Plano Wellness

Interval Patient Health History Questionnaire

Form must be filled out completely. Please check ☐ (Box) labeled "None" or "No" if it does not apply.

Name: _____ **DOB:** _____ **Age:** _____

E-mail: _____ **Phone #**: _____

(ALL PATIENTS MUST PROVIDE AN E-MAIL ADDRESS TO ACCESS WEB PORTAL)

Address/City, State, Zip_____

***A PHARMACY MUST BE PROVIDED**

Local Pharmacy: _____→ **Pharmacy Phone # *or* Address:** _____

Mail Order Pharmacy: _____ Compounding Pharmacy: _____

I give permission to Plano Wellness personnel to give any/all medical information pertaining to myself to the following: ☐ *I would not like my information shared with anyone.*

Name: _____ **Phone#:** _____ **Relationship:** _____

Any Insurance Change? ☐ **No** ☐ **Yes**

Insurance Main Card Holder: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **No Insurance, I will be Self-Pay**

If Spouse or Parent, Name: _____ DOB: _____

HEALTH SCREENING

HPV/Gardasil Vaccine completed? ☐ No ☐ Yes, Year: _____	**Last Pap Smear**	Date:_____
Is your Tetanus vaccine current? ☐ No ☐ Yes, Year:_____	**Last Mammogram**	Date:_____
COVID vaccine? ☐ No ☐ Yes, Year: _____	**Last Colonoscopy**	Date:_____
Shingles vaccine? ☐ No ☐ Yes, Year:_____	**Last Bone Density**	Date:_____

Tobacco:	☐ Never	☐ Sporadic	☐ Daily	☐ Quit, Year: _____
Alcohol:	☐ Never	☐ Sporadic	☐ Daily	☐ Quit, Year: _____
Exercise:	☐ Never	☐ Sporadic	☐ 3-4/wk	☐ Daily
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Separated ☐ Widowed

PCP: _____ **(DR. DIAZ & LISA PRICE, FNP-C are NOT Primary Care)**

MEDICATIONS:

Since your last Visit, have you started taking any **NEW** medications or supplements? ☐ YES ☐ No

OFFICE USE	**Ht:**	**Wt:**	**BP:**	**P:**	**UA:**	**Temp:**

*PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. MARK BOXES WITH "NO"/ "DECLINE" IF SECTION DOES NOT PERTAIN TO YOU.

Since your last visit, have you been diagnosed with any NEW allergies to medication, food or environmental allergens? ☐NO ☐YES

If yes, please explain: _____

Since your last visit, have you been diagnosed with any of the following? ☐ NONE

- ☐ AIDS
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clotting disorder
- ☐ Breast cancer
- ☐ Cardiac arrhythmia
- ☐ Cholesterol(Hypercholesterolemia)
- ☐ Colon cancer
- ☐ Congestive heart disease
- ☐ COPD (Lung disease)
- ☐ Coronary heart disease
- ☐ Depression
- ☐ Diabetes
- ☐ DVT (venous embolism)
- ☐ Epilepsy
- ☐ Esophageal reflux
- ☐ Fibromyalgia
- ☐ Genetic disorder
- ☐ Hepatitis (**A**, **B**, or **C**)
- ☐ Hernia
- ☐ HIV
- ☐ Hypertension (HTN)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney stone
- ☐ Lung cancer
- ☐ Migraine headaches
- ☐ Mitral valve prolapse (MVP)
- ☐ Myocardial infarction
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Skin cancer
- ☐ Stroke (CVA)
- ☐ Suicide Attempt
- ☐ Thyroid (**Hypo** or **Hyper**)
- ☐ Transient Ischemic attack
- ☐ Triglycerides, Elevated
- ☐ Ulcer
- ☐ Other:_____
  _____
  _____
  _____

Since your last visit, have you been hospitalized? *(excluding surgeries & childbirth)* ☐NO ☐YES

Since your last visit, have YOU had surgery? ☐NO ☐YES

If yes, please explain: _____

Since your last visit, has any FAMILY member been diagnosed with a NEW medical condition or cancer? ☐NO ☐YES

If yes, please explain: _____

Has a FAMILY member ever had genetic testing for Hereditary cancer risk? ☐NO ☐YES

If yes, please explain: _____

GYN History

Next Section

Sexually Active? ☐ No ☐ Yes

Is your intimate life satisfactory? ☐ No ☐ Yes

Sexual Partner Preference: ☐ Male ☐ Female

Physical, Emotional, Sexual Abuse? ☐ No ☐ Yes

Attempting Pregnancy? ☐ No ☐ Yes

If yes, For how long? _____

Menstrual Cycles

Not having menstrual Cycles? **(Check any that apply)**

- ☐ Menopause
- ☐ Birth Control
- ☐ Hysterectomy
- ☐ Nursing
- ☐ Ablation

At what age was your first cycle? _____

Last cycle started on: _____/_____/_____

Menstrual Timing: ☐ Regular Cycle ☐ Irregular Cycle

How often? _____

Flow: ___Heavy Days ___Moderate Days ___Light Days

Cramps: ☐ No ☐ Yes **Clots:** ☐ No ☐ Yes

*PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. MARK BOXES WITH "NO"/ "DECLINE" IF SECTION DOES NOT PERTAIN TO YOU.

Method of birth control you are using? ☐ **NONE**

- ☐ ***Not sexually active yet***
- ☐ ***None, would welcome pregnancy***
- ☐ ***None, History of Infertility***
- ☐ Abstinence
- ☐ Birth Control Pill
- ☐ Condoms
- ☐ Depo Provera
- ☐ Diaphragm
- ☐ Essure
- ☐ IUD Hormone Progestin
- ☐ IUD 10 yr Copper
- ☐ Natural Family Planning
- ☐ Hysterectomy
- ☐ Patch
- ☐ Vaginal Ring
- ☐ Progestin Implant (Nexplanon)
- ☐ Rhythm
- ☐ Salpingectomies, Bilateral
- ☐ Same-sex partner
- ☐ Tubal Ligation, Bilateral
- ☐ Vaginal hormone inset
- ☐ Vaginal spermicide
- ☐ Vasectomy
- ☐ Withdrawal

Past GYN History - **Do you have or have you ever had:** ☐ **NONE**

- ☐ Abnormal Pap Smear
- ☐ Amenorrhea
- ☐ Anovulation
- ☐ Bartholin's gland cyst
- ☐ Cervical cancer
- ☐ Candidiasis (chronic yeast)
- ☐ Chlamydia
- ☐ Condyloma (genital warts)
- ☐ Cryotherapy
- ☐ Cystocele (dropped bladder)
- ☐ DES exposure in utero
- ☐ Dysplasia (pre-cancer)
- ☐ Dyspareunia (painful sex)
- ☐ Endometriosis
- ☐ Fibroid uterus
- ☐ Gonorrhea
- ☐ Heavy periods
- ☐ Herpes, genital
- ☐ HPV
- ☐ Hydrosalpinx
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular menses
- ☐ LEEP
- ☐ Ovarian cancer
- ☐ Ovarian problems
- ☐ Pelvic adhesions
- ☐ PID
- ☐ PMS
- ☐ Polycystic Ovaries (PCOS)
- ☐ Syphilis
- ☐ Trichomonas
- ☐ Uterine cancer
- ☐ Uterine Polyps
- ☐ Uterine Prolapse
- ☐ Vaginal or Vulvar Cancer

Review of Systems: *(Please **circle** any symptoms you **currently** have):* ☐**NO SYMPTOMS**

General	Chills Fatigue Fever Night sweats Weight gain Weight loss
Eyes	Blind spots Floaters in the visual field Eye pain
Ears, Nose, Throat, Neck	Bleeding gums Hoarseness Swollen neck Decreased hearing Difficulty swallowing Nosebleed
Endocrine	Cold intolerance Heat intolerance Excessive hair growth Hair Loss Excessive Thirst Breast discharge Hot Flashes
Respiratory	Hemoptysis (bloody cough) Shortness of breath Wheezing
Cardiac	Faint Chest pain Palpitations Shortness of breath at rest
GI	Abdominal pain Blood in stool Constipation Diarrhea Nausea Vomiting
Heme/Lymph	Anemia Easy bruising Prolonged bleeding Swollen glands
GU	Nocturia (urination at night) Pelvic pain Vaginal dryness Vaginal discharge Vaginal itching Vaginal burning Low sex drive Difficult to climax Painful intercourse Blood after intercourse Blood in urine Frequent urination Painful urination
Musculoskeletal	Back problems (pain) Painful joints Weakness Swollen joints
Skin	Acne Dry skin New mole Rash
Neurologic	Dizziness Headache Poor memory Tingling/Numbness
Psychiatric	Anxiety Depressed mood Irritability Insomnia Suicidal thoughts Difficulty Sleeping

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Plano Wellness Medical, PLLC
Plano Wellness, PLLC

Patient Financial Agreement

The following information is provided to all our patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements. Please ask a team member if you have any questions regarding these policies.

- We are happy to bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are your responsibility as our patient. We do expect payment for your portion at the time of service. (co-pays, co-insurance, deductibles). We ask that if your insurance has not paid within 45 days that you follow up with them.
- If you are seen for both an annual preventative exam and a separate problem/illness is identified and also addressed, proper coding will be used. This may result in a charge for both services. Additionally, some medically indicated lab tests may not be covered as a preventative screen by your policy. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.
- Injections and some medical supplies must be paid for in advance at the time of service. Specialized products or services must be preauthorized with insurance prior to service; otherwise, these services will need to be paid in full by the patient at the time of service.
- For surgical care, we will pre-certify your insurance and obtain the estimated patient responsibility for the procedure. This amount is due prior to the scheduled date of surgery. If the procedure results in additional charges, these fees will be billed to you. We would ask that you pay the balance within 30 days following your surgery.
- We routinely send our laboratory testing to third-party laboratory companies. The aforementioned providers may or may not participate with your health plan. You may request that we refer your testing to another location. This request will need to be done with each visit.
- It is necessary to strictly enforce the policy of financial obligation. All co-pays, patient self-payment, and estimated patient financial responsibility may be paid by cash, check, or VISA, MasterCard.
- There will be a charge for no show of $50 for missing a scheduled appointment without a cancellation notice. A charge of $25 will be applied to a cancellation notice of less than 24 hours (business hours) for office visits and $100 for surgical procedures. Payment of this fee is the responsibility of the patient and cannot be filed with insurance companies. These fees will not be waived.
- The charge for paperwork (for example Family Medical Leave Act (FMLA) & Short-Term Disability applications) is $25 for a long form and $10 for short forms. This is payable in full at the time the form is left for completion.

Assignment of Benefits: (ALLOWS US TO FILE YOUR CHARGES WITH YOUR INSURANCE):
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service. If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.
I understand that I am responsible for providing all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **Plano Wellness Medical, PLLC or Plano Wellness, PLLC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that in the event my health plan determines a service to be "non-covered", I will be responsible for all non-covered and allowable charges. I hereby authorize said assignee to release all information necessary to secure payment.

I have read and understand the above information and agree to comply with these financial policies.

Signature: _____ Date: _____

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Plano Wellness, PLLC
Plano Wellness Center, PLLC

Consent to Treat

General Patient Consent for Care

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

Telemedicine

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care.
Billing and payment for a Televisit is the same process for billing and payment for an in-person, face-to-face visit.
A Televisit is available to you as an established patient through your secure patient portal. Your patient portal incorporates network and software security protocols to keep your identification and data confidential, preventing unauthorized parties from being able to access messages while they are in transmission. Video clips, audio clips, and/or photos may be taken of you during the visit for medical documentation and treatment purposes. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.
Potential risks in utilizing this technology include but are not limited to distortions, interruptions or disconnections of the audio/video link which prompt discontinuation of a visit. If a Televisit do not adequately address my medical needs, an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a Televisit, I will alert my treating physician and, in the case of emergency dial 911, or go to the nearest hospital emergency department.
I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. Unlike traditional office visits, my provider does not have the use of senses such as touch or smell. **I may discontinue a Televisit at any time.**

Medication Records

I authorize Plano Wellness Medical, PLLC, Plano Wellness, PLLC and/or Plano Wellness Center, PLLC to download my medication history and Rx benefits into my account from a Rx clearinghouse.

Signed Consent

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Notice of Privacy Practices Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. You have the right to review the Notice before signing this acknowledgment. A copy of the current Notice is available at the front check in counter. The Notice contains the effective date and as provided in our Notice, the terms of our Notice may change.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.
By signing this form, you consent to our use and disclosure of protected health information about you as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent.

_____ _____

Signature of Patient or Guardian **Patient Date of Birth**

_____ _____

Relationship to Patient, if not signed by the Patient **Date**

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