Welcome to Our Practice

Welcome to Texas EliteMD Care! Our mission is to provide you and your loved ones with the highest quality care. Our doctors will closely monitor your health and medications, provide special instructions to you, and carefully review your progress notes and test results to ensure continuity of care and treatment.

Here is some helpful information and answers to frequently asked questions.

1. Our medical team works collaborately together and shares insights and information to make sure you always receive excellent care.
2. Please bring all your medicines (in their bottles) with you. This includes any herbal remedies and OTC you may take.
3. Please allow two weeks for normal labs and imaging reports to be notified via call, mail or email. If you don't hear from us after two weeks, please contact our office.
4. Please limit after-hours and weekend calls to urgent matters only. Remember that we are open on some Saturdays if you have a question or need to come in for a consultation, please call the office and schedule in advance.
5. Please allow 7-10 business days for your physician to sign or complete any forms you request to be reviewed, created, and/or signed. Please note that there is an extra charge for completion of these forms.
6. If it is necessary to cancel your schedule appointment, we require that you call at least 24 hours in advance and calling early in the day is appreciated. Appointment are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. No-show/missed appointment/cancellation Policy: 1st time: verbal reminder; 2nd time: a $25 fee charged; 3rd time: termination/discharge of care automatically.

Thank you for giving us the opportunity to serve you and your family. We appreciate confidence you have placed in us and we look forward to providing you with the best care in the future.

Print Name:

Signature: Date:

PATIENT NAME: _____ DOB: _____

CELL PHONE: _____ EMAIL: _____

Pharmacy Phone:

FOR PATIENT PRIVACY RIGHTS PLEASE CHECK MARK YOUR REASON FOR TODAYS VISIT

____ Annual Physical/Well Women Exam/Sports Physical

____Refill Medications for Chronic Disease Conditions:

Asthma/COPD/Diabetes/Depression/Anxiety/Hypercholeserolemia/Hypertension/Heart disease/Insomnia

____Flu shots/shots

____Pre-op Evaluation/Post-Hospital Follow up and Care

____Screenings

____Sick Visit/other type of Visit (Please your concerns and Symptoms. Please be upfront all the issues which you would like to discuss during the visit. We will address the most critical issues and may ask you to come back and discuss the rest, if needed)

_____

_____

_____

_____

_____

Please present your insurance card/I.D. at time of check-in. Settlement of patient financial responsibility is expected at time of service.

New Patient: ◯ Yes Exsiting patient, updating info? ◯ Yes

Type of Visit: ◯ Insurance (present you card at check-in)

◯ Self Pay (payment due at time of service)

PATIENT REGISTRATION INFORMATION

Last Name:_____ First, Middle Name:_____ Social Security #:_____.

Date of Birth(M/D/Y): _____Sex: ◯ Male ◯ Female Preferred Language: _____

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated Ethnicity: _____

Race: ◯ White ◯ Hispanic ◯ African American ◯ Asian ◯ Pacific Islander ◯ Unknown ◯ Other

Home Address: _____ City:_____ State:_____ Zip:_____.

Cell Phone:_____ Work/Daytime Phone:_____ Home Phone:_____.

Preferred Phone:_____Email:_____.

Name of Employer:_____ Occupation:_____ .

Preferred Pharmacy:_____ Pharmacy Phone:_____.

Address:_____ State:_____ Zip:_____ .

How did you hear about us? ◯ Friend/relative ◯ Billboard ◯ Internet ◯ Mailer ◯ Other

OTHER REGISTRATION INFORMATION

If married:

Name of Spouse:_____ Social Security #_____Date of Birth: _____ .

Name of Employer:_____ Occupation:_____ .

Address of Employer:_____.

If a child:

Father's Name:_____ Social Security #: _____ Date of Birth:_____.

Mother's Name:_____ Social Security #:_____ Date of Birth:_____.

Father's Employer:_____ Work/Daytime Phone:_____.

Address of Employer:_____ Occupation:_____.

Mother's Employer:_____ Work/Daytime Phone: _____ .

CLOSEST RELATIVE OR FRIEND IN CASE OF EMERGENCY

Name:_____ Relationship to Patient: _____.

Address:_____City:____State:____Zip:_____ Phone:_____.

HEALTH INSURANCE INFORMATION

Insured: Name_____ Relationship to Patient_____ .

Date of Birth(M/D/Y): _____Social Security #:_____.

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

Insured's Address: _____ City:_____ State:_____ Zip:_____ .

Home Phone:_____ Work/Daytime Phone:_____.

Name of Insurance_____ Telephone #_____ .

Claims Address:_____ .

Effective date_____ Group #_____ Member ID #_____ .

Do you have other insurance? if yes please provide information_____ .

Authorization and Release

Authorization of Treatment: I voluntarily consent to the administration and cost of medical and procedures, EKG, lab, and medications for myself and my dependents. **Assignment of Insurance Benefits**: I authorize payment directly to Texas EliteMD Care Clinic for all benefits otherwise payable to me. **Guarantee of Payment**: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Texas EliteMD Care Clinic by text, voice, or email at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. **Release of Records**: I authorize Texas EliteMD Care Clinic to release (verbal or in writing) confidential medical information to my insurance carrier, employer if treatment is related to employment purposes, or other health care entity or individual which may be liable to me or my practioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes. **Receipt of Privacy Practices:** I acknowledge that I have received and read the notice of Privacy Practices of Texas EliteMD Care Clinic. I also acknowledge that my prescription history from non-Texas EliteMD Care providers and pharmacies will be available to Texas EliteMD Care. I permit a copy of this authorization to be used in place of the original.

Medicare beneficiaries: I request that payment of authorized Medicare benefits be made to Texas EliteMD Care Clinic. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature:_____ Date :_____.

Responsible Party: _____ Date:_____.

Confidential Health Questionnaire

Patient Name:_____DOB:_____Date:_____.

Please mark with a Y/N or (√) the following illnesses and medical problems you have or have had and indicate the year when each started.

Major Illnesses	Y/	N	Year		Y/	N	Year
Amputation(s)				Hemorrhoids			
Anemia				High Blood Pressure			
Arthritis or Gout				High Cholesterol			
Asthma				Hypo or Hyperthyroid			
Back Problems				Kidney Disease			
Bladder Incontinence				Liver disease or Hepatitis			
Brain Aneurysm				Lupus			
Cancers				M.S.			
Cataracts				Osterporosis			
Colon Polyps				Pneumonia			
COPD or Emphysema				Recurrent Bladder Infections			
Colitis or Diverticulosis				Seasonal Allergies			
Chronic Recurrent Cough				Seizures			
Depression or Anxiety				Sexually Transmitted Disease			
Dementia or Memory Loss				Sinus Problems			
Diabetes				Stomach/Duodenal Ulcer			
Diabetic Foot Infections				Stroke or TIA			
Diabetic Nerve Pain/Numbness				Thyroid Nodules			
Diabetic Eye Disease				Tuberculosis			
Glaucoma				Vascular Disease (plaque in arteries)			
Headaches				Vision Loss/Blindness			
Hearing Loss or Ear Problems							
Heart Disease				Other Heart Conditions			
Heart Murmur				Other Kidney problems			
Hernia				Other Health Problems			

MALES ONLY:

◯Prostate Enlarged or Cancer_____ ◯ Impotence or Erectile Dysfunction_____.

FEMALES ONLY:

◯Gynecological/Obstetrical_____ ◯ Breast Problems_____ .

Cancer Screenings and Routine Health Maintenance:

Females Only: Please indicate result (negative/positive or normal or abnormal)

Last PAP(DD/MM/YY)_____Result _____Performed by name of Physician/ Obgyn Dr_____

Last Mammogram(DD/MM/YY) _____Result_____Ordered by Name of physician _____

Last Hemoglobin A1c with _____ and Last Diabetic eye exam _____by Ophthalmologist_____

Colon Cancer Screening: stool card/cologuard/colonoscopy (DD/MM/YY)_____performed by GI Dr_____

VACCINES and Tests (Year) :

Tetanus:_____ Pneumonia:_____ Zostavax (Shingles):_____Flu:_____ Bone Density:_____ .
Hepatitis C Screening_____(year) HIV Screening_ ___ (year)

Last Primary Physician name/address/number:

_____

Please list all Specialists you currently see:

_____

_____

Please list all times you have been hospitalized, operated on, or injured.

Year	Operation, Illness or Injury	Hospital and City

Current Medications:

Drug	Dosage	Physician

ALLERGIES to Medicationas/Substance

Medications	Substance (Latex,Gloves, etc)

Non-prescription drugs or supplements:_____.
Smoking or Tobacco products: Packs per day_____Years_____ Quit date:_____.
Alcohol drinks per day _____ or month:_____ Drug use:_____.
Sexual Orientation:_____

Your Family's Health History

	Age if living	Age at Death	Did/Do they have High Blood Pressure, Heart Disease, Strokes Cancers or Diabetes?	State of Health or Cause of Health
Father				
Mother				
Siblings				
Spouse				
Children				

Do you have an Advanced Directive or Living Will? _____
Do you have a Medical Power of Attorney? _____ Who is it?_____

Patient Signature _____ Date _____

Name/Relationship of Individual Completing Form (if other than patient):_____ .

PATIENT RIGHTS AND NOTICE OF PRIVACY PRACTICES

This document outlines patient rights and describes how individually identifiable health information may be used and disclosed. Please read it carefully.

At times it is necessary for this facility and its business associates to use and disclose confidential personal health information about patients. This information is specific individually identifiable health information or "protected health information" (PHI). HIPAA regulations require that this information be shared with patients in the from of a Notice of Privacy Practices that indicates the means of use and disclosure of PHI.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

HIPAA privacy rules permit the use and disclosure of PHI for the purposes of treatment, payment and certain health care operations without obtaining a specific written permission from you, known as an "authorization".

FOR TREATMENT: This facility may use or disclose PHI to coordinate patient healthcare services. This may include consultation with other health care providers who are involved in a patient's care. For example, information may be shared to create and carry out a plan for patient specific treatment.

For PAYMENT. This facility may use or disclose information to obtain payment for the health care services that are rendered. For example, PHI may be provided to a health plan for services provided to a patient.

FOR HEALTH CARE OPRATIONS: This facility may use or disclose information in performing certain business activities, which are referred to as health care operations. Certain areas within our operations allow us to improve the quality of care we provide.

APPOINTMENTS AND OTHER HEALTH INFORMATION: A patient may be sent reminders for individual upcoming medical services or other information that pertains to medications or treatments prescribed.

Other uses and disclosure for which authorization is not required.

In addition to using and disclosing PHI for treatment, payment and health care operations, the HIPAA Privacy rules permits (or requires) us to use and disclose PHI without your written authorization under the circumstances described below:

AS REQUIRED BY LAW AND FOR LAW ENFORCEMENT: The use and disclosure of information when required or permitted by federal or state law or by a court order. If federal or state law creates higher standards of privacy, the higher standard will be followed.

FOR ABUSE REPORTS AND INVESTIGATIONS: If it is reasonably believed that a patient has been a victim of abuse or neglect, the facility may disclose PHI as required by law.

FOR GOVERNMENT PROGRAMS: This facility may use and disclose information for public benefits under other government programs. For example, we maybe required to disclose information for determination of Supplemental Security Income (SSI) benefits.

TO AVOID HARM: The facility may disclose PHI to law enforcement agencies in order to avoid a serious threat to the health, welfare and safety of a person or the public.

FOR RESEARCH: PHI may be disclosed for the use of research, studies, and to develop reports.

DISCLOSURE TO FAMILY, FREIEND AND OTHERS: PHI may be disclosed to specific listed family, friends, or other persons who are involved in the patient's medical care. The patient has the right to revoke all or part of the list of persons upon written request.

Please list the names of the persons to whom PHI may be disclosed and state the relationship to the patient.

Name:_____ Relationship:_____Date:_____.

Name: _____Relationship:_____ Date:_____ .