PREMIER
WELLNESS CLINICS

Patient Registration Form

Patient Legal Name: _____

Address: _____ City/State/Zip _____

Phone: (Primary) _____ (Cell) _____ (Work) _____

Driver's License #_____ DOB: _____
Email: _____ Preferred Language _____

SS# _____ DOB: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Legally Separated ☐ Divorced ☐ Widow/Widower ☐ Unknown Spouse Name: _____

Employment Status: ☐ Full Time ☐ Part time Employer: _____

Student: ☐ Full Time ☐ Part time ☐ N/A School: _____

Race: ☐ American-Indian or Alaska-Native ☐ White ☐ Asian ☐ Native Hawaiian ☐ Black or African-American ☐ More than One Race Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Insurance Carrier _____ Member ID: _____

Subscriber Name: _____ Subscriber ID: _____

Subscriber Date of Birth: _____ Group #: _____

Secondary Ins _____

Emergence Name/ Relationship: _____ Phone: _____
Preferred Local Pharmacy: _____ Telephone: _____
Pharmacy Address: _____
Please complete if PATIENT is a student or minor:

Mother's Name: _____ DOB: _____ SS#: _____
Address: _____ Phone: _____
Father's Name: _____ DOB: _____ SS#: _____
Address: _____ Phone: _____

Patient Signature _____ Patient/Guardian _____
(If patient is under 18)

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Dear **Patient**,

The purpose of this consent form is to notify you that if you carry an HMO plan (this includes Ambetter), you are responsible for finding the:

- Physician
- Location Address
- Phone Number
- Fax Number
- NPI Number

for **ANY** referrals.

Sincerely,

Premier Wellness Clinics Team

I acknowledge that I am aware of the terms and conditions.

_____
Printed Patient Name Date

_____ Signature of Patient

2601 Little Elm Parkway, Building 12, Unit 1204, Little Elm, TX 75068
Tel: (972) 292-0300 | Fax: (972) 292-0301 | www.premierwellnessclinics.com

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Patient Medical History

Patient Name: _____ **Date:** ____/____/____

Please check any illness or condition you have had:

- ○ ADD
- ○ Abnormal Pap Smear
- ○ Alcoholism
- ○ Allergies
- ○ Anemia
- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Back pain, chronic
- ○ Breast cancer
- ○ Colon polyp
- ○ Depression (current)
- ○ Depression (past)
- ○ Diabetes Type I
- ○ Are you in good health?
  - ○ YES
  - ○ NO
- ○ Diabetes Type II
- ○ Diabetes, gestational
- ○ Diverticular disease
- ○ Eczema
- ○ Endometriosis
- ○ Erectile dysfunction
- ○ Fibromyalgia
- ○ Genital herpes
- ○ Heart disease
- ○ Glaucoma
- ○ Hemorrhoids
- ○ High cholesterol
- ○ High blood pressure
- ○ Irritable bowel
- ○ Kidney Stones
- ○ Low thyroid
- ○ Migraine
- ○ Obesity
- ○ Osteoporosis
- ○ Osteopenia
- ○ Postmenopausal
- ○ Prostate enlargement
- ○ Reflux
- ○ Rheumatoid arthritis
- ○ Seizure disorder
- ○ Sleep apnea
- ○ Stroke
- ○ Tobacco use

SURGERIES

- ○ Appendix
- ○ Ear Tubes
- ○ Gall bladder
- ○ Heart bypass
- ○ Hernia repair
- ○ Knee ACL
- ○ Knee other
- ○ Lumbar back
- ○ Neck C-spine
- ○ Shoulder
- ○ Tonsils

Women

- ○ Breast augmentation
- ○ C-section
- ○ Hysterectomy
- ○ Tubal ligation

Routine Health Screening: (most recent dates)

Colonoscopy: _____ Mammogram: _____

Bone Density: _____ Pap Smear: _____

Tetanus Booster: _____

Other:

_____

Any allergic reactions to medications or substances? ○ YES ○ NO

If **yes**, please list: _____

Pharmacy Name and Location: _____

Social History:

Do you smoke?	○ YES	○ NO	If YES, amount & type:	_____
Do you drink alcohol?	○ YES	○ NO	If YES, how often:	_____
Any drug use?	○ YES	○ NO	If YES, type & amount:	_____
Do you have any history of abuse?	○ YES	○ NO	If YES, type, age, by whom:	_____

Family Medical History (Please include any medical illnesses and cause of death)

Father: _____

Mother: _____

Siblings: _____

Others: _____

Medications (please include "over the counter meds" as well)

Name:	Strength:	How Often:

Allergy Impact Questionnaire

OFFICE STAFF ONLY: ICD-10 CODES FOR PATIENT: _____ : _____ ; _____ ; _____ : _____

Patient's Name: _____ **D.O.B.** ___/___/___ **Date of Service:** ___/___/___
Insurance _____

1. Do you think you suffer from Allergies? ☐ Yes ☐ No

2. Are the symptoms year-round or seasonal? ☐ Year Round ☐ Seasonal

3. How long do your symptoms last during an allergy flare up?
   ☐ > than 7 days ☐ < than 7 days

4. What time of the day are your symptoms the worst?
   ☐ Morning ☐ Afternoon ☐ Night ☐ All day

5. Are the symptoms worse in the Spring, Fall or both?
   ☐ Spring ☐ Fall ☐ Both

6. Do you have any sinus drainage issues?
   ☐ Yes ☐ No **If yes, when?** ☐ AM ☐ PM ☐ All Day

7. Do you ever have watery or itchy eyes?
   ☐ Always ☐ Most Times ☐ Sometimes ☐ Never

8. Do you cough or sneeze on a regular basis?
   ☐ Yes ☐ No **If yes, when?** ☐ AM ☐ PM ☐ All Day

9. Do you have regular Upper Respiratory Infections?
   ☐ Yes ☐ No **If yes**, < 3 or >3 per year

10. Do you think you might be allergic to animals?
    ☐ Yes ☐ No

11. Have you been diagnosed with Asthma?
    ☐ Yes ☐ No **If yes, when?** _____

12. Do you have a family history of Asthma?
    ☐ Yes ☐ No

13. Have you ever been hospitalized for asthma?
    ☐ Yes ☐ No **If yes, when?** _____

14. How long have you lived in Texas? ____ Years / ____ Months

15. How long have you lived in your current residence? ____ Years / ____ Months

16. Did you have allergies in your previous residence or state?
    ☐ Yes ☐ No

17. Are you currently taking any allergy medications?
    ☐ Yes ☐ No
    If yes, please list all medications including any over the counter (OTC) medications as well.
    _____, _____, _____, _____

18. Are you currently taking blood thinner medications?
    ☐ Yes ☐ No If yes, please list: _____, _____, _____

19. Are you currently taking a beta blocker for a heart condition? ☐ Yes ☐ No ☐ Unsure

20. Are you or could you be pregnant? ☐ Yes ☐ No

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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please REQUEST medical information FROM:

Clinic/Physician: _____
Specialty: _____
Address: _____
City: State: Zip _____
Phone: _____ Fax: _____

Please SEND medical information TO:

Dr Khalida Yasmin, MD
2601 Little Elm Pkwy, Bld 12 Ste 1204
972-292-0300 phone
972-292-0301 fax

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and /or drug abuse. Release and/or disclose records and information regarding:

Patient Information Section

Name (Print) _____ Date of Birth _____ Ph _____

Address _____ City/State/Zip _____

Date(s) of Service for Release from _____ to _____

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED: ___Entire medical records__ Progress Note ___Radiology ___Medication History ___History and Physical __ Chart Summary ___Pathology ___Immunization History ___Physician Consultation __ Labs Results ___Physician Report If Other (please specify)_____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only: ___Physician or Health Care Facility ___Legal ___Personal Other (please specify)_____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for my records. I understand that there may be a fee for preparing and furnishing this information

Patients signature or legal representative_____ Date _____

Relationship to patient_____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:

_____

_____

_____ _____

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

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

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Consent to Obtain Prescription History

This consent form authorizes Premier Wellness Clinics to obtain and review my prescription history. Detailed prescription history provides your Medical Practitioner with information about medications being prescribed by other providers in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as drug names or dosages.

By signing this consent form, you agree that Premier Wellness Clinics can request and use you prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding the above, I hereby provide informed consent to Premier Wellness Clinics to request, view, and use my external prescription history for treatment purposes.

Patient Name (please print): _____

Patient Date of Birth: _____

Patient Signature: _____

Date of Signing Consent: _____

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PATIENT PORTAL COMMUNICATION CONSENT

To sign up for access to your health information through our secure patient portal, complete the first portion of this form. To grant access to another adult who helps manage your medical care, complete all portions of this form. Patient portal sign up includes FREE access to the following online services: lab results, appointment management, prescription refill requests, submitting billing questions, referral requests, and medical summary including immunization records.

o **YES**, I want PWC to communicate my information with me, or those that I grant access, to my records through the secure patient portal system that is designed to keep my personal information safe.

YOUR INFORMATION: (All sections required)

Name: (last, first, middle initial): _____

DOB:_____ Sex: **M** **F** Phone Number: _____

Please provide the email address you would like to use to be notified of secure messages

Email Address: _____

Primary Care Physician: _____

- I understand I must be 18 years or older to be signed up to my access my record through the patient portal. If I am under 18 years of age and have become legally emancipated, I must provide legal documentation in order to be provided access to my records for the patient portal.
- I understand that the patient portal is intended as a secure online source of confidential medical information. If I share my user ID and password with another person, that person may able to view me or my family member's health information.
- Is my responsibility to select a confidential password to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in anyway.
- I understand that the patient portal contains limited medical information from my or my family member's medical record and that it does not reflect the complete contents of my medical record. I also understand that a paper copy of my records maybe requested from the clinic.
- I understand that my activity within the patient portal may become part of my medical record.
- I understand that access to the patient portal is provided by Premier Wellness Clinics as a convenience to its patients and PWC has the right to deactivate access to the portal at anytime for any reason. I understand that use is voluntary and I am not required to use the portal.
- By signing below, I acknowledge that I have read and understand this Patient Portal Communication Consent and agree to its terms.

_____ _____

Patient Signature **Date**

Grant Access to Another Adult

Please grant access to my medical record through the secure patient portal to the following adult who helps to manage my medical care. I understand that all portal communication will be sent to their email.

Name (last, first, middle initial): _____

Relationship to Patient: _____ Email Address: _____

Sex: **M** **F** Date of Birth: ____/____/____ Phone Number: _____

Address: _____

_____ _____

Patient Signature **Date**

Financial and Office Policies

Thank you for choosing Premier Wellness Clinics (PWC) as your healthcare provider. We are committed to providing you with quality and affordable healthcare. The following are our Financial and Office Policies. Please read, initial on the left, sign at the bottom, and return to the Front Office Representative. Please ask us if you have any questions about this form or your medical care. We are here to serve you.

Initial Below

_____ **Patient Responsibility:** We participate in many insurance plans. We recommend you become familiar with your insurance benefits and confirm our participation with your plan. Most misunderstandings about insurance can be avoided if you understand why your policy covers. **Please contact your insurance company with any questions you may have regarding your coverage.**

_____ **Insurance Carries Requiring Referral:** If you are referred to a specialist and your insurance carrier requires a referral number, our office must have at least **4 – 7 days notice** to complete the referral.

_____ **Proof of Insurance:** All patients must complete our patient information form before seeing a Provider. We must obtain a copy of a valid drivers license and a current, valid insurance ID card. Please bring these items with you to each appointment. Payment in full is required if we are unable to verify your current insurance information.

_____ **Payments Due at Time of Service:** Any co-pay, deductible, or co-insurance

- Private pay patients, cash patients, or those without insurance: See Front Office Representative for special pricing and/or discount programs.
- ***Payment due at time of service.***

_____ **Claims Submission:** If we are contracted with your insurance company, we will submit your claims. Your insurance may require additional information from you in order to process the claim. Failure to comply with their request within 30 days will result in full patient responsibility for the claim.

_____ **Nonpayment & Returned Checks:** Unpaid accounts will be referred to an outside collection agency and could result in dismissal from the practice. **There will be a $25 fee for all returned checks.**

_____ **Late Arrivals:** Please arrive 15 minutes before your appointment. If you arrive late to your appointment, our office may have to reschedule your appointment to a new time and/or date.

_____ **No Shows:** Please notify us 24 hours in advance by phone or secure portal if you must cancel or change your appointment time. ***Failure to do so will result in a $30 no show fee that is not covered by your insurance. A third no show fee may result in dismissal from the practice.***

Patient's Name (Please Print) _____ **DOB** _____

Signature of Patient, Parent, or Legal Guardian _____ **Date** _____