FAMILY HEALTH & WELLNESS CENTER OF NORTH TEXAS, LLC
New Patient Information

Patient Information

Please Circle: Mr. Mrs. Ms. Sr. Other

Patient's Name (Last):_____(First):_____(Middle):_____

Also Known as Name: _____

Please Circle: Married Single Divorced Widowed Separated Ethnicity: _____

Social Security Number:_____Date of Birth: _____ Sex: Female *I* Male

E-mail Address:_____

Phone Numbers Daytime:_____Cellular:_____Evening:_____

Address: _____

City:_____State: _____ Zip code_____

Employment Status Please circle: Employed Retired Self Employed Unemployed Full-Time Student Part-Time Student

Employer:_____Phone Number:_____

Emergency Contact Name:_____Phone Number:_____

Emergency Contact Relationship to Patient: _____

Referring Provider Name:_____Phone Number:_____

Insured Party Information

Insured Party Name (Last): _____ (First):_____

Social Security Number:_____ Date-Of Birth: ____/____/____

Phone Numbers Home:_____ Work: _____

Primary Insurance

Name:_____

Insurance Phone Number: _____

Secondary Insurance

Name: _____

Secondary Phone Number: _____

I hereby give permission to Family Health & Wellness Center of North Texas, LLC to disclose and discuss any information related to *my* medical condition(s) to/with the following family member(s), other relative(s) and/or close friend(s):

Name:_____Relationship:_____Phone Number:_____

You would prefer to be contacted in the following manner:

- **0** Okay to leave message with detailed information at home
- **0** Ok to Leave Message with call back number only at home
- **0** Ok to Leave Message with detailed information at work
- **0** Ok to Leave Message with Call Back Number only at work
- **0** Written Communication:
- **0** Ok to mail to *my* home address:
- **0** Ok to mail to *my* work/office address:
- **0** Ok To fax to this number: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

FAMILY HEALTH & WELLNESS CENTER OF NORTH TEXAS, LLC

General Consent for Evaluation and Treatment

TO THE PATIENT: Welcome to our practice. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I understand that at any time I can refuse to see the mid-level provider and make an appointment to see a physician.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient / Guardian Signature Date

_____ _____

Printed Name of Patient / Guardian Relationship

Pre-Treatment Notification

Some health plans require that we inform you in advance that they may deny payment for services not covered and for services not deemed by the health plan to be reasonable and customary or medically necessary.

Family Health & Wellness Center of North Texas will render only services that, in its professional judgment, are needed to provide quality medical care for you. For us to collect from you for our services when payment is denied by your health plan, your health plan requires that you sign the following agreement.

The agreement:

1. I have been notified by the physician that payment maybe denied for 'services not covered" or for "services not deemed by the health plan to be reasonable and customary or medically necessary" or that have been specifically requested by me, the patient.

   If payment is denied, I agree to be personally and fully responsible for the payment.

Signature:_____ Date:_____

Your Health Plan Coverage

Family Health & Wellness Center of North Texas is committed to providing you with the best possible care and helping you to receive maximum allowable benefits under your health plan. In order to achieve these goals, we need your assistance.

Regarding Office Visits, Lab Work and X-Rays

1. Co-payments, Co-insurances, and/or deductibles are due at the time of the visit.
2. A valid, current card must be presented at each office visit.
3. If the service is not covered benefit or if your health plan tells us you are not covered, payment in full for all services are due when rendered. If your insurance company subsequently makes payment, any overpayment will be refunded to you.

Regarding Your Health Plan

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to the contract. While we may have an agreement with many of the health plans to provide services, any questions regarding coverage must be resolved by you with the insurance company.

   Not all services are a covered benefit with all contracts. Some health plans select certain services which they will not cover.

By signing below, I acknowledge that I have read this information and understand all the above.

Signature:_____ Date:_____

Witness:_____ Date:_____

FAMILY HEALTH & WELLNESS CENTER OF NORTH TEXAS, LLC

Mid-Level Provider Consent for Treatment

Family Health & Wellness Center of North Texas, LLC has on staff a mid-level provider to assist in the delivery of medical care.

A mid-level provider is not a doctor. A mid-level provider is a registered professional healthcare provider who is prepared, thru advanced graduate education and clinical training, to provide a wide range of health care services, including the diagnosis and management of common, as well as complex, medical conditions to individuals of all ages.

A mid-level provider can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the mid-level provider may treat minor lacerations and other minor injuries.

Mid-level providers provide comprehensive care within an area of specialization and can:
Evaluate an individual's health by taking a history, performing a physical examination and ordering and interpreting results from appropriate laboratory and diagnostic tests/procedures;
Diagnose health and medical conditions by reviewing all available health information, and applying advanced clinical decision making processes;
Manage health problems by developing an individualized plan of care, prescribing medications or treatments, obtaining consultations and referrals, and coordinating health care services;
Promote health by ordering screenings, prescribing preventive therapies (vaccinations, diets, exercise, etc.) and teaching and counseling of individuals, families, and groups;
Collaborate with patients and families, and other health care providers.

A mid-level can serve as a patient's primary health care provider and is able to provide the coordination and management of care required in various health care delivery models, such as medical home, accountable care organizations, transitional care, etc.

I have read the above, and hereby consent to the services of a mid-level provider for my health care needs.

I understand that at any time I can refuse to see the mid-level provider and make an appointment to see a physician.

_____
Patient Name (PRINTED)

_____ _____
Patient/Guardian Signature Date

Family Health & wellness Center of North Texas, LLC

Patient Consent and Acknowledgment of receipt of Privacy Notice

I understand that as part of the provision of health care services, Family Health & Wellness Center, LLC creates and maintains health records and other information describing should among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of my revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.), and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance upon my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or electronic form, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or FAX of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which are used or disclosed for purposes of treatment, payment, or health operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information, and agreed to terminate any restrictions in writing on the use and disclosure of Protected Health Information which have been previously agreed upon.

_____ _____

Patient's Name Printed Date

_____ _____

Patient Signature (or Guardian, if a Minor) Social Security Number (for ID purposes only)

FAMILY HEALTH & WELLNESS CENTER OF NORTH TEXAS, LLC
FINANCIAL POLICY

Thank you for choosing Family Health & Wellness Center of North Texas, LLC.as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- It **is your responsibility to provide us with your most current insurance information.**
  - If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
  - We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. **Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.**
  - We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
  - Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers, or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
  - We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company' aro1trary determ1ination of usual and customary rates.
  - Co-payments, coinsurance and or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim - regardless of our estimation.
- **It is your responsibility to provide us with your most current billing information.**
  - You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
  - We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance. it is your responsibility to contact our business office within 30- days after receipt of the initial statement. You can call **(214) 294-8989**
  - **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
  - If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.

- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from Family Health & Wellness Center of North Texas, LLC. Failure to accept this certified letter (and or to pick it up at the post office) serves as notice of termination of services.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add *$25.00* to your original balance. In addition, we may seek all additional legal remedies provided to us
- A $15.00 service fee will be charged for all triplicate prescription requests.
- A *$25.00* service fee will be charged for completion of all" FMLA" or insurance related correspondence.
- We may charge you a "'No Show" fee of S25.0O if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Full payment is due at the time of service. We accept cash, check and credit cards.

I have read and understand this Financial Policy.

Signature of Responsible Party:_____Date: _____

Patient Name: _____ Date of Birth: _____

PATIENT HISTORY FORM

Page 1 of 3

Date Today:_____

We strive to keep all information in confidence and will not release without signed consent. It may be sent to consultants, if referred.

Name_____ Birth Date:_____ Age:_____

Last **First** **M.I.**

Marital Status: Single ____ Married ____ Widowed ____ Separated ____ Divorced ____

Occupation:_____

Reason for Visit Today: _____

_____

Last Medical Exam / Previous Physician: _____

Last Chest X-Ray (Date and Location): _____

_____

Allergies (DRUGS. X-RAY DYE, TAPE, LATEX)1 & Type of Reaction

_____

Local Pharmacy Name & # _____

Medications (List all including ones not prescribed, such as Alternative Agents or Herbal Agents).

Drug	Strength	How often You Take Per Day	Length of Time You Have Taken
1.e. Advil	**200 mg.**	**3 times per day**	**6 months**

Please know what medications and doses you take: if you need refills let the nurse know when she places you in the exam room.

Childhood Illnesses: Chicken Pox ( ) Measles, Rubeola ( ) Mumps ( ) Rubella ( ) Scarlet Fever ( )

Previous Medical Illness/ Hospitalization: _____

_____

If Diabetic, do you self-test with glucose meter? _____ Do you get yearly eye exam? _____ Have you been to a self-management course _____

Do you know what to do for low blood sugar? _____ Foot care _____ Hgb AIC current value_____

_____

Surgery: (IF Yes, Please Check and Give Approximate Date in Blank Space)

Appendectomy_____ C- Sections_____

Breast Biopsy_____ Gallbladder_____ Hysterectomy_____ Ovary R ____ L ____

Carotid artery_____ Heart angioplasty_____ Vasectomy_____ Stomach surgery_____

Cataracts_____ Heart bypass_____ Prostate removal_____ Tonsillectomy_____

Other Surgery not listed: _____

OBGYN History Pregnancies: # ___ Deliveries: #____ Vaginal Deliveries # _____ Last menstrual cycle: _____

If you see a Gynecologist, List name _____

PATIENT HISTORY FORM

Page 2 of 3

Name _____ **Birth Date:**_____ **Age:**_____

Last **First** **M.I.**

Family History· Place a Check mark next to the condition that your family member has then specify their relation to you and the disease, using the abbreviations as follows: Mother (M). Father (F). Brother (B). Sister (S), Grandparent (GP), Aunt *(A)*, Uncle (U)

For example. if your Aunt and Mother had breast cancer·. Breast Cancer A, **M**

Alcoholism	Breast Cancer	Glaucoma	Kidney Disease	Thyroid disease
Anemia	Colon Polyps	Gout	Mental Illness	Tuberculosis
Asthma	Colon cancer	Heart Disease	Migraine	Osteoporosis
Arthritis	Diabetes	High Blood Pressure	Prostate cancer	
Bleed easily	Glaucoma	hm Disease	Seizures	

	Living	Age or Age at Death	Present Health or Cause of Death
Father	___ Yes, __) No	_____	_____
Mother	___Yes. __) No	_____	_____
Siblings	___Yes .___) No	_____	_____

Immunizations. (Please check the Disease against wl1ich you haw been immunized and Date of last booster.)

"Tetanus or Td booster is due every lO years." Let the nurse know if you are due for a booster.

( ) Hepatitis B _____

( ) Tetanus_____

( ) Measles, Mumps, Rubella_____

( ) DT (Diphthel ia Tetanus)_____

( ) Pneumonia_____

( ) Hepatitis A_____

( ) Flu vaccine_____

( ) Varicella_____

( ) Meningitis vaccine_____

Check if YES or Write **NO, in front of items that follow below.

_____ Drug **use?**

_____ **Use Tobacco** Currently? # of packs per day:_____# of years:_____

Are you interested in stopping? Yes_____ No_____

_____**Alcohol Use?** Beer ___ Wine_____ Mixed Liquor_____ Oz I or glasses or cans per week average): _____

_____ **Tobacco Use in past?** When did you stop? _____

_____ **Caffeine Use?** Coffee: cups per day·_____Sodas per day: _____

_____ **Exercise regularly?** Type·_____Times per week_____

** Place a Check. Mark if YES or W1ite **NO.** for items that follow.

___ **Diet: Are** you interested in information on diets for weight or cholesterol or diabetes?

___ Calcium intake: Do you know women need about 1000mg. of Calcium intake per day"

___ **Bone Density tests:** check if interested in information: considered after age 50 in women.

___ **Colon exams:** Did you know most experts recommend a colon exam every 5 years, after age 50"? Please let us know if you have a family history of colon cancer.

___ **Mammography:** recommended yearly in women after age 4O: check if due for this test.

Advanced Directives:

*** Please discuss with your spouse or family and your physician. **

Living Wi1l? No( ) Yes ( ) Organ Donor'? No ( ) Yes ( )

Durable Power of Attorney for Health Care? No ( ) Yes( ) Who?_____

PATIENT HISTORY FORM

Page 3 of 3

Name _____ Birth Date: _____ Age: _____
Last **First** **M.I.**

Please Place an (X) By the Current Complaint or Ailment That Applies to You. If Unsure. Place A Question Mark (?)

Head
___Blurred Vision
___Last Eye Exam Date
___Glaucoma
___Frequent Headaches
___Migraine Headaches
___Lumps or Swelling in Neck
___Constant Ringing in Ears
___Hearing Problems
___Frequent Earaches
___Frequent Nosebleeds
___Sinus infection
___Allergies Hay Fever
___Hoarse Voice, Persistent
___Mouth or Tongue Sores

Lungs
___Asthma
___Have Coughed Up Blood
___Increasing Shortness of Breath with activity
___Emphysema
___History of Tuberculosis
___Chronic Cough

Heart
___Frequent irregular Heartbeat
___Chest Pain or Tightness in Chest
___Heart Murmur ____ Mitral Valve
___History of Enlarged Heart
___Swelling of Feet, Ankles Present after sleep
___Rheumatic Fever
___High Blood Pressure
___Previous Heart **Attack Date:** _____

Abdomen
___Frequent Heartburn
___Difficulty or Pain in Swallowing
___Have Vomited Blood
___Rectal Pain or Bleeding (Black or Bloody)
___Recent Change in Bowel Habits
___Diverticulitis or Diverticulosis
___Colon Polyps
___Last Colon Exam Date:
___Hepatitis Yellow Jaundice
___Liver Disease
___Nausea
___Constipation
___Diarrhea; How Many Per Day_
Abdominal Pain with Fatty Food
___Suspect Ulcers
___Hemorrhoids
___History of Ulcers
___Bleeding
___Loss of Appetite

Neuro
___Seizure
___Loss of Consciousness
___Double Vision
___Memory Loss
___Numbness of Hands or Feet
___Nervousness Affecting Home Life or Work
___Speech Problems
___Stroke

Kidney
___Recurrent Urinary Tract Infection
___Urination at Night More Than Once
___Brown, Black or Bloody U1ine
___Burning on Urination
___Kidney Stones
___Difficulty Starting Stream
___Problems with Sexual Function
___Urinary Incontinence

Joints
___Back Trouble
___Swollen Joints
___Frequent Painful Feet
___Frequent Shoulder Pain
___Frequent or Persistent Aching of Muscles / Joints
___Gout
___Arthritis
___Osteoporosis: How diagnosed? _____

General
___Diabetes · Date Diagnosed: _____
___Weight Loss Greater Than IO lbs in Last Yr
___Loss of appetite
___Sleeping Difficulty
___Thyroid Problems
___Blood Pressure Problems
___Mole or Sore Not Healing
___Hot or Cold Natured
___Suspect Se1ious Disease or Cancer
___Leg Cramps While Walking
___Thirstier Lately
___Fatigue
___Work or Family Problems
___Anxiety
___Anemia
___High Cholesterol & last result_____
___Frequent Crying Spells, Depression

Males Only
___Weak Urine Stream
___Painful or Sore Genitals (Privates)
___Prostate Trouble
___Hard to Empty Bladder Completely
___**Perform Self Testicle Exam: Monthly**
___**Last PSA Test** (If Over Age 50) Date_____

Females Only
___Last Menstrual Period_____
___Vaginal Discharge or Problems
___Painful or Sore Genitals (Privates)
___Lumps or Pain in Breasts
___Last Bone Density Test_____
___ Last Mammogram: Date_____
___Last Pap Smear Date_____
___Perform Self Breast Exam Monthly