FAMILY HEALTH & WELLNESS CENTER OF NORTH TEXAS, LLC
12201 Merit Dr., Suite 300
Dallas, TX 75251
214.294.8989 Fax 214.294.8977

Dear New Patient;

We would like to welcome you to our practice, and look forward to meeting you! We believe in utilizing cost-effective, evidence-based medicine providing patients with the best in comprehensive and preventive health care. Our philosophy is to help you maintain excellent health.

Our staff diligently strives to exceed the expectations of our patients and their families. Attached you will find an introductory package for you to fill out to better help us meet your health care needs. We will be happy to assist you in verifying your insurance information.

We will do everything possible to make your visits pleasant. Our patients' trust in our health care is the highest honor we can receive. We thank you for trusting us to provide quality health care for you and look forward to serving you.

Yours truly,

Family Health & Wellness Center of North Texas

New Patient Information
FAMILY HEALTH & WELLNESS CENTER OF NORTH TEXAS, LLC

Patient Information

Please Circle: Mr. Mrs. Ms. Sr. Other

Patient's Name (Last): ______________________ (First): ____________________ (Middle): __________

Also Known As Name: ______________

Please Circle: Married Single Divorced Widowed Separated Ethnicity: __________

Social Security Number: ______________ Date of Birth: ____/____/____ Sex: Female / Male

E-mail Address: ____

Phone Numbers Daytime: ______________ Cellular: ____________________ Evening: ____________________

Address: ____

City: ____ State: _______ Zip: ______

Employment Status Please circle: Employed Retired Self Employed Unemployed Full-Time Student Part-Time Student

Employer: ____ Phone Number: ______________

Emergency Contact Name: ________________________________ Phone Number: ______________

Emergency Contact Relationship to Patient: ____

Referring Provider Name: ________________________________ Phone Number: ______________

Insured Party Information

Insured Party Name (Last): ______________________________ (First): ______________________

Social Security Number: ______________________ Date-Of Birth: ____/____/____

Phone Numbers Home: ________________________________ Work: ______________

Primary Insurance

Name: ____

Insurance Phone Number: ____

Secondary Insurance

Name: ____

Secondary Phone Number: ____________________

I hereby give permission to Family Health & Wellness Center Of North Texas, LLC to disclose and discuss any information related to *my* medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name: ______________________________ Relationship: ____________ Phone Number: ______________

Wish to-be contacted in the following manner:

- ❑ Okay to leave message with detailed information at home
- ❑ Ok to Leave Message with call back number only at home
- ❑ Ok To Leave Message with detailed information at work
- ❑ Ok To Leave Message With Call Back Number only at work
- ❑ Written Communication:
- ❑ Ok to mail to *my* home address:
- ❑ Ok to mail to *my* work/office address:
- ❑ Ok To fax to this number: ______________

The duration of this authorization *is* indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

FAMILY HEALTH & WELLNESS CENTER OF NORTH TEXAS, LLC

Pre-Treatment Notification

Some health plan to require that we inform you in advance that they may deny payment for services not covered and for services not deemed by the health plan to be reasonable and customary or medically necessary. Family Health & Wellness Center of North Texas will render only services that, in his professional judgment, are needed to provide quality medical care for you. In order for us to collect from you for our services when payment is denied by your health plan, your health plan requires that you signed the following agreement. The agreement:

1. I have been notified by the physician that payment maybe denied for `services not covered" or for "services not deemed by the health plan to be reasonable and customary or medically necessary" or that have been specifically requested by me, the patient.
2. If payment is denied, I agreed to be personally and fully responsible for the payment.

Signature:________________________________ Date:_____________________________________

Your Health Plan Coverage

Family Health & Wellness Center of North Texas is committed to providing you with the best possible care and helping you to receive maximum allowable benefits under your health plan. In order to achieve these goals we need your assistance.

Regarding Office Visits, Lab Work and X-Rays

1. Co-payments, Co-insurances, and/or deductibles are due at the time of the visit.
2. A valid, current card must be presented at each office visit.
3. If the service is not covered benefit or if your health plan tells us you are not covered, payment in full for all services are due when rendered. If your insurance company subsequently makes payment, any overpayment will be refunded to you.

Regarding Your Health Plan

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to the contract. While we may have an agreement with many of the health plans to provide services, any questions regarding coverage must be resolved by you with the insurance company.
2. Not all services are a covered benefit with all contracts. Some health plans select certain services which they will not cover.

By signing below, I acknowledge that I have read this information and understand all of the above.

Signature:__________________________________ Date:_________________________________

Witness:__________________________________ Date:__________________________________

Mid-Level Provider Consent for Treatment

Family Health & Wellness Center of North Texas, LLC has on staff a mid-level provider to assist in the delivery of medical care.

A mid-level provider is not a doctor. A mid-level provider is a registered professional healthcare provider who is prepared, thru advanced graduate education and clinical training, to provide a wide range of health care services, including the diagnosis and management of common, as well as complex, medical conditions to individuals of all ages.

A mid-level provider can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the mid-level provider may treat minor lacerations and other minor injuries.

Mid-level providers provide comprehensive care within an area of specialization and can:
Evaluate an individual's health by taking a history, performing a physical examination and ordering and interpreting results from appropriate laboratory and diagnostic tests/procedures;
Diagnose health and medical conditions by reviewing all available health information, and applying advanced clinical decision making processes;
Manage health problems by developing an individualized plan of care, prescribing medications or treatments, obtaining consultations and referrals, and coordinating health care services;
Promote health by ordering screenings, prescribing preventive therapies (vaccinations, diets, exercise, etc.) and teaching and counseling of individuals, families, and groups;
Collaborate with patients and families, and other health care providers.

A mid-level can serve as a patient's primary health care provider and is able to provide the coordination and management of care required in various health care delivery models, such as medical home, accountable care organizations, transitional care, etc.

I have read the above, and hereby consent to the services of a mid-level provider for my health care needs.

I understand that at any time I can refuse to see the mid-level provider and make an appointment to see a physician.

____
Patient Name (PRINTED)

______________________________________ ________________
Patient/Guardian Signature Date

Family Health & wellness Center of North Texas, LLC

Patient Consent and Acknowledgment of receipt of Privacy Notice

I understand that as part of the provision of health care services, Family Health & Wellness Center, LLC creates and maintains health records and other information describing should among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment.

I had been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of my revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.), and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance upon my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or electronic form, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or FAX of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which are used or disclosed for purposes of treatment, payment, or health operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information, and agreed to terminate any restrictions in writing on the use and disclosure of Protected Health Information which have been previously agreed upon.

______________________________	______________________________
Patient's Name Printed	Date
______________________________	______________________________
Patient Signature (or Guardian, if a Minor)	Social Security Number (for ID purposes only)

PATIENT HISTORY FORM

Date Today: ___________

We strive to keep all information in confidence and will not release without signed consent. It may be sent to consultants, if referred.

Name: ______________________________ Birth Date: ______________ Age:: __________

Last First M.I.

Martial Status: ( ) Single; ( ) Married; ( ) Widowed; ( ) Separated; ( ) Divorced

Occupation: ______________________________

Reason For Visit Today: ______________________________

____

Last Medical Exam: ______________________________

Last Doctor: ______________________________

Last Chest X-Ray (Date And Location): ______________________________

____

Allergies (DRUGS, X-RAY DYE, TAPE, LATEX)/ & Type Of Reaction:

____

Local Pharmacy Name & #: ______________________________

Medications: (List all including ones not prescribed, such as Alternative Agents or Herbal Agents).

Drug	Strength	How Often You Take Per Day	Length Of Time You Have Taken
i.e. Advil	200 mg.	3 times per day	6 months

Please know what drugs and doses you take; if you need refills let the nurse know when she places you in the exam room.

Childhood Illnesses: Chicken Pox ( ). Measles/Rubeola ( ). Mumps ( ). Rubella ( ). Scarlet Fever ( ).

Previous Medical Illness/ Hospitalization (other than under surgery): ______________________________

____

____

*If Diabetic, do you self-test with glucose meter? _____; Do you get yearly eye exam? _____; Have you been to a self-management course? ___;
Do you know what to do for low blood sugar? ____; foot care? _____; HgbA1C current value? ________

____

Surgery: (IF Yes, Please Check (✓) And Give Approximate Date In Blank Space)

( ) Appendectomy_______ ( ) C- Sections___________ ( ) Hernia repair__________

( ) Breast Biopsy _______ ( ) Gallbladder___________ ( ) Hysterectomy__________ ( ) Ovary R L _______

( ) Carotid artery_______ ( ) Heart angioplasty________ ( ) Mastectomy___________ ( ) Stomach surgery______

( ) Cataracts _________ ( ) Heart bypass___________ ( ) Prostate removal_________ ( ) Tonsillectomy________

Other Surgery not listed: ______________________________

OB/GYN History: Pregnancies: # _______. Deliveries: # _______. Last menstrual cycle: ____________

Check (✓) if YES or Write **NO, in front of items that follow below.

________ **Use Tobacco** Currently? # of packs per day: _____________ # of years: ________

Are you interested in stopping? (Y ___) (N ___)

________ **Tobacco Use** in past? When did you stop? ____________

________ **Alcohol Use**? Beer ___; Wine ___; Mixed Liquor ___. Oz (or glasses or cans per week average): ____

**** Do not mix drinking and driving please. ****

________ **Caffeine Use**? Coffee cups per day: ________ Sodas per day: _________

________ **Exercise regularly**? Type: ______________________; Times per week: ______________________

**** Goal of 30 minutes of walking-type exercise 5 days per week recommended. ****

PATIENT HISTORY FORM

Date Today:____________

Name: ____ Birth Date:________________ Age:: ____________

Last First M.I.

Family History: Check the box (✓) next to the condition that your family member has; then specify their relation to you after the disease, using the abbreviations as follows: Mother (**M**), Father (**F**), Brother (**B**), Sister (**S**), Grandparent (**GP**), Aunt (**A**), Uncle (**U**)

For example, if your Aunt and Mother had breast cancer: (✓) Breast Cancer A, M

( ) Alcoholism	( ) Breast Cancer	( ) Glaucoma	( ) Kidney Disease	( ) Thyroid disease
( ) Anemia	( ) Colon Polyps	( ) Gout	( ) Mental Illness	( ) Tuberculosis
( ) Asthma	( ) Colon cancer	( ) Heart Disease	( ) Migraine	( ) Osteoporosis
( ) Arthritis	( ) Diabetes	( ) High Blood Pressure	( ) Prostate cancer	
( ) Bleed easily	( ) Glaucoma	( ) Iron Disease	( ) Seizures	

	Living	Age or Age At Death	Present Health or Cause Of Death
Father	( ) Yes, ( ) No	________________	________________________________
Mother	( ) Yes, ( ) No	________________	________________________________
Siblings	( ) Yes, ( ) No	________________	________________________________

Immunizations: (Please check (✓) the Disease against which you have been immunized and Date of last booster.)

"Tetanus or Td booster is due every 10 years." Let the nurse know if you are due for a booster.

( ) Hepatitis B __________	( ) D.T. (Diphtheria/Tetanus) _______	( ) Flu vaccine _______
( ) Tetanus ____________	( ) Pneumonia _______	( ) Varicella _________
( ) Measles/Mumps/Rubella _________	( ) Hepatitis A _______	( ) Meningitis vaccine ________

*** If you have **Hepatitis C** or chronic liver disease, talk to your doctor about keeping up to date with your shots. You may benefit from **Hepatitis A or B** vaccine, or even the Pneumonia shot.

*** If you have **Lung Disease**, keep up to date with the **Influenza** and **Pneumonia** shots.

*** **Illicit Drugs Use**? Please discuss with your physician.

Risk factors for **AIDS & Hepatitis B and C** are the following. If any apply, please let your physician know during your visit. We will observe confidentiality.
Blood transfusion; Homosexual relations; IV Drug use; Relations with IV Drug user; Needle Sticks; Work with body fluids, such as dental work, nursing, ER, etc.; or Sex with multiple partners.

Check : (✓) f YES or Write **NO, for items that follow.

___**Diet**: Are you interested in information on diets for weight or cholesterol or diabetes?

___**Calcium intake**: Do you know women need about 1000mg. of Calcium intake per day?

___**Bone Density tests**: check if interested in information; considered after age 50 in women.

___**Colon exams**: Did you know most experts recommend a colon exam every 5 years, after age 50? Please let us know if you have a family history of colon cancer.

___**Mammography**: recommended yearly in women after age 40; check if due for this test.

Safety Measures: Examples of action you can take are: Seat belts (every time), bicycle helmets (even adults), wrist protection during roller-blading, eye protection (weed-eating, power sawing, etc.), proper gun use (locking, unloading, and keeping out of children's access).

Advanced Directives:

*** Please discuss with your spouse or family and your physician. **

Living Will? No ( ); Yes ( ). Organ Donor? No ( ) Yes ( );

Durable Power of Attorney for Health Care? No ( ); Yes ( ). Who? ________________________________

PATIENT HISTORY FORM

Name: ______________________________ Birth Date: __________ Age: ________
Last First M.I.

Please Place an (**X**) By The Current Complaint or Ailment That Applies To You. If Unsure, Place A Question Mark (**?**)

Head
- ____ Blurred Vision
- ____ Last Eye Exam Date
- ____ Glaucoma
- ____ Frequent Headaches
- ____ Migraine Headaches
- ____ Lumps or Swelling In Neck
- ____ Constant Ringing In Ears
- ____ Hearing Problems
- ____ Frequent Earaches
- ____ Frequent Nosebleeds
- ____ Sinus Infection
- ____ Allergies / Hay Fever
- ____ Hoarse Voice, Persistent
- ____ Mouth or Tongue Sores

Lungs
- ____ Asthma
- ____ Have Coughed Up Blood
- ____ Increasing Shortness Of Breath
- ____ With Activity
- ____ Emphysema
- ____ History Of Tuberculosis
- ____ Chronic Cough

Heart
- ____ Frequent Irregular Heart Beat
- ____ Chest Pain or Tightness In Chest
- ____ Heart Murmur ___Mitral Valve Prob.
- ____ History Of Enlarged Heart
- ____ Swelling Of Feet, Ankles Present After Sleep
- ____ Of Rheumatic Fever
- ____ High Blood Pressure
- ____ Previous **Heart Attack Date:** __________
- ____

Abdomen
- ____ Frequent Heartburn
- ____ Difficulty or Pain In Swallowing
- ____ Have Vomited Blood
- ____ Rectal Pain or Bleeding (Black or Bloody)
- ____ Recent Change In Bowel Habits
- ____ Diverticulitis or Diverticulosis
- ____ Colon Polyps
- ____ Last Colon Exam Date:
- ____ Hepatitis / Yellow Jaundice
- ____ Liver Disease
- ____ Nausea
- ____ Constipation
- ____ Diarrhea; How Many Per Day____
- ____ Abdominal Pain With Fatty Food
- ____ Suspect Ulcers
- ____ Hemorrhoids
- ____ History Of Ulcers
- ____ Bleeding
- ____ Loss Of Appetite

Neuro
- ____ Seizure
- ____ Loss Of Consciousness
- ____ Double Vision
- ____ Memory Loss
- ____ Numbness Of Hands or Feet
- ____ Nervousness Affecting Home Life or Work
- ____ Speech Problems
- ____ Stroke

Kidney
- ____ Recurrent Urinary Tract Infection
- ____ Urination At Night More Than Once
- ____ Brown, Black or Bloody Urine
- ____ Burning On Urination
- ____ Kidney Stones
- ____ Difficulty Starting Stream
- ____ Problems With Sexual Function
- ____ Urinary Incontinence

Joints
- ____ Back Trouble
- ____ Swollen Joints
- ____ Frequent Painful Feet
- ____ Frequent Shoulder Pain
- ____ Frequent or Persistent Aching Of Muscles of Joints
- ____ Gout
- ____ Arthritis
- ____ Osteoporosis- How diagnosed? ______________

General
- ____ Diabetes : Date Diagnosed: ______________
- ____ Weight Loss Greater Than 10 Lbs In Last Yr
- ____ Loss Of Interest In Eating
- ____ Sleeping Difficulty
- ____ Thyroid Problems
- ____ Blood Pressure Problems
- ____ Mole or Sore Not Healing
- ____ Hot or Cold Natured
- ____ Suspect Serious Disease or Cancer
- ____ Leg Cramps While Walking
- ____ More Thirsty Lately
- ____ Fatigue
- ____ Work or Family Problems
- ____ Anxiety
- ____ Anemia
- ____ High Cholesterol & last result________
- ____ Frequent Crying Spells, Depression
- ____ Weak Urine Stream

Males Only
- ____ Painful or Sore Genitals (Privates)
- ____ Prostate Trouble
- ____ Hard To Empty Bladder Completely
- ____ **Perform Self Testicle Exam Monthly**
- ____ **Last PSA Test** (If Over Age 50).Date ____________

Females Only
- ____ Last Menstrual Period ________________
- ____ Vaginal Discharge or Problems
- ____ Painful or Sore Genitals (Privates)
- ____ Lumps or Pain In Breasts
- ____ If You See A Gynecologist, List Name ________________
- ____ **Last Bone Density Test** ______________
- ____ **Last Mammography**. Date ______________
- ____ **Last Pap Smear** Date ______________
- ____ **Perform Self Breast Exam Monthly**

FAMILY HEALTH & WELLNESS CENTER OF NORTH TEXAS, LLC
FINANCIAL POLICY

Thank you for choosing Family Health & Wellness Center of North Texas, LLC.as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
  - If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
  - We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
  - We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
  - Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
  - We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
  - Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.
- **It is your responsibility to provide us with your most current billing information.**
  - You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
  - We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30- days after receipt of the initial statement. You can call **(214)294-8989**
  - **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
  - If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
  - If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from Family Health & Wellness Center of North Texas, LLC. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
  - In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us

- A $15.00 service fee will be charged for all triplicate prescription requests.
- A $25.00 service fee will be charged for completion of all "FMLA" or insurance related correspondence.
- We may charge you a "No Show" fee of $25.00 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

Signature of Responsible Party: ______________________________ Date: ________

Patient Name: ________________________________Patient Date of Birth: ____________

Signature of Responsible Party: ______________________________ Date: ________

Signature of Responsible Party: ______________________________ Date: ________

Signature of Responsible Party: ______________________________ Date: ________

Signature of Responsible Party: ______________________________ Date: ________

This Financial Policy must be Signed Annually.