ELITE HEALTHCARE

PATIENT HISTORY QUESTIONNAIRE

A Patient's Name: _____ Date: _____

1. Referring Physician: _____
2. How did you hear about us? _____
3. Preferred Phone Number: _____
4. Text/Voice Mails OK: ☐ Yes ☐ No

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

Medication	Dose	Frequency

Name of pharmacy and location:_____

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

Please list ALL conditions you have been diagnosed with

☐ Arthritis
☐ Diabetes: Controlled? Y / N
☐ Diet ☐ Pill ☐ Insulin
☐ High blood pressure
☐ Heart disease
☐ Other:_____
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease (including Hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Eating Disorder

Any drug allergies? ☐ Yes ☐ No If yes: _____

D **PAST SURGICAL HISTORY (NOT OB/GYN)**

5. List all surgeries and their year:

Surgeries	Year

E **PAST OBSTETRICAL/ GYNECOLOGICAL SURGERIES** Check any that apply:

Surgery	Year	**Surgery**	Year
☐ D&C		☐ Myomectomy	
☐ Hysteroscopy		☐ Cyst(s) removed ovarian L / R	
☐ Infertility surgery		☐ Ovary removed L / R	
☐ Tubal Ligation		☐ Vaginal or bladder repair	
☐ Laparoscopy		☐ Other (specify) _____	
☐ Hysterectomy (Vaginal)/ (Abdominal)			

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

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Other:_____
☐ Ovarian Cancer ☐ Endometrial Cancer ☐ Colon Cancer

List :_____

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G **DO YOU CURRENTLY?**

6. Smoke? ☐ No ☐ Yes: ____ Packs/day
7. Alcohol? ☐ No ☐ Yes: wine (glasses/day) ____ Beer(Bottles/day)____ Hard Liquid (oz/day) _____
8. Exercise _____ How often:_____

H **PAST GYNECOLOGICAL HISTORY** Check any that apply:

☐ Venereal Warts ☐ Herpes-genital ☐ Syphilis ☐ Pelvic Inflammatory Disease ☐ Chlamydia ☐ Gonorrhea
☐ Endometriosis ☐ Fibroids ☐ Cysts

I **MENSTRUAL HISTORY** (**Complete even if post-menopausal or no longer having periods**)

1. First day of last menstrual period _____
2. If your menstrual periods are regular; periods start every: _____ days.
3. If your menstrual periods are irregular; periods start every: ____ to ____ days (e.g. 12 to 60).
4. Duration of bleeding: _____ days
5. Age at first period _____Years Menopause _____ Age

J **BIRTH CONTROL /SEXUAL HISTORY**

1. What birth control method(s) do you currently use? _____
2. Do you have a sexual partner? ☐ Yes ☐ No ☐ Male ☐ Female

K **PAP SMEAR/MAMMOGRAM HISTORY**

3. Date of last pap smear: _____/_____/_____
4. Have you had abnormal pap smears? ☐ Yes ☐ No
5. Have you had treatment for abnormal smears? ☐ Yes ☐ No
6. Date of last mammogram: _____
7. Facility Name: _____
8. Have you had an abnormal mammogram? ☐ Yes ☐ No
9. Have you had a bone density? ☐ No ☐ Yes When _____ Where _____
10. Have you had a colonoscopy? ☐ No ☐ Yes When_____ Where_____

If Yes what type(s)	Year
Cryotherapy	
Laser	
Cone Biopsy	
Loop Excision (LEEP)	

L **PREGNANCY HISTORY (ALL PREGNANCIES)**

OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Location	Duration of Pregnancy	Hours of Labor	Type of Delivery	Complications Mother/Infant	Child: Sex	Child: Birth Weight	Child: Present Health

_____ _____

Patient Signature Date

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(Please Print)

Today's date:		PCP:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ 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:	❑ Self	❑ Spouse	❑ Child	❑ 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:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

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.

Patient/Guardian signature: *Date:*

ELITE HEALTHCARE

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 Date
(Expires after 12 months)

ELITE
HEALTHCARE

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: _____

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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: _____

ELITE
HEALTHCARE

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: _____

ELITE HEALTHCARE

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