PREMIER
WELLNESS CLINICS

AUTHORIZATION and CONSENT AGREEMENT

Thank you for reviewing our Financial and Office Policies and Notice of Privacy Practices. Please sign in the spaces provided below to acknowledge receipt of this information, and to enter your authorized contacts.

ASSIGNMENT of BENEFITS

I authorize direct payment to be made to the physicians of Premier Wellness Clinics (PWC) for any and all medical or surgical services rendered. I also authorize the release of any medical records for the purpose of my healthcare services.

FINANCIAL and OFFICE POLICIES

I have read and understand the Financial and Office Polices of PWC and agree to abide by its guidelines.

HIPAA

I have reviewed this offices notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent.

I have had the opportunity to receive and review the notice of privacy practices of Premier Wellness Clinics (PWC).

APPROVED HIPPA CONTACTS

Disclosure of Protected Health Information

Keeping information private is important to us and by default we 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 health information with your spouse or anyone else, 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 on a routine basis. I give information for PWC to share my protected health information with:

Contact Name	DOB	Relationship
Contact Name	DOB	Relationship

CONSENT AND AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the assignment of Benefits, Financial Policy, HIPPA Policy, and Approved HIPPA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

Patient's Name (Please Print)	DOB
Signature of Patient, Parent, or Legal Guardian	Date

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Consent to Obtain Prescription History

This consent form authorizes Premier Wellness Clinics to obtain and review my prescription history. Detailed prescription history provides your Medical Practitioner with information about medications being prescribed by other providers in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as drug names or dosages.

By signing this consent form, you agree that Premier Wellness Clinics can request and use you prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding the above, I hereby provide informed consent to Premier Wellness Clinics to request, view, and use my external prescription history for treatment purposes.

Patient Name (please print): _____

Patient Date of Birth: _____

Patient Signature: _____

Date of Signing Consent: _____

Financial and Office Policies

Thank you for choosing Premier Wellness Clinics (PWC) as your healthcare provider. We are committed to providing you with quality and affordable healthcare. The following are our Financial and Office Policies. Please read, initial on the left, sign at the bottom, and return to the Front Office Representative. Please ask us if you have any questions about this form or your medical care. We are here to serve you.

Initial Below

_____ **Patient Responsibility:** We participate in many insurance plans. We recommend you become familiar with your insurance benefits and confirm our participation with your plan. Most misunderstandings about insurance can be avoided if you understand why your policy covers. **Please contact your insurance company with any questions you may have regarding your coverage.**

_____ **Insurance Carries Requiring Referral:** If you are referred to a specialist and your insurance carrier requires a referral number, our office must have at least **4 – 7 days notice** to complete the referral.

_____ **Proof of Insurance:** All patients must complete our patient information form before seeing a Provider. We must obtain a copy of a valid drivers license and a current, valid insurance ID card. Please bring these items with you to each appointment. Payment in full is required if we are unable to verify your current insurance information.

_____ **Payments Due at Time of Service:** Any co-pay, deductible, or co-insurance

- Private pay patients, cash patients, or those without insurance: See Front Office Representative for special pricing and/or discount programs.
- ***Payment due at time of service.***

_____ **Claims Submission:** If we are contracted with your insurance company, we will submit your claims. Your insurance may require additional information from you in order to process the claim. Failure to comply with their request within 30 days will result in full patient responsibility for the claim.

_____ **Nonpayment & Returned Checks:** Unpaid accounts will be referred to an outside collection agency and could result in dismissal from the practice. **There will be a $25 fee for all returned checks.**

_____ **Late Arrivals:** Please arrive 15 minutes before your appointment. If you arrive late to your appointment, our office may have to reschedule your appointment to a new time and/or date.

_____ **No Shows:** Please notify us 24 hours in advance by phone or secure portal if you must cancel or change your appointment time. ***Failure to do so will result in a $30 no show fee that is not covered by your insurance. A third no show fee may result in dismissal from the practice.***

Patient's Name (Please Print) **DOB**

Signature of Patient, Parent, or Legal Guardian **Date**

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:

_____

_____

Patient's Name (Please Print) **DOB**

Signature of Patient, Parent, or Legal Guardian **Date**

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Patient Medical History

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

Please check any illness or condition you have had:

- ADD
- Abnormal Pap Smear
- Alcoholism
- Allergies
- Anemia
- Anxiety
- Arthritis
- Asthma
- Back pain, chronic
- Breast cancer
- Colon polyp
- Depression (current)
- Depression (past)
- Diabetes Type I
- Are you in good health?
  - YES
  - NO
- Diabetes Type II
- Diabetes, gestational
- Diverticular disease
- Eczema
- Endometriosis
- Erectile dysfunction
- Fibromyalgia
- Genital herpes
- Heart disease
- Glaucoma
- Hemorrhoids
- High cholesterol
- High blood pressure
- Irritable bowel
- Kidney Stones
- Low thyroid
- Migraine
- Obesity
- Osteoporosis
- Osteopenia
- Postmenopausal
- Prostate enlargement
- Reflux
- Rheumatoid arthritis
- Seizure disorder
- Sleep apnea
- Stroke
- Tobacco use

SURGERIES

- Appendix
- Ear Tubes
- Gall bladder
- Heart bypass
- Hernia repair
- Knee ACL
- Knee other
- Lumbar back
- Neck C-spine
- Shoulder
- Tonsils

Women

- Breast augmentation
- C-section
- Hysterectomy
- Tubal ligation

Routine Health Screening: (most recent dates)

Colonoscopy: _____ Mammogram: _____

Bone Density: _____ Pap Smear: _____

Tetanus Booster: _____

Other:

_____

Any allergic reactions to medications or substances? ○ YES ○ NO

If **yes**, please list: _____

Pharmacy Name and Location: _____

Social History:

Do you smoke?	○ YES ○ NO	If YES, amount & type:	_____
Do you drink alcohol?	○ YES ○ NO	If YES, how often:	_____
Any drug use?	○ YES ○ NO	If YES, type & amount:	_____
Do you have any history of abuse?	○ YES ○ NO	If YES, type, age, by whom:	_____

Family Medical History (Please include any medical illnesses and cause of death)

Father: _____

Mother: _____

Siblings: _____

Others: _____

Medications (please include "over the counter meds" as well)

Name:	Strength:	How Often:

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PATIENT REGISTRATION FORM
(Please Print)

www.premierwellness.org
2833 Eldorado Parkway
Suite 307
Frisco, Texas 75033

Today's Date: _____/_____/_____ Primary Care Doctor: _____

PATIENT INFORMATION

_____
Legal First Name | Legal Last Name | Suffix | Gender

_____
Address | Apt # | City | State | Zip

(_____)_____(_____)_____-_____-_____
Primary Phone | Cell Phone | Social Security #

_____/_____/_____ O Married O Single O Divorced O Widowed O Other
Birth Date

_____ O
Email Address (this will be used for appointment reminders and newsletters) Check for portal access

Preferred Contact Method O Cell O Home O Email

_____
Race | Ethnicity | Preferred Language

_____(_____)_____
Employeer Name | Employeer Phone Number

_____(_____)_____
Pharmacy Name | Pharmacy Phone Number

PARENT/GUARDIAN/GUARANTOR INFORMATION (required if patient is under 18 years of age)

_____
Legal First Name | Legal Last Name | Suffix | Gender

_____
Address | Apt # | City | State | Zip

(_____)_____(_____)_____-_____-_____
Primary Phone | Cell Phone | Social Security #

_____/_____/_____ O Married O Single O Divorced O Widowed O Other
Birth Date

Relationship to Patient O Self O Spouse O Parent

EMERGENCY CONTACT

_____(_____)_____
Name | Phone number

_____
Relationship to Patient

PRIMARY INSURANCE

Do you have health insurance? O Yes O No

_____
In Co. Name

_____(_____)_____
Member ID | Group # | Phone Number:

Do you have any other insurance? O Yes O No

HOW DID YOU HEAR ABOUT US?

O Google O Employeer O Health Fair O Drive-by O Friend O Physician Referral
O Website O Facebook O Insurance O Direct Mail O Advertisment O Other

_____
Patient Signature: Patient/Guardian Signature (if patient is under age 18)

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PATIENT PORTAL COMMUNICATION CONSENT

To sign up for access to your health information through our secure patient portal, complete the first portion of this form. To grant access to another adult who helps manage your medical care, complete all portions of this form. Patient portal sign up includes FREE access to the following online services: lab results, appointment management, prescription refill requests, submitting billing questions, referral requests, and medical summary including immunization records.

- O **YES**, I want PWC to communicate my information with me, or those that I grant access, to my records through the secure patient portal system that is designed to keep my personal information safe.

YOUR INFORMATION: (All sections required)

Name: (last, first, middle initial): _____

DOB:_____ Sex: **M** **F** Phone Number: _____

Please provide the email address you would like to use to be notified of secure messages

Email Address: _____

Primary Care Physician: _____

- I understand I must be 18 years or older to be signed up to my access my record through the patient portal. If I am under 18 years of age and have become legally emancipated, I must provide legal documentation in order to be provided access to my records for the patient portal.
- I understand that the patient portal is intended as a secure online source of confidential medical information. If I share my user ID and password with another person, that person may able to view me or my family member's health information.
- Is my responsibility to select a confidential password to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in anyway.
- I understand that the patient portal contains limited medical information from my or my family member's medical record and that it does not reflect the complete contents of my medical record. I also understand that a paper copy of my records maybe requested from the clinic.
- I understand that my activity within the patient portal may become part of my medical record.
- I understand that access to the patient portal is provided by Premier Wellness Clinics as a convenience to its patients and PWC has the right to deactivate access to the portal at anytime for any reason. I understand that use is voluntary and I am not required to use the portal.
- By signing below, I acknowledge that I have read and understand this Patient Portal Communication Consent and agree to its terms.

_____ _____

Patient Signature **Date**

Grant Access to Another Adult

Please grant access to my medical record through the secure patient portal to the following adult who helps to manage my medical care. I understand that all portal communication will be sent to their email.

Name (last, first, middle initial): _____

Relationship to Patient: _____ Email Address: _____

Sex: **M** **F** Date of Birth: _____/_____/_____ Phone Number: _____

Address: _____

_____ _____

Patient Signature **Date**