EXCEED HEALTH CLINIC

3725 Mall Drive. Texarkana, Texas 75501
P: 903-306-0001 F: 903-306-2838. E: DARClinic@yahoo.com
www.exceedhealthclinic.com AND Facebook@ExceedDPC

Welcome Packet

Thank you for choosing Exceed Health Clinic for your healthcare needs! We are no longer an Urgent Care facility.
We are a Family Practice now!

Enclosed in this document is our New Patient Paperwork. We require all new patients to fill out all the forms in this packet before being seen. You can return these upon your appointment, fax them to us, or e-mail them to us. However, if you use e-mail, please be aware that e-mail is not the most secure way of transmitting personal data.

If you have any questions, please call 903-306-0001.

Thank you!
Exceed Health Clinic Staff

EXCEED HEALTH CLINIC
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Go to exceedhealthclinic.com for EASY online appointment access!

Ask us about our Membership Program!

Patient Information

Last Name _____ First Name_____ Middle Name_____

DOB(Date of Birth)_____ SS#_____ Male or Female

Address_____ City_____ ST____ Zip_____

Home Phone_____ Cell Phone _____

Employer's Name_____ Employer's Phone#_____

Emergency Contact Name_____ Phone#_____

Marital Status: Single Married Widowed Divorced Separated (**Females**): Are you pregnant? **Y N**

Preferred Pharmacy_____ Patient Email_____

Where did you hear about us? _____

Our office uses an automated calling and texting system for appointment reminders, billing/invoices, 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.

Please authorize (by circling) **your choice(s) of communication and messages below.**
(Please include the numbers or addresses above.)

Home Phone Cell Phone Work Phone E-Mail Address

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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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 (Blood Pressure)
☐ 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

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****Cont. Past Medical History**

☐ Osteoporosis	☐ Stroke	**Surgeries:** _____
☐ Pulmonary Embolism	☐ Tuberculosis	_____
☐ Pancreatitis	☐ Vision/Eye Problems	_____
☐ Seizures/Epilepsy	☐ Migraines	_____
☐ Sickle Cell	☐ Emphysema	**Other**: _____
☐ Skin Problems	☐ 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:_____

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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, and money orders 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 copayment, 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. Balances MUST be PAID IN FULL in 3 months or less.

PERSONAL INJURY (accidents)

We do NOT get involved with third-party claims such as motor vehicle accidents.

SELF PAY

Payment of services is due at the time services are rendered.

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**

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CONSENT TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI or HIPAA)

PATIENT NAME:_____ DOB_____ SSN_____

Due to the Health Insurance Portability and Accountability Act (HIPAA) 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**

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:_____(Optional)

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

_____ _____
Signature **Date**

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**

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