TEXAS ELITE HEALTH CLINIC, LLC

TODAY'S DATE_____/_____/_____

Sex: Male Female

Patient Name: _____ **Birth Date:** _____/_____/_____

Social Security #:_____-_____-_____ **Email Address:** _____

Phone Number: H (_____) _____ **W** (_____) _____ **C** (_____) _____

Address: _____

City, State, Zip: _____

Marital Status: Single Married Divorced Widowed **Employment Status:** Full Time Part Time Student

Employer Name: _____ **Phone:** _____

Employer Address: _____

City, State, Zip: _____

Emergency Contact Name: _____ **Phone:** _____

Emergency Contact Relation to You (Spouse, Parent, Friend, etc.): _____

Pharmacy Preference: _____ **Phone:** _____

Pharmacy Address/Nearest Cross Street: _____

I, (*print patient name)* _____, HEREBY AUTHORIZE PAYMENT directly to the office of Texas Elite Health Clinic, LLC any health insurance benefits otherwise payable to me but not to exceed the balance due for the regular charges for treatment. I understand I am financially responsible to the office of Texas Elite Health Clinic, LLC for charges not covered by this authorization and for insurance claims, which are denied by the insurer. I also authorize the physician to release any information required to process any claims.

Patient Signature _____ **Date** _____

Who referred you to our practice? _____

Reason for your visit today? _____

Is this due to an accident? Yes No **When did the symptoms appear?** _____

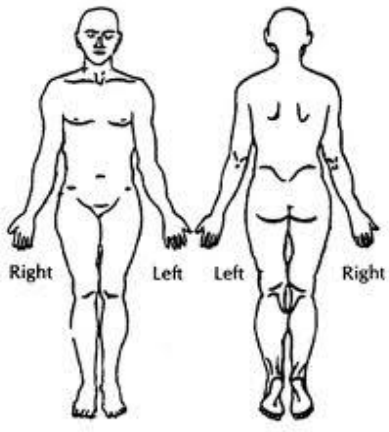
Is this condition getting progressively worse? Yes No Unknown

How often do you have this pain? _____ **Is the pain (circle one)** Constant Comes & Goes

Type of pain (Circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling *Other (Please describe)* _____

Does the pain interfere with (Circle all that apply): Work Sleep Daily Routine Recreation

Activities/movements that are painful to perform: Sitting Standing Walking Bending Lying Down



Severity of your pain on a scale from 1 *(least pain)* to 10 *(most pain)* _____

Current Medications *(Attach list if necessary)*

Drug Name	Dosage	Directions	Year Started
1. *Example: Aspirin*	*500mg*	*1 pill in the morning*	*1996*
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Known Allergies *(Please use the back of page if additional space is needed)*

Medication or Food	Reaction
1.	
2.	
3.	

Past/Present Medical History *(Circle all that apply)*

SYSTEM	ILLNESS
Cardiovascular	High Cholesterol - Hypertension - Heart Attack - CHF - CAD - Irregular Heartbeat Blood Clots
Pulmonary	Asthma - COPD - Pneumonia - TB
Gastrointestinal	Reflux - GERD - Stomach Ulcers
Hematological	Anemia
Neurological	Dementia - Alzheimer's - Stroke - TIA - Anxiety - Depression
Endocrine	Diabetes Type I - Diabetes Type II - Hypothyroidism
Musculoskeletal	Arthritis - Osteoporosis - Fractures (Please Specify):
Cancer	*(Please Specify Type(s) of Cancer):*
Other	Kidney Disease/Stones - Glaucoma/Cataracts - Prostate Problems/ED - Seasonal Allergies Insomnia - Reproductive Problems
Other (Write-In)	

Surgical History *(Please use back of page for additional information)*

Surgery/Procedure	Date	Reason
1.		
2.		
3.		

Preventive and Immunization History

Test	Date	Result *(Normal, Abnormal, Unknown or Specify if needed)*
Mammogram		
Pap Smear		
Bone Density Test		
Stress Test or EKG		
Colonoscopy		
Eye Exam		

Influenza *(Yearly):* Yes No	Hepatitis A & B *(Once, 2 or 3 dose schedule):* Yes No
Tetanus *(Every 10 years):* Yes No	Pneumovax *(After age 65, every 5 years):* Yes No

Social History

Tobacco ***(Circle One):*** Current - Former - Never Smoked ***(Circle Type):*** Cigars - Cigarettes - Smokeless **Year Started**: _____ **Year Quit**: _____ **Packs/Cans per day**: _____	**Alcohol** **Do you drink?** Yes - No - Former Drinker **Type:** Beer - Wine - Liquor **Times per week:**_____ **Amount of drinks Consumed:**_____
Education Status *(Circle One)* High School - Some College College Graduate - Post Graduate	**Exercise** **Specify Type(s):** _____ **How many times per week?** _____
Caffeine **Type:** Coffee - Soda - Tea - Energy Drinks **Amount/Servings per day:** _____	**Family** **Number of Children:** _____ **Mother:** Living Deceased-Age_____ **Father:** Living Deceased-Age _____

Family Medical History

Illness	Relative(s) *(Circle all family that apply)*	Age Diagnosed/Death
Diabetes (Specify Type I or II)	Mother/Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Strokes or "TIA"	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Heart Problems (Specify Type):	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
High Blood Pressure or High Cholesterol (Circle One)	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Osteoporosis or Arthritis (Circle One)	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Alcohol and/or Drug Dependency (Circle One)	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Cancer (Specify Type):	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Mental Illness (Specify Type):	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Depression or Anxiety (Circle One)	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Alzheimer's or Dementia (Circle One)	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Other (Specify):	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	

DISCLOSURE AND CONSENT
Medical and Chiropractic Procedures

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical, chiropractic or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent to the procedure.

I (we) voluntarily request that Dr. Julie Powell, DC, RN, FNP, of Texas Elite Health Clinic, L.L.C. ("Provider"), serve as my healthcare provider. I (we) understand that the Provider is currently licensed by the Texas State Board of Nursing as an Advance Nurse Practitioner and, in such capacity, is authorized to provide me with medical services and prescriptive medicine in accordance with the regulatory program of the State Nursing Board and the Texas Board of Medicine. I (we) further understand that the Provider also holds a valid Doctor of Chiropractic license issued by the Texas Board of Chiropractic Examiners and is thereby authorized to provide all service(s) within the scope of practice of chiropractic. I (we) understand that in treating my condition(s) Provider may be called upon to provide both chiropractic procedures, such as a spinal manipulation, and medical services in her capacity as a licensed Nurse Practitioner. I (we) agree that Provider may utilize any associates, technical assistants and other healthcare providers as she may deem necessary to treat my condition which has been explained to me/us as:

_____

_____

I (we) understand that the following medical, chiropractic and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these **procedures**:

_____

_____

I (we) understand that Provider may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize the Provider, and such associates, technical assistants and other healthcare providers to perform such other procedures which are advisable in their professional judgment.

I (we) do/do not consent to the use of blood and blood products as deemed necessary.
I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, chiropractic and/or diagnostic procedures to be employed by Provider is the potential risk for infection, blood clots in veins and lungs, hemorrhage, bruising or broken bones, allergic reactions, and even death. I (we) also realize that the following **risks and hazards** may occur in connection with this particular procedure:

_____

_____

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.
I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (Signature Required):

_____DATE:_____TIME:_____A.M./P.M.

OFFICE USE ONLY

Witness: _____

TEXAS ELITE HEALTH CLINIC
1304 Village Creek Drive, Suite 300 Plano, TX 75093
Phone (972) 402-9700/Fax (972) 402-9706

TEXAS ELITE HEALTH CLINIC, LLC

Authorization to Release Medical Information to Individuals/Family Members

In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of TEXAS ELITE HEALTH CLINIC, LLC to discuss your condition with members of your family or other individuals that you designate, we must obtain authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____ I **do not** authorize TEXAS ELITE HEALTH CLINIC, LLC to release any or all information concerning my medical care to any individual except set forth as above.

____ I **do** authorize TEXAS ELITE HEALTH CLINIC, LLC to verbally release any or all information concerning my medical care to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date of Birth: _____

****Only fill out the following section if requesting records****

Authorization for Release of Medical Information

This authorization is effective from the date on which it was signed and expires in 90 days. I understand that I may revoke the authorization at any time, except to the extent that action has already been taken in reliance upon to Texas Elite Health Clinic, LLC.

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, ZIP: _____

Phone: _____

I authorize my records to be released from:

Name (Doctor and/or Practice): _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____

Type of Information/Record requested:

____ Complete Records ____ Labs ____ X-Ray Films/CD ____ EKG ____ H&P

Purpose of Release:

____ Transfer of Care ____ Moving ____ Other (Specify): _____

I authorize my records to be released to:
TEXAS ELITE HEALTH CLINIC, LLC
1304 Village Creek Drive-Suite 300
Plano, TX 75093
P: 972-402-9700/F: 972-402-9706

TEXAS ELITE HEALTH CLINIC, LLC

HIPPA Privacy Rule Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plan for future care or treatment. I acknowledge that I have been provided with and understand this facility's **Notice of Privacy Practices** which provides a complete description of the uses and disclosures of my health information.

I understand that:

**I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;*

**This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I have provided if requested*.

Signature of Individual or Legal Representative: _____ Date: ____/_____/_____

Printed Name of Individual or Legal Representative: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained for one or more of the following reasons:

____ Individual Refused to Sign
____ Communication/Language barrier
____ An emergency situation
____ Other (Specify):_____

Signature of HIPPA Officer: _____ Date: ____/____/_____

Missed Appointment Policy

Our practice is here to serve you with the latest technology and sincere compassion. We are committed to offering you the best quality healthcare possible through relief, corrective care, and preventive care. However, if you miss your appointments, you compromise that care, and the care of another individual who could have taken that appointment. Therefore, we want to inform you of our office policy, effective immediately, regarding untimely and missed appointments.

A "missed appointment" is when you fail to show up for your appointment (or are late), without a phone call or email cancellation within at least 24 hours of your scheduled time.

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the courtesy of a call when you are unable to keep your appointment. If for any reason you feel that you will be more than 10 minutes late for your appointment, please give us the courtesy of a phone call at least 30 minutes before your scheduled time so that we can reschedule you and offer your appointment to another patient. If a phone call is not received at least 30 minutes in advance, a missed appointment fee will be assessed.

Listed below are our missed appointment policies and outlines:

1st Missed Appointment: We will call you and offer to reschedule your appointment.
2nd Missed Appointment: We will call and offer to reschedule your appointment. You will be charged a missed appointment fee of $25.
3rd Missed Appointment: You will be charged a missed appointment fee of $25. This may result in a discharge from the practice.

Let us work together to provide you with the best possible care you deserve.

~ The Texas Elite Health Clinic Team

Print Name: _____ Signature: _____

Date: _____/_____/_____