

**A** Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Referring Physician: \_\_\_\_\_ Occupation: \_\_\_\_\_

2. Preferred Phone Number: \_\_\_\_\_ Text/Voice Mails OK:  Yes  No

3. Primary Care Physician: \_\_\_\_\_ Men's Specialist: \_\_\_\_\_

4. Is your wife or partner a patient here?  If 'YES', then their name: \_\_\_\_\_

**B CURRENT MEDICATIONS (Include dose (amount) per day)**

Medication	Dose	Frequency

Name of pharmacy and location: \_\_\_\_\_

**C PAST MEDICAL HISTORY** Check all that apply:

**Please list ALL conditions you have been diagnosed with**

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Controlled?	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Diet <input type="checkbox"/> Pill <input type="checkbox"/> Insulin	<input type="checkbox"/> Liver Disease (including Hepatitis)	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV+
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Anxiety, depression or mental illness		

Any drug allergies?  No  Yes : \_\_\_\_\_

**D PAST SURGICAL HISTORY**

5. List all surgeries and their year:

Surgeries	Year

Have you ever had a blood transfusion?  Y  N

**E HEALTH CONCERNS**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**F FAMILY HISTORY** List who Maternal(M) or Paternal(P) & what disease or cancer

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Stroke or TIA		

**G DO YOU CURRENTLY?**

6. Smoke?  No  Yes \_\_\_ Packs/day  Chew  Pipe Year Quit Smoking \_\_\_\_\_

7. Alcohol?  No  Yes: Beer(Bottles/day)\_\_\_ Hard Liquor (oz/day) \_\_\_\_\_

8. Do you currently use recreational or street drugs?  No  Yes  
Have you ever given yourself street drugs with a needle?  No  Yes

<b>H DIAGNOSTIC PROCEDURES</b>	<b>Normal?</b>
3. PSA: ___/___/___	Y <input type="checkbox"/> N <input type="checkbox"/>
4. Prostate Exam: ___/___/___	Y <input type="checkbox"/> N <input type="checkbox"/>
5. Colonoscopy: ___/___/___	Y <input type="checkbox"/> N <input type="checkbox"/>
6. Bone Density: ___/___/___	Y <input type="checkbox"/> N <input type="checkbox"/>
7. Cardiac Scan: ___/___/___	Y <input type="checkbox"/> N <input type="checkbox"/>
8. Other _____	Y <input type="checkbox"/> N <input type="checkbox"/>
9. Last general physical ___/___/___	

**I HEALTH**

**EXERCISE: (check box that applies)**

Sedentary (No Exercise)  Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)

Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min)

Regular Vigorous Exercise (i.e. work out or recreation 4x/week for 30 min)

Do you work out at a Gym?  Y  N

Do you participate in other sports?  Y  N List here: \_\_\_\_\_

**J SEXUAL HISTORY**

1. Do you have a sexual partner?  Yes  No  Male  Female

2. Are there concerns about your sexual activity that you would like to discuss?  Yes  No

3. Have you had a vasectomy?  Yes  No

**K BODY COMPOSITION**

4. Do you consider yourself:  overweight  just right

5. Have you had unintentional weight loss or gain of 10 pounds or more in the last three months?  
 Yes  No

6. Are you dieting?  Yes  No

7. If yes, are you on a physician prescribed medical diet?  Yes  No  
# of meals you eat in an average day \_\_\_\_\_

8. Salt Intake:  Hi  Med  Low

9. Fat Intake:  Hi  Med  Low

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



(Please Print)

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Marital status (circle one)			Single / Mar / Div / Sep / Wid
Email Address:	May we contact you by email:		YES   NO
Preferred Language	Race/Ethnicity	Gender	Birth date:    Age:
		Male   Female	/   /   /
Mailing Street address:		City / State:	ZIP Code:
Home Phone:	Cell Phone:	Social Security no.:	
(   )			
Occupation:	Employer:	Employer phone no.:	
		(   )	
Other family members seen here:			

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/   /		(   )
Occupation:	Employer:	Employer address:	Employer phone no.:
	/   /		(   )
Primary insurance:		Address:	City/State/ZIP:
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:
		/   /	
Policy no.:		Co-payment:	
		\$	
Patient's relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Secondary insurance:		Address:	City/State/ZIP:
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:
		/   /	
Policy no.:		Co-payment:	
		\$	
Patient's relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

IN CASE OF EMERGENCY			
Local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		(   )	(   )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elite Healthcare, LLC. or insurance company to release any information required to process my claims.</p>			
Patient/Guardian signature:			Date:



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I give *Elite Healthcare, LLC* permission to disclose my protected health information to the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I give *Elite Healthcare, LLC* permission to contact me at the following telephone number or send a message to the most current e-mail address on file:

Telephone Numbers(s): \_\_\_\_\_

E-mail Address: \_\_\_\_\_

May we leave a message on the above phone numbers regarding appointments, test results, and prescriptions?

**YES                      NO**

May we email the above email regarding appointments, test results and prescriptions?

**YES                      NO**

By signing below, I acknowledge that I have been presented with a copy of *Elite Healthcare, LLC* Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law and that I have read and understand such Notice.

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Signature of Patient/Patient Representative  
(Expires after 12 months)

\_\_\_\_\_  
Date



**MISSED APPOINTMENT POLICY**

Reserved appointment times at any Family Practice office is limited and valuable. It is extremely important that all patients honor their reserved appointments. Failure to do so deprives our other patients from receiving care in a timely fashion.

We understand that there may be situations that prevent you from keeping your scheduled appointment. If you are unable to keep your appointment, we ask that you call us at least 24 hours prior to your appointment. **Failure to give sufficient notice will result in being charged \$75 per appointment.** Any fees assessed must be paid prior to scheduling another appointment with any provider at our office. Under certain circumstances, you may be asked to prepay a deposit to schedule an appointment, and if that appointment is kept and/or rescheduled/canceled within 24 hours, the deposit is eligible to be applied as a credit to your account. Our office uses an automated system for reminder text messages; however, this is a courtesy and if you do not receive the text, we are not responsible for your missed appointment.

I have read and understand the Missed Appointment Policy of Elite Healthcare, LLC.

Patient Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_



## FINANCIAL POLICY

**Fees for Services and Payments:** Fees are standard and based on the complexity of your visit. Payment in full is expected at the time of service and can be made with cash, check, Visa, MasterCard, Discover or American Express. This payment will include any unmet deductible, co-insurance, co-pay, or non-covered charges from your insurance company. If you do not carry insurance, payment in full for services rendered will be required at the time of service.

**Insurance:** We participate with many insurance plans, including Medicare. As a courtesy to our patients, we will bill your insurance provided we have your current information. It is your responsibility to inform us of current insurance at **every visit**. Before your visit, it is your responsibility to contact your insurance company to verify that we are participants in your particular plan and that the services you intend to receive are covered.

*\*Please note: Not all services are a covered benefit on all policies, so it is very important that you understand the provisions of your individual policy. Each health plan selects certain services that they will not cover; therefore, we cannot guarantee payment of all claims by your insurance carrier. (Examples of non-covered services: contraception, infertility, weight loss. Rejection of your claim does not relieve you of your financial responsibility!)*

**Returned checks:** There is a \$30 returned check charge for nonsufficient funds, stop payment or any other reason. This fee, as well as the original check amount, is due in our office within 10 business days after notification. If the amount owed is not received within that time, we reserve the right to turn this bad debt over to the Denton County District Attorney's office.

**Annual Exams and Problem Visits:** Please be aware that an annual physical exam or an annual well-woman exam or preventative visit covers the cost of a breast exam and pelvic exam along with a pap smear and refill of your medications ONLY. Any additional problems addressed, or procedures performed, will be billed to your insurance carrier, and may result in additional out of pocket expenses. These additional expenses will be expected at the time of service.

**Short-term disability forms, Leave of absence and/or Family Medical Leave Act (FMLA) forms:** If your employer requires FMLA and/or Disability paperwork to be completed by your provider, we are happy to complete these forms for you; however, due to the considerable amount of information required, we require a prepayment of \$40 for completion of each set of above forms. Please allow 7 working days for the completion of these forms.

**Lab Charges:** Depending on your insurance, you may get a separate bill from the lab facility that performs your labs and/or pathology. These charges will need to be discussed directly with the lab facility as we do not collect nor bill for these services.

**Medical Records:** To be in compliance with Texas State Law and HIPAA regulations, you may submit a request in writing should you need a copy of your medical records. There will be a fee of \$25 for the first 20 pages and \$.50 per page thereafter. Our office will have 15 business days to process your request once payment has been made and a signed records release has been obtained. As a professional courtesy, a fee will not be applied to transfer your records to another provider's office, given we have obtained a signed release form from you.

**Missed Appointments:** If you are not able to keep your scheduled appointment, you must provide our office with a 24-hour notice to cancel. If proper notice is not given, regardless of the circumstance, the following fees will apply: **\$75 for any office visit**. *We do not double book, so if you do not show up, you are disrupting the office schedule and preventing another patient from being seen*

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will reflect the previous balance, any new charges to the account, payments and credits applied to your account during the month. If you fail to remit payment or establish payment arrangements, your account will become past due and may be subject to further collection activity.

**Past due account:** If your account becomes past due, you have received two statements and have failed to remit payment or make payment arrangements, we reserve the right to terminate the availability of our services to you until the balance is paid in full. Accounts that are not paid within 90 days from the due date will automatically be transferred to our external collection agency. If you have not paid the collection agency within 30 days of notice, they will report this to the Credit Bureau. *We reserve the right to file past due accounts in small claims court.*

**Assignment of Benefits/Medical Release:** With my consent, Elite Healthcare, LLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. I also assign all payment for medical services rendered to my dependents or myself to Elite Healthcare. I understand that I am responsible for any amount not covered by insurance or any amount deemed my responsibility by my insurance.

I have read and understand the Financial Policy of Elite Healthcare, LLC.

Patient Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_



**CONSENT TO TREAT**

By signing this consent, I am authorizing my physician and/or other individuals she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Elite Healthcare, LLC unless revoked by me in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick; or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of the Elite Healthcare, LLC if any of these situations occur during your treatment period.

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

**PATIENT CONTROLLED SUBSTANCE AGREEMENT:**

The purpose of this agreement is to set out the rules that this office follows in order to prescribe medications that are controlled by the Drug Enforcement Agency (DEA). We are committed to making sure we address your needs while providing you with alternatives designed to minimize the addictive potential of the controlled substance treatments we use. In this regard, we may refer you to a Pain Management program to ensure you have access to the best, safest treatments available. If your controlled substance medication (pain, stimulant, sedative) requires ongoing prescriptions that have significant addiction potential we will be requesting you to see a specialist as applicable. To clarify our expectations in giving you this medication and to emphasize the risk of taking these substances we are requesting you to read and sign this agreement.

1. I understand that I am being prescribed a controlled substance; therefore, I must adhere to the following restrictions. **Failure to conform to any of the below listed restrictions may result in being dismissed as a patient and being reported to the Police.**
2. I will not use alcohol/illegal drugs while being prescribed medication(s).
3. I will not take any other prescribed controlled medications without first notifying my provider.
4. I will notify my provider immediately of any other provider(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty days (including emergency rooms and immediate care center). Legally, failure to do so is a crime (obtaining or attempting to obtain drugs by fraud and/or deceit) and may be reported to the Police.
5. I will submit to random urine and/or serum drug screens as ordered.
6. I authorize my provider to communicate with all providers I have seen.
7. I understand it is illegal to share this medication.
8. I agree to keep my medication safe and secure in order to prevent loss or theft.
9. I understand that I will be taken off these medications there is evidence of addiction and/or abuse.
10. I understand that some of these medications may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and short-term memory impairment. I understand that overdose of this medication may cause death.
11. I agree to keep all scheduled appointments with my provider. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.
12. I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications. I understand and except the risk of addiction that can occur with this medication.
13. I authorize this office to release a copy (or original) of this controlled substance agreement to the Police if I violate any of the listed terms or at their request.
14. (Y or N) Have you received any prescription medications from any other physician in the past thirty days? If yes, please list physician and medication below.  
Physician: \_\_\_\_\_ Medication(s): \_\_\_\_\_
15. I understand I may be called at any time to the office for a count of all my remaining medications. I agree to arrive on the day notified and will be responsible for any costs this may incur.
16. I waive my right of privacy and authorize my provider to contact any health care provider, legal authority, friend and/or relative in order to obtain or provide information about my care (including abuse of controlled substances).
17. No refills will be authorized on weekends, holidays or after office hours. An exception may be made at the doctor's discretion if you are seen for an office visit with a copy of a completed police report.

I have read the above, asked questions and understand this agreement. If I violate this agreement, I know the physician may discontinue my treatment.

\_\_\_\_\_  
Patient Name (PRINTED)

\_\_\_\_\_  
Patient/ Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date