2017 N Frazier St Suite
G8A,Conroe, TX 77301
T: (936) 703-3468
F: (936) 703-3469

PRIME VITAL CLINIC

Today's Date _____

Patient name_____ DOB: _____ Sex: ☐ Male ☐ Female

Mailing Address_____ City _____ State _____ Zip _____

Home # _____Work # _____ Cell #_____

Email _____ SS#_____

Employer_____Occupation_____

How did you find our office?_____Name, if referred by a friend or family_____

Parents/Guardians (if minor) _____

PREFERRED PHARMACY

Name:_____Address/Phone number:_____

Would you like to receive a text message or automated phone call from the clinic once medications are called into the pharmacy. Standard text rates apply. ☐ Yes ☐ No

Emergency Contact Information:

Name_____Relationship_____Phone_____

Primary Insurance

Insurance Co._____

Policy Holder Name _____

Policy Holder's DOB _____

Relationship to Pt _____

Financial Policy

Any out-of-pocket expense for the patient such as co-pays, deductibles, or co-insurances must be paid at the time of the clinic visit including services that are not covered under the patient's benefit plan.

Authorization and Release (please sign below)

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payments of benefits be made to Prime Vital Clinic. I acknowledge that I am financially responsible for payment of services not covered by insurance.

Signature:_____Date: _____

PRIME VITAL CLINIC

Office and Financial Policies

Welcome and thank you for choosing Prime Vital Clinic for your medical care. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that by providing our patients with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____Insurance: The patient is responsible for knowing their insurance benefits including their deductible and out- of-pocket expenses. Copay, deductibles, and patient's financial portion including any balance will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials:_____Cancellations/No Show Fee: Please call our office at least 24 hours in advance if you are unable to keep a scheduled appointment. You will be charged a No-Show Fee of $25 for failure to keep the appointment as scheduled.

Initials:_____PCP Assignment: Patients with an HMO policy need to choose one of our doctors as their PCP to be seen at Prime Vital Clinic. Please note that when changing your PCP, it may not get updated within 24 hours. You may be asked to reschedule if insurance still shows another physician as a PCP.

Initials:_____Patient Balances: Please be prepared to pay for the current visit as well as any past balances on your account. Copay, deductible, out-of-pocket expenses, and non-covered services must be paid at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____Late Arrivals: We do our best to reduce patient wait time but when a patient arrives late, it is impossible to stay on schedule. If you arrive 15 minutes or more after your scheduled appointment time, you will need to reschedule your appointment.

Initials _____ Dishonored Checks: A $30 Return Check Fee will be assessed on all dishonored checks. If you have dishonored checks on file, check payment will no longer be a payment option for you, but we will gladly accept cash or credit card payments at your future visits.

Initials:_____Collections: You will be receiving at least 3 statements from our office for balances owed before it gets referred to collections. Please make payment arrangements, if necessary, to keep your account current. If your address changes, it is your responsibility to inform Prime Vital Clinic to update our records. Your account will be turned over to collections when your statement returned due to a bad address. When your account is already in collections, you may not be seen until the account is paid in full at the collection agency.

Initials:_____Prescriptions Refills: It is the patient's responsibility to notify the office 3 business days prior to running out of medication.

Initials:_____ Medication Prior Authorization: Any medication that is not covered under your insurance as preferred and needs additional information from the office will require a $25 fee. The patient has the right to call the insurance to find out what medication may be covered before paying the fee.

I have read understand and agree to the above office and Financial/Office policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing by signing this statement.

Patient Name:_____Date: _____

Patient Name: _____

DOB: _____

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PATIENT HEALTH HISTORY

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notesyouthink areimportant.

Date of Last: **Colonoscopy** (mm/yr) _____ ☐ Normal ☐ Abnormal
Date of Last: **Mammogram** (mm/yr) _____ ☐ Normal ☐ Abnormal
Date of Last: **PAP** (mm/yr) _____ ☐ Normal ☐ Abnormal

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION	☐ **NO ALLERGIES**
1. _____	_____	
2. _____	_____	
3. _____	_____	

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over the counter drugs, such as vitamins and inhalers.

	DRUG NAME	**DOSE / STRENGTH**	**FREQUENCY TAKEN**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date given:

Flu shot	Date: _____	Tetanus	Date: _____
Pneumonia (Pneumovax)	Date: _____	Tdap	Date _____
Pneumonia (Prevnar 13)	Date: _____	MMR	Date:_____
Shingles (Zostavax / Shingrix)	Date: _____	Meningitis	Date:_____
Hepatitis B	Date:_____	Gardasil (HPV)	Date:_____
Hepatitis A	Date: _____	Varicella (chicken pox):	Date:_____

PAST MEDICAL HISTORY

Patient Name: _____

DOB: _____

PRIME VITAL CLINIC

Please check all that apply:

- ☐ Acne
- ☐ ADHD/ADD
- ☐ Autoimmune Disorders
- ☐ Anxiety Disorder
- ☐ Arrythmia
- ☐ Anemia
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots (DVT, PE)
- ☐ Blood transfusion
  Reason: _____
- ☐ Cancer _____
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Chronic Pain
- ☐ Chemical dependency/Alcoholism
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Epilepsy/Seizure disorder
- ☐ Fibromialgia
- ☐ GERD
- ☐ Gout
- ☐ HIV
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Irritable Bowel Disorder
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lower extremity edema
- ☐ Memory Loss
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Pacemaker
- ☐ History of Pneumonia
- ☐ Prostate Disease
- ☐ Psoriasis
- ☐ Osteoporosis/Osteopenia
- ☐ Recurrent UTI
- ☐ Seizure Disorder
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid
- ☐ Tremors
- ☐ Other _____

PAST SURGICAL HISTORY / HOSPITALIZATIONS

	SURGERY AND REASON	YEAR
1.		
2.		
3.		
4.		
5.		

SOCIAL HISTORY

OCCUPATION: _____

EDUCATION:

- ☐ Less than 8th grade ☐ High school
- ☐ Some college ☐ Bachelor's degree
- ☐ Advanced Degree

EXERCISE LEVEL: ☐ None (No exercise)

- ☐ 1-2 days per week ☐ 3-4 days per week
- ☐ 5 + days per week

MARITAL STATUS: ☐ Married ☐ Single

☐ Widowed ☐ Domestic partner

TOBACCO:

Do you use tobacco? ☐ Yes ☐ No

How often: ☐ Occasionally

Cigarettes pks./day _____

If not currently, did you ever use tobacco? ☐ Yes ☐ No

# of years ____ Or year quit _____

☐ Chew _____/day ☐ Cigars/day

ALCOHOL:

Do you drink alcohol? ☐ Yes ☐ No

☐ < 3 times week ☐ > 3 times week

DRUGS:

Do you currently use recreational or street drugs? ☐ Yes ☐ No

If Yes: _____

Patient name:_____
DOB:_____

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FAMILY MEDICAL HISTORY

Please check all that apply:

Mother:
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Depression/Mental Illness
- ☐ Cancer If yes, please specify _____
- ☐ Other Please specify _____

Father:
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Depression/Mental Illness
- ☐ Cancer If yes, please specify _____
- ☐ Other Please specify _____

Siblings:
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Depression/Mental Illness
- ☐ Cancer If yes, please specify _____
- ☐ Other Please specify _____

Grandparents:
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Depression/Mental Illness
- ☐ Cancer If yes, please specify _____
- ☐ Other Please specify _____

Health Insurance Portability and Accountability Act (HIPAA)

A. Inspection and copies of protected health information – you may inspect and / or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that a request for copies be made in writing and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: The information is psychotherapy notes; the information reveals the identity of a person who provided information under a promise of confidentiality; the information is subject to the Clinical Laboratory Improvements Amendments of 1988; the information has been compiled in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for review of our decision to deny access. Texas law requires us to be ready to provide copies or a narrative report within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based-fee.

B. Amendments of Medical Information – you may request an amendment of your medical information in the designated records set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons: The information was not created by this practice or physicians in this practice; the information is not part of the designated records set; the information is not available for inspection because of an appropriate denial; the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical records. If we refuse to allow an amendment to be made and tell others that we now have the correct information.

C. Accounting of Certain Disclosures – HIPAA privacy regulations permit you to request, and us to provide, and accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by our or your representative. Please submit any request for an accounting to the person at the end of this document. You first accounting of disclosures (within a 12-month period) will be free. For additional request within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits – We may contact you by (telephone, mail or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints – If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filling a complaint with us or the government.

F. Our Promise to you – We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of your privacy practices with respect to protected health information, and to abide by the terms of notice of privacy practices in effect.

G. Questions and Contact Person for Requests - If you have any question or want to make a request pursuant to rights described above, please contact our office at 936-703-3468.

I acknowledge that I have been given an opportunity to review Prime Vital Clinic Notice of Privacy Policies and have been provided a copy if I desire one.

Signature of Patient or Legal Representative	Relationship to Patient	Date

Your Birthday AND address will be used to verify identity on your behalf

PRIME VITAL CLINIC

Health Disclosure Consent Form

I,_____, DOB_____, will allow Prime Vital Clinic, to disclose information to the following person(s) about my health. I have also reviewed and acknowledged the Notice of Privacy Practices.

I will disclosure to the following person(s):

Name:	Relationship:
1._____	_____
2. ._____	_____
3._____	_____
4._____	_____
5._____	_____

Can we leave a message to your voicemail? ☐ Yes ☐ No

If Yes, at what number? _____(I understand that I am the only person who can receive this message for privacy and security purposes)

_____ _____

Signature of Patient or Personal Representative Date