumonia	
Cardiac Stress Test				Hepatitis B	
Bone Density				Influenza (Flu)	
Mammogram				Shingles	
Breast Exam				Other	

OB/GYN HISTORY

Number of Pregnancies	
Number of full term babies	
Number of premature babies	
Number of abortions/miscarriages	
Number of living children	

ACCIDENTS - TRAUMA:

Have you ever had a severe accident? **YES NO** Do you have any metal pins/plates in your body? **YES NO** **If yes, please describe**

Patient Initials: _____ _____

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MEDICAL HISTORY FORM

Patient's Name: _____ Today's Date: _____/_____/_____

PAST SURGICAL HISTORY			
Date	**Surgery**	**Date**	**Surgery**

Please List Any Additional Medical Information:_____

HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ___

How many packs per day? ___ Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____ How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where? _____

Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

Device	Yes/No	Device	Yes/No	Device	Yes/No
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

LIST *ALL* PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS			
Name	**Dose**	**Frequency**	**Ordering Provider**

PHYSICIANS LIST

(Please list any other physicians currently assisting in your care)

Specialty	Physician	Specialty	Physician	Specialty	Physician
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? **YES NO (circle one)**

If yes, please supply the office with a copy for your chart. If no, would you like one? **YES NO (circle one)**

Patient Initials: _____ _____

MANI K MD PA
Primary Care Provider

Consent for Treatment

I, _____, am voluntarily seeking healthcare and hereby consent
Patient's Name (Printed)
to medical treatment, procedures, laboratory tests and other health care services. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general, to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physicians assisting in my care.

The consent given shall be valid and binding and the physician(s) can rely on this authorization and accept any consent given by the patient until such time as physician receives written notice that the authorization is revoked.

_____ Patient Name (please print)

_____ Date of Birth

_____ Signature of Patient or Legal Representative

_____ Relationship

_____/_____/_____
Today's Date

Mani Khoshnejad, MD
2223 Rollingbrook Drive | Suite 125 | Baytown, TX 77521
P|281-420-3565 F| 281-427-7808

MANI K MD PA

Primary Care Provider

Permission to Release Personal Health Information

Patient Name: _____ Today's Date____/____/_____

Date of Birth: ____/____/_____

Due to HIPPA requirements we are not allowed to release any personal medical information without that patients' consent. If the patient wishes to allow a family member (i.e. spouse, child, parents, etc.) to have access to their medical or billing information, the patient must complete and sign this form prior to any information being requested or released. Signing this form will only give access to the person(s) listed below and should be updated regularly to protect the patients' information.

I authorize the release my health and billing information to the following person(s):

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

By signing this form, I authorize the release of my confidential health information, including medical records, summary, narrative of my protected health information, and/or any billing information to the person(s) listed above. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect and/or copy the health information to be disclosed. I understand that any information that is disclosed to any person(s) above is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. I understand that MANI K MD PA is not to be held liable for any redisclosure of health information conducted by any of the above person(s), regardless of status of consent to release. I understand that, in order to revoke this consent, I must do so in writing with my signature then submit the original document to MANI K MD PA either by standard mail or in person but that I may keep a copy for my records.

_____ _____ / ____ / _____

Patient Signature Date

_____ _____ / ____ / _____

Legal Guardian Signature (If applicable) Date

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MANI K MD PA
Primary Care Provider

Patient Consents and Disclosures

Patient Name:_____ Date of Birth: _____

WELCOME LETTER: I understand trust can be established and maintained only when there is a mutual respect in interactions with anyone in the office of MANI K MD PA, including my provider(s), office staff, and patients. I understand that there is a zero-tolerance policy for derogatory language, disrespectful language and inappropriate conduct when interacting with one another. I understand that if this policy is violated, I will be discharged from the practice. I certify that I have reviewed this letter and received a copy.

COMMUNICATION: To ensure I receive the highest quality of care from my provider(s) at MANI K MD PA, I understand it is my responsibility to keep my provider(s) up to date with any past or new health-related conditions and I certify that I will bring a list of my current medications to every office visit.

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize MANI K MD PA, its medical practices and providers including physicians, technicians, nurses, and other qualified personnel, including appropriately supervised students and residents to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I recognize that I have the right to refuse any service or treatment. I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.

TREATMENT OF MINOR CHILDREN: I understand minor children patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

PHOTOGRAPHY/VIDEO: I acknowledge that my photograph may be taken for chart identification and documentation purposes for my electronic health record and is the property of MANI K MD PA unless I withdraw my consent in writing. I consent to videotaping for a telehealth appointment for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations. I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

RESTRICTED SERVICE: I understand that all account balances must be in good standing prior to receiving additional services and will contact MANI K MD PA staff if I am unable to pay your balance. Past Due Accounts of 30 days or longer may be turned over to a third-party for collection, along with collection costs, attorneys' fees, and court fees. I also understand I may be discharged from the practice.

ADDITIONAL SERVICE CHARGES: Checks may be processed at time of service, if there are insufficient funds available, I understand I will be responsible for providing an alternate payment for the account amount, plus a $35.00 NSF fee.

LABORATORY SERVICES: I understand that Laboratory Services are available to me at the practice as a courtesy for all orders placed by my provider(s) at MANI K MD PA. I understand Laboratory services are separate entity from MANI K MD PA. I understand I have the right to choose the Laboratory Facility I want labs to be sent to and can deny services at any time by contacting the office to notify of changes.

LABORATORY BILLS: I understand that MANI K MD PA will submit necessary coding information to the insurance. I certify I will receive an explanation of benefits (EOB) from my insurance notifying me balances I owe for services rendered. I certify if I should have any questions or concerns regarding my EOB to contact the laboratory.

NO SHOW/SAME DAY CANCEL: A "No Show" is failure to be present at least 15 minutes prior to a scheduled appointment. A "Same Day Cancel" is failure to cancel/reschedule 24 hours prior to a scheduled appointment. I hereby understand that I must cancel or reschedule my appointment at least 24 hours prior to my appointment date and failure to do so will result in a $65 fee. I am aware that after my third violation I will be discharged from the practice.

ELECTRONIC PRESCRIBING: I understand that MANI K MD PA may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my provider(s) and my pharmacy. I have been informed and understand that MANI K MD PA providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to MANI K MD PA to see this health information.

CONSENT FOR VIRTURAL HEALTH/TELEMEDICINE SERVICES: I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. I understand the services provided will be filed/billed through my insurance. Once the insurance processes the claim, I understand I am responsible for any remaining balance, including inactive insurance coverage. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.
I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

ELECTRONIC HEALTH RECORD: I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. MANI K MD PA has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. MANI K MD PA can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.
I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). MANI K MD PA will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status, and adoption records. If I have provided my e-mail address, I am requesting the ability to access my medical information through the on-line Patient Portal.

IMMUNIZATION REGISTRY: I understand that MANI K MD PA participates in the Texas Dept. of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws. I do hereby grant permission for MANI K MD PA to send or fax childhood immunization records to schools, upon request.

WORKMAN'S COMP/AUTOMOBILE ACCIDENT: I certify that MANI K MD PA does not accept workman's comp or automobile accident claims. If I have an ongoing workman's comp or automobile claim, I understand that MANI K MD PA will not be able to see me for that injury. A patient cannot choose to use his/her insurance to cover a claim that has previously been started. This is considered insurance fraud. I certify that I will be responsible for refunding any private insurance money paid to Mani K MD PA for services performed on an unreported workman's comp injury or automobile accident injury and balances recouped from my insurance. If at any time, I decide to file an accident after services are performed, I will be responsible for reimbursing my insurance carrier and payments paid to Mani K MD PA for services rendered for my claim(s).

CHRONIC PAIN MANAGEMENT: I understand that MANI K MD provider(s)will not prescribe chronic pain medication and as treatment I will be referred to a Pain Management Specialist.

URINE DRUG SCREENING/CONTROLLED MEDICATION: To comply with the State of Texas regulations; I understand that I must see the Doctor every 3 months or upon request and complete a mandatory Urine Drug Screening at an additional cost. I acknowledge the State of Texas enforces strict regulations for prescribing controlled medications and mandates that they are written on a Triplicate Prescription Pad or sent electronically to your pharmacy using the software EPCS Gold. For all refill requests, I understand there will be an additional fee for each prescription refilled and payment is collected prior to filling the request.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that MANI K MD PA provides no facilities for safekeeping of valuables. I do hereby release MANI K MD PA from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a MANI K MD PA medical practice, office, or facility.

NOTICE OF PRIVACY & SECURITY PRACTICES: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of MANI K MD PA Notice of Privacy & Security Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy & Security Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested. The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

_____	_____
Patient Signature	Today's Date
_____	_____
Legal Guardians Signature (if applicable)	Today's Date

Mani Khoshnejad, MD
2223 Rollingbrook Drive | Suite 125 | Baytown, TX 77521
P| 281-420-3565 F| 281-427-7808

MANI K MD PA
Primary Care Provider

Financial Disclosure

Patient Name: _____ Today's Date____/____/_____

Date of Birth: ____/____/_____

Dear Patient,

INSURANCE AUTHORIZATION AND ASSIGNMENT: I certify that I will provide valid insurance information prior to my visit and that it is my responsibility to notify you with any changes in my coverage. I certify that non-covered services will be paid in full at the time services are rendered. I am aware that whether my insurance pays my claim, I am responsible for the balance on my account. I acknowledge I will receive an Explanation of benefits (EOB) from my insurance and a mailed statement (to the address on file) from MANI K MD PA notifying me of balances I owe. I authorize MANI K MD PA to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s) directly to MANI K MD PA. If in the case there is a credit on my account, I understand that a refund will not be given and instead will be applied to future visits until physician/patient relationship is discontinued. I hereby authorize that photocopies of this form to be valid as the original.

SELF-PAY PATIENTS: I understand if I do not have active coverage or choose not to utilize my insurance benefits, I am responsible for all charges occurred at time of service.

PAYMENT GUARANTEE: I understand that all payments must be paid in full prior to receiving service. I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through MANI K MD PA medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a MANI K MD PA billing statement whether it is an interim or final bill. In the event that I fail to make full payment, I understand that appropriate collection measures may be initiated. I understand and agree that my payments will be processed by a third-party business associate. I hereby consent to have my payment information collected and stored securely by MANI K MD PA.

As a patient, you have the unfettered right to choose your health care providers, treatment entities and/or pharmacies. This financial disclosure form is intended to disclose certain information to allow you, as the patient, to make a fully informed decision.
In compliance with Section 102.006 of the Texas Occupations Code and in connection with my informed consent, personal choice of doctors, facilities, and pharmacies, my physician and/or practice have disclosed to me at the time of initial contact: (A) his/her affiliation with any health care providers, treatment entities, or pharmacies for whom my orders may be sent to, and (B) whether he/she will directly or indirectly receive remuneration for his/her affiliation with any health care providers, treatment entities, or pharmacies.

- Affiliation and remuneration interest: ALTUS HEALTHCARE NETWORK, WELL LAKE PHARMACY, CARDIACUS DIAGNOSTICS
- I understand that this disclosure form is intended to help me make a fully informed decision about my personal choice with any health care providers, treatment entities and/or pharmacies.
- I understand that I will not be treated differently by either my physician or his/her staff should I choose to decline his/her orders with any health care providers, treatment entities and/or pharmacies.
- I understand and certify that my physician has informed me that referrals are based solely on the patient's medical needs, the receiving pharmacies quality of care, professional reputation, and past patient satisfaction.
- I have read and fully understand the disclosures listed under the Texas Occupations Code.

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Legal Guardian Signature (If applicable) Date

Mani Khoshnejad, MD
2223 Rollingbrook Drive | Suite 125 | Baytown, TX 77521
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MANI K MD PA

Primary Care Provider

Release of Medical Records

Patient Name:_____ Today's Date: _____/_____/_____

Date of Birth: _____ /_____ /_____

Legal Guardian:_____

Release my health information **TO** the following person(s) or entity:

Name: Dr. Mani Khoshnejad

Address: 2223 Rollingbrook Dr. Suite 125

City: Baytown State: Texas Zip: 77521

Phone: (281) - 420 - 3565 Fax: (281) - 427 - 7808

Release my health information **FROM** the following person(s) or entity:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____

The reason(s) for this release are as follows (check all that apply):

( ) Continue Patient Care ( ) Attorney/Legal ( ) Insurance ( ) X-Rays Only ( ) Labs Only ( )Other

By signing this form, I authorize the release of my confidential health information, copy of my medical records, summary, and/or narrative of my protected health information to the person(s) or entity listed below. I understand that this information is to be provided within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners.

_____ ___/___/_____

Patient Signature Date

_____ ___/___/_____

Legal Guardian Signature (If applicable) Date

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