Texas Elite HEALTH CLINIC

Today's Date:______/______/______

PATIENT INFORMATION

Name:____

Date of Birth:______/______/______ Gender: Male/ Female

Marital Status: Single Married Divorced Widowed

Address:____

City:____________________ State:______Zip:____________

Email Address:______________________________________

Primary Phone:______________________________________

Phone Type: Cell Home Work

Secondary Phone:____________________________________

Phone Type: Cell Home Work

Work Status: Unemployed Employed Self- Employed
Retired Disabled Full-Time Student Part-Time Student

Employer:____

Occupation:____

Address:____

City:____________________ State:______Zip:____________

Ethnicity:___________________ Race:___________________

Preferred Language:__________________________________

PARENT/GUARDIAN INFORMATION (REQUIRED IF PATIENT IS UNDER 18 YEARS OF AGE

Name:____

Relation:____

Phone Number:______________________________________

EMERGENCY CONTACT: [ ] same as Parent/Guardian

Name:____

Relation:____

Phone Number:______________________________________

PRIMARY INSURNACE

Insurance Company Name:____________________________

Do you have any other insurance? [ ] Yes [ ] No

PRIMARY POLICY HOLDER

[ ] same as Patient [ ] same as Parent/Guardian [ ] Other

Relationship to patient:_______________________________

Name:____

Date of Birth:______/______/______ Gender: Male/ Female

Address:____

City:____________________ State:______Zip:____________

Primary Phone:______________________________________

Phone Type: Cell Home Work

I, *(print name)*_____________________________________,
HEREBY AUTHORIZE PAYMENT directly to the office of Texas Elite Health Clinic, LLC any health insurance benefits payable to me but not to exceed the balance due for the regular charges of 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 Texas Elite Health Clinic, LLC to release and information required to process any claims.

Patient Signature:____________________________________

TODAY'S VISIT

What is the reason for your visit today?__________________

____

When did the symptoms appear?________________________

Is this due to an auto accident? [ ] Yes [ ] No

Pharmacy Name:_____________________________________

Pharmacy Address:___________________________________

Pharmacy Phone:____________________________________

Who referred you to our practice?______________________

KNOWN ALLERGIES/ADVERSE DRUG REACTIONS

Medication or Food	Reaction
1.	
2.	
3.	

CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS

Drug Name & Dosage	Directions	Condition
1. *Example: Aspirin 500 mg*	*1 pill in the morning*	*Heart problems*
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

FAMILY HISTORY

Illness	**Relative(s)** *(Circle all family that apply-Please indicate MATERNAL OR PATERNAL family members if necessary)*	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	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Arthritis	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	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Anxiety	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Dementia	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Alcohol Dependency	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	
Drug Dependency	Mother/ Father - Sister/Brother - Aunt/Uncle Grandmother (Maternal/Paternal) - Grandfather (Maternal/Paternal)	

SOCIAL HISTORY

Tobacco	**Alcohol**
[ ] Never Smoked **[ ] Current** **[ ] Former** **Type *(circle all that apply)***: Cigars Cigarettes Smokeless **Year Started**:________________ **Year Quit**:_______________ **Packs/Cans per day**:_____________	**Do you drink?** [ ] Yes [ ] No [ ] Former Drinker **Type *(circle all that apply)*:** Beer Wine Liquor **Frequency (*Circle one*):** Occasional Moderate Heavy **Times per week**:_______________ **Amount of drinks consumed**:_____________
Education Status *(Circle one)* High School – Some College College Graduate – Post Graduate	**Exercise *(Circle One)*** Inactive – Light Moderate – Heavy – Vigorous **Specify Type**:____________________________ **How many times per week?**_______________
Caffeine **Type *(circle all that apply)*:** Coffee – Soda – Tea – Energy Drinks **Amount of servings per day**:____________________________	**Family** **Number of Children:**________ **Mother: [ ] Living [ ] Deceased-Age:**__________ **Father: [ ] Living [ ] Deceased-Age:**__________

SURGICAL HISTORY

Surgery/Procedure	Date	Reason
1.		
2.		
3.		

PAST/PRESENT MEDICAL HISTORY

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)	

Texas Elite HEALTH CLINIC
1304 Village Creek Dr. Suite 300, Plano, TX 75093 P: 972-402-9700 F: 972-402-9706

CONSENT TO TREAT

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 the 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 Julie Powell, DC, RN, FNP, of Texas Elite Health Clinic, LLC ("Provider"), serve as my healthcare provider. I (we) understand that the Provider is currently licensed by the Texas Board of Nursing as an Advanced 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 spinal manipulation, and medical services in her capacity as a licensed Nurse Practitioner. I (we) agree that Provider may utilize any associated, technical assistants and or other healthcare providers as she may deem necessary to treat my condition.

Patient/Other Legally Responsible Person Signature:____Date:____________________

OFFICE POLICIES AND PROCEDURES

Thank you for choosing us as your healthcare provider and welcome to our practice! We pride ourselves in providing the best healthcare possible. Please review the following and sign and date the bottom of the form.

Financial

We require that all payments be made at the time of service. We accept the following forms of payment:

- Checks-***($25 non-sufficient fund fee)***
- Cash
- Credit/Debit- Visa Discover MasterCard

Cancellations and Missed Appointments

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 preventative care. Our office will send you a courtesy reminder via email with your appointment date and time. *(Please ensure that we have your correct email address on file.)* We require that all cancellations be made at least 24 hours before your scheduled appointment. A **"missed appointment" is when you fail to show up for your appointment (or are late), without a phone call within at least 24 hours of your scheduled time.** A missed appointment will result in a **$25 charge** to be paid on or before your next scheduled appointment.

Phone consultations

Our telephones are answered from 9 am to 5 pm Monday through Thursday and Friday 9 am to 1 pm. Our staff has been instructed to handle all incoming calls in order to allow the provider to attend to their scheduled patients with a minimum amount of interruptions. If you feel you need to speak to the provider you will be asked to leave a message and your message will be relayed to the provider. It is very possible that the provider will instruct a staff member to respond to your call with their instructions. ***There will be a $30 phone consultation charge should the provider return your call.*** *(Someone from our staff will contact you the following business day to collect payment.)*

Prescription and Refill Request

We are dedicated to providing you with the best medical care available. In order to do that, we will need your assistance when requesting prescriptions.

- *An appointment is required for any prescription or refill requests for a condition that has not been treated in our office within the prior 6 months. Keep in mind; your health and safety are our top concern.*
- *Any requests received after hours will be reviewed the next business day.*
- *Please allow 24-48 hours for your request to be processed.*

By signing below, I agree that I have read and understand the above policies and procedures of Texas Elite Health Clinic, LLC
Patient Signature:____ Date:_______________________________

Texas Elite HEALTH CLINIC

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HIPPA AND PRIVACY POLICY

HIPPA Privacy Rule Receipt of Notice of Privacy Practices*-Written Acknowledgment*

I,_____________________________________(Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plan or future care of 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 acknowledgment upon my request;*
- *This facility reserves the right to change their Notice of Privacy Practices and notify me of those changes. I will receive a copy of any changes upon my request.*

Keeping information private is important to us and by default will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian.** Please note, in order to share protected information with your spouse or any other individual, they **must be** listed as an approved contact.
The following names are people I would like to be involved in or have access to my protected health information. I give permission for *Texas Elite Health Clinic* to share my protected health information when necessary with:

Name:____ DOB:__________________ Relationship to patient:_____________________________

Name:____ DOB:__________________ Relationship to patient:_____________________________
[ ] I do not consent for *Texas Elite Health Clinic* to release any of my healthcare information to any individuals other than my insurance company and healthcare providers.

Patient Signature:____ Date:______________________________

Patient-Provider Contact
Please provide the best number(s) to contact you with results and necessary treatments:

Phone:______________________________________
Phone Type: Cell Home Work

Phone:______________________________________
Phone Type: Cell Home Work

May we leave a <u>detailed</u> message on your voicemail regarding results and necessary treatments for the number(s) you provided? [ ] Yes [ ] No

May we email you regarding results and necessary treatments? [ ] No [ ] Yes: Email address:____
In choosing your email address, please consider the privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/or ability to review all email received at your work address. Texas Elite Health Clinic, LLC will not share your email address with anyone unauthorized to view your medical record.

Are we allowed to speak with anyone else regarding your results? [ ] Yes [ ] No

Name:___________________________________ Phone:_______________________________Relationship to patient:________________________

Name:___________________________________ Phone:_______________________________Relationship to patient:________________________

Patient Signature:____ Date:______________________________

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AUTHORIZATION FOR RELEASE OF 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 Code:___________________________________

Phone Number:_____________________________________

I authorize my records be released from:

Doctor or Practice:____

Address:____

City:____State:______________Zip Code:___________________________________

Phone Number:_____________________________________ Fax:____

I authorize my records to be released to:

Texas Elite Health Clinic, LLC

1304 Village Creek Dr.

Suite 300-B

Plano TX 75093

Phone: 972-402-9700 Fax: 972-402-9706

Requesting the following records:

[ ] Complete Records [ ] Labs [ ] Imaging Reports [ ] EKG [ ] Exam report [ ] Other:_________________________

Purpose of Release:

Coordination of Care

Patient Signature:____Date:______________________________