3725 MALL DR, TEXARKANA, TX 75501
PHONE:903-306-0001 FAX:903-306-2838
EMAIL: DARClinic@yahoo.com

Patient Information

Last _____ **First**_____ **MI**_____

DOB_____ **SS#**_____ ☐**Male or** ☐**Female**

Address_____ **City**_____ **ST**____ **Zip**_____

Home Phone_____**Cell**_____

Employer Name_____ **Phone#**_____

Emergency Contact Name_____**Phone#**_____

Marital Status: Single☐ **Married**☐ **Divorced**☐ **Separated**☐ **Widowed**☐

Preferred Pharmacy_____ **Patient Email**_____

PRIMARY INSURANCE INFORMATION

Plan Name_____ **ID#**_____ **Group**_____

Policy Holder's Name_____ **DOB**_____**SS#**_____

SECONDARY INSURANCE INFORMATION

Plan Name_____ **ID#**_____ **Group**_____

Policy Holder's Name_____ **DOB**_____**SS#**_____

The undersigned patient (or patient's representative) consents to allow *EXCEED HEALTH CLINIC* to provide medical care, testing, and treatment according to the judgement and diagnosis of the provider in attendance that are deemed necessary and advisable. This care may include additional testing such as laboratory tests, EKGs, X-rays, and other necessary test to ensure proper diagnosis and accurate treatment. Treatment may include administering medications (injections, IVs), surgical procedures (lancing abscesses, sutures, removal of skin anomalies, etc.), as well as papsmears, toenail removal, ear irrigations, and other invasive procedures. I understand that if, at any point, I do not wish to have such testing or treatment performed I am responsible for notifying the provider or nursing staff that I want to decline testing and/or treatment. I also understand that if I fail to notify the provider or nursing staff, I cannot hold the provider or clinic liable for any incurred charges from such testing or treatment. I understand that it is my responsibility to contact my insurance carrier prior to testing and/or treatment to determine coverage for such services.

_____ _____

Patient (or Guardian Signature) **Date**

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CONSENT FOR MEDICAL TREATMENT

The undersigned patient (or patient's representative) consents to allow EXCEED HEALTH CLINIC to provide medical care, testing, and treatment according to the judgement and diagnosis of the provider in attendance that are deemed necessary and advisable. This care may include additional testing such as laboratory tests, EKGs, X-rays, and other necessary test to ensure proper diagnosis and accurate treatment. Treatment may include administering medications (injections, IVs), surgical procedures (lancing abscesses, sutures, removal of skin anomalies, etc), as well as papsmears, toenail removal, ear irrigations, and other invasive procedures.

I understand that if, at any point, I do not wish to have such testing or treatment performed I am responsible for notifying the provider or nursing staff that I want to decline testing and/or treatment. I also understand that if I fail to notify the provider or nursing staff, I cannot hold the provider or clinic liable for any incurred charges from such testing or treatment. I understand that it is my responsibility to contact my insurance carrier prior to testing and/or treatment to determine coverage for such services.

By signing below, I am stating that I have read and understand the above *Consent for Medical Treatment*.

_____ _____

Patient Name (Please Print) **Patient DOB**

_____ _____

Patient (or Guardian) Signature **Date**

REV 7/2021 JS

EXCEED HEALTH CLINIC

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FINANCIAL POLICY

We are committed to providing you the best possible care. Please understand that payment of your bill is considered part of your care. The following is a statement of our FINANCIAL POLICY which we require that you read and sign prior to any treatment. You are required to provide us with your most current billing information and notify us immediately of any changes.

We accept cash, checks, credit cards, as form of payment.

There is a $60.00 charge for every returned check.

PPO/HMO AND OTHER MANAGED CARE

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, we are happy to file your insurance claims. However, you are responsible for paying all co-payment, deductibles, coinsurance, and non-covered services. We are not a party to the contract between the patient and their insurance company and have our own contractual obligations with each of the insurance companies we participate with. Even with assignment of benefits, you are still ultimately responsible for all charges.

SELF PAY

Payment of services is due at the time services are rendered. Balances MUST be PAID IN FULL before your next appointment. Payment plans may be arranged but must have approval prior to appointment time. Balances on payment plans MUST be PAID IN FULL in 3 months or less.

DELINQUENT ACCOUNTS

Accounts that are not paid in full or satisfactory arrangements have not been made within 3 months (90 days) of the date services were rendered will be considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau, and/ or to our attorney for further action. All collection fees are charged to the patient.

Please let us know if you have any questions. Sign and date below stating that you have read and understand our Financial Policy.

_____ _____

Signature **Date**

EXCEED HEALTH CLINIC

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CANCELLATION AND NO-SHOW POLICY

We understand that situations arise making you unable to keep your appointment with EXCEED HEALTH CLINIC. If you must cancel your appointment please provide 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled at that time.

Office appointments which are cancelled with less than a 24-hour notification may be subject to a $20.00 cancellation fee. Procedure cancellations also require a 24-hour advance notice, and without proper notification you may be subject to a minimum $60.00 Cancellation fee. Cancellation fees may be higher if medications and supplies are ordered specific to the scheduled procedure.

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

Any Cancellation and 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 special unavoidable circumstances may cause you to cancel with less than 24 hours notice. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician-patient relationship is based mutual respect with understanding and good communication. Questions about Cancellation and NO-SHOW fees should be directed to the Billing Department at (903)306-0001.

Please sign that you have read and understand this Cancellation and NO-SHOW Policy.

_____ _____

Patient Name (Please Print) **Date of Birth**

_____ _____

Signature of Patient or Patient Representative **Date**

REV 7/2021 JS

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CONSENT TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME:_____ DOB_____ SSN_____

Due to the Health Insurance Portability and Accountability Act (HIPPA) of 1996, medical records and account information are, by law, very protected. EXCEED HEALTH CLINIC will only communicate or disclose your PHI to the person(s) listed below and only as designated below:

I grant permission to EXCEED HEALTH CLINIC to communicate information about my MEDICAL TREATMENT (PHI) and/or my MEDICAL ACCOUNT INFORMATION to the person(s) listed below:

_____ _____ ☐ TREATMENT ☐ ACCOUNT
NAME RELATION TO PATIENT

_____ _____ ☐ TREATMENT ☐ ACCOUNT
NAME RELATION TO PATIENT

_____ _____ ☐ TREATMENT ☐ ACCOUNT
NAME RELATION TO PATIENT

_____ _____ ☐ TREATMENT ☐ ACCOUNT
NAME RELATION TO PATIENT

I understand that myself or my legal representative may revoke this authorization at any time by providing written notice to EXCEED HEALTH CLINIC.

I understand that information released to authorized individuals listed above may be disclosed to others via these recipients which may cause this information to no longer be protected by Federal and Texas privacy laws.

I understand that this consent does not apply to release of information regarding my spouse, children or any other family member over the age of 18. I understand that the persons identified above must authorize their own individual consent for release and disclosure of their Protected Health Information (PHI).

I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); treatment for drug and/or alcohol abuse; mental behavioral health or psychiatric treatments.

☐ I have chosen to create a password to authorize release of PHI and I understand it is my responsibility to relay this password to the above listed authorized person(s).
Password:_____

☐ I have read and understand the information on this form.

_____ _____
Signature Date

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Privacy & Communication Consent

Patient Name:_____

Date Of Birth:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The notice of Privacy Practices for EXCEED HEALTH CLINIC has been made available for me to review. I understand that I may request a copy for myself of this notice or obtain a copy from their website exceedhealthclinic.com at any time. I also understand that I will receive notice of any changes made to the Privacy Practices for EXCEED HEALTH CLINIC when any changes are made or access the revised copy on the website provided above.

_____ _____

Signature **Date**

COMMUNICATIONS CONSENT

I authorize EXCEED HEALTH CLINIC to contact me in the following manner: (please mark all that apply and provide phone numbers for those choices)

Phone Communication:

☐ **HomePhone#:**_____ **Leave message w/information: Y N**

☐ **Cell Phone #:**_____ **Leave message w/information: Y N**

☐ **Work Phone #:**_____ **Leave message w/information: Y N**

☐ **E-Mail Address:** _____ **Leave message w/information: Y N**

Our office uses an automated calling system for appointment reminders, account notifications, and notifications of receipt of test results. If you DO NOT wish to receive communications via automated system, you must notify the receptionist so that this service can be turned off.

_____ _____

Signature **Date**

EXCEED HEALTH CLINIC

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MEDICAL HISTORY

Name:_____DOB:_____Age:_____
Allergies:_____
_____ ☐ NKDA (No known drug allergies)

PATIENT PAST MEDICAL HISTORY
Do you have to have you ever been diagnosed with:

☐ ADD/ADHD	☐ Chicken Pox	☐ GERD
☐ Allergies	☐ Chronic Pain	☐ Gout
☐ Anemia	☐ Congenital Anomalies	☐ H-Pylori
☐ Angina	☐ Constipation	☐ Head Injury (concussion)
☐ Anxiety Disorder	☐ Coronary Artery Disease	☐ Headaches
☐ Arthritis	☐ DVT/blood clot	☐ Heart problems/disease
☐ Asthma	☐ Depression	☐ Heart Attack
☐ Autism	☐ Developmental/Behavior	☐ Hepatitis Type_____
☐ Auto Immune	☐ Diabetes Type 1	☐ High Cholesterol
☐ BPH	☐ Diabetes Type 2	☐ Hypertension
☐ Bedwetting	☐ Diabetes Type 2-insulin	☐ Hyperthyroidism
☐ Bipolar	☐ Diverticulitis	☐ Hypothyroidism
☐ Bladder/kidney problems	☐ Diverticulosis	☐ Liver disease
☐ Blood disease	☐ Erectile Dysfunction (ED)	☐ Lupus
☐ COPD	☐ Ear/Hearing problems	☐ Mental Illness
☐ Cancer	☐ Fibromyalgia	☐ Muscle/Joint/Bone problems

**Cont. Past Medical History

Other:

☐ Osteoporosis
☐ Pulmonary Embolism
☐ Pancreatitis
☐ Seizures/Epilepsy
☐ Sickle Cell
☐ Skin Problems
☐ Stroke
☐ Tuberculosis
☐ Vision/Eye Problems
☐ Migraines
☐ Emphysema
☐ Vascular disease

MEDICATIONS

Please list current medications:

_____
_____
_____
_____
_____
_____
_____
_____

OTHER PROVIDERS

Please list other providers you may see:

_____
_____
_____
_____
_____
_____
_____
_____

HEALTH HABITS

Mark all that apply:

☐ Caffeine - small moderate heavy

☐ Tobacco/Vape - packs per day_____ Dip-cans per day_____ Vape mg_____

***If you are not a smoker, have you ever smoked? Y Or N Date you quit_____

☐ Alcohol - Frequency:_____ Street Drugs - Type_____ Frequency:_____