



WHERE YOUR FAMILY BECOMES OURS

General Information:

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____ SSN: _____

Marital Status (Please Circle One of the Following): Single Married Relationship Widowed

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

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Language: _____ Race: _____ Ethnicity: _____

In Case of Emergency:

Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone/Other Number: _____

Insurance Information:

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

How did you hear about us? () Google () Website () Signage () Billboard

Or who can we thank for sending you to us _____



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Medical Questionnaire:

Name: _____

Date: _____

Are you currently a patient of any specialist or any other health provider? (E.g. Cardiologist, nephrologist, etc.)

YES _____

NO _____

If yes, please list the Providers name and specialty:

Provider:

Specialty:

Reason for Todays Visit:

Are you in any pain today? _____

On a scale from 1-10, 1 being minimal and 10 being severe, how would you rate your pain today? _____



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Medical History:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgical History:

_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations:

Date:	Hospital	Reason for Hospitalization:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:



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Family History:

Mother: Living _____ Deceased Age/Cause of Death: _____

Medical History: _____

Father: Living _____ Deceased Age/Cause of Death: _____

Medical History: _____

Number of Siblings: _____ Number of Children: _____

Do you have any family in the local area? Yes _____ No _____

Social History:

Do you have assistance at home: Yes _____ No _____

Do you live by yourself? Yes _____ No _____

Are you retired? Yes _____ No _____

Do you have a Medical Power of Attorney or Living Will? Yes _____ No _____

Who would assist you in an emergency? _____

Do you smoke or have you ever smoked? _____ How many years? _____

If so, how many years? _____ How many cigarettes/packs per day? _____

Do you still smoke? _____ When did you quit? _____

Do you drink alcohol? _____ How often? Daily _____ Occasional _____ Monthly _____

Do you currently use illicit drugs? _____ If so what? _____ How often? _____

Recent Preventative Care:

Date of your last Bone Density Exam: _____ Results: _____

Date of your last Colonoscopy: _____ Results: _____

Date of your last Dental Exam/Cleaning: _____ Results: _____

Date of your last eye exam: _____ Results: _____

Date of your last hearing exam: _____ Results: _____

Date of your last Mammogram: _____ Results: _____



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Date of your last Pelvic or Pap: _____ Results: _____

Date of your last Prostate Exam: _____ Results: _____

Date of your last Pneumococcal Immunization: _____ Results: _____

Date of your last Flu Shot: _____ Results: _____

Date of your last Covid vaccine: _____ Results: _____

Date of your last Tetanus vaccine: _____ Results: _____

Do you exercise regularly? _____ How often: _____

Activities of Daily Living:

Do you need assistance with Toileting?	Yes: _____	No: _____
Do you need assistance with Eating?	Yes: _____	No: _____
Do you need assistance with Walking?	Yes: _____	No: _____
Do you do your own Cleaning?	Yes: _____	No: _____
Do you do your own Cooking?	Yes: _____	No: _____
Do you do your own Driving?	Yes: _____	No: _____
Do you handle your own finances?	Yes: _____	No: _____
Have you ever gotten lost?	Yes: _____	No: _____
Do you handle your own medications?	Yes: _____	No: _____
Do you do your own Shopping?	Yes: _____	No: _____
Have you had any car accidents in the last two years?	Yes: _____	No: _____



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Patient Authorization for the Release of Medical Records

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I hereby authorize **Elite Primary Care**, to request the medical records from

Records requested are as follows:

Lab Reports, X-Rays, EKG Reports

History and Physical, Echocardiograms

Nuclear/Regular Stress Tests

Holter Monitors

Cath/ PTCA/ Stent Reports

All Records

Other: _____

I specifically release of information relating to:

Substance abuse (including alcohol/drug abuse)

STD related information (HIV and AIDS related testing)

Mental health (including psychotherapy notes)

Signature of patient and Legal Guardian

I understand that I have the right to revoke this authorization at anytime. I also understand that I must do so in writing and present my written revocation to Elite Primary Care at the above address. I understand that the revocation will not apply to my insurance company when insurers contest a claim under my policy.

Signature of patient and Legal Guardian

Date

Relationship to Patient

Witness Printed Name and Signature

Date



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Release of Medical Information

I, _____ hereby give authority to _____,
Patient's Name Name and Relationship

to have access to the indicated medical information below, effective _____.
Date

- Procedures
- Medications
- Appointment times and cancellations
- Patient history
- All medical information may be released

I understand that I may request to cancel this release of information in writing for whatever reason, at anytime and that information about me or anything pertaining to me will not be released to anyone but the person mention above. I also understand that Elite Primary Care cannot be held liable for any misuse of information obtained by the person mentioned above.

Signature of patient and/or Legal Guardian Date Relationship to Patient

Witness Printed Name and Signature Date



WHERE YOUR FAMILY BECOMES OURS

HIPAA Compliance Patient Consent Form

Our notice of privacy practices (on the back) 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 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.

Your rights:

- Get a copy of your health and claims records
- Ask us to correct health and claims records
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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.



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Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. Elite Primary Care offers a 50% discount for uninsured patients and this is payment is required at the time service is rendered.

We may charge an upfront \$35.00 administrative fee for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a 25% collection-processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a \$35.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Elite Primary Care also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current no-show fee is \$25.00 and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.



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By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient 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
- The practice may condition receipt of treatment upon execution of this consent

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY, READ, AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- Patient Rights Regarding Medical Records
- HIPPA Policy and Responsibilities
- Patient Financial Responsibility including collections, no-show policy
- Give Elite Primary Care, LLC consent for treatment

This consent was signed by: _____

Please PRINT Name _____

Signature: _____ Date: _____

Witness: _____ Date: _____



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CONTROLLED SUBSTANCE TREATMENT AGREEMENT

Patient: _____ Date: _____

The purpose of this contract is to define the expectations between the prescriber:

Dr. _____ and the patient regarding the use of narcotic medications.

I understand that I have a chronic pain syndrome requiring the use of narcotics for the control of the pain. In addition, I understand that the use of chronic narcotic medication carries the risk of addiction as well as side effects from the medication. I understand that narcotics may impair my ability to operate a motor vehicle or heavy equipment.

In order to reduce the chances of abuse of the medication, certain parameters regarding the prescription are agreed to:

1. I will not use the medicines at doses higher than prescribed.
2. I will not ask for or receive narcotic prescriptions from other medical providers, except as authorized by my physician.
3. I will not ask for early prescription refills except under the most adverse conditions.
4. No replacements will be provided for lost medications or prescriptions.
5. If an early refill is granted for reasons of travel, etc., the next refill will be delayed by an amount of time equal to the number of days early the refill is given.
6. I understand that my physician will need to see me for regularly scheduled visits to follow up on my chronic pain issues. It is my responsibility to schedule the appointments so that I do not run out of medication.
7. I will request medication refills at least 3 business days ahead of the time I will run out.
8. I agree to release information from all pharmacies where I obtain medications. I will choose one pharmacy to fill my pain medications and I will notify my physician if I change pharmacies.
9. I will consent to random drug testing.
10. No refills will be made at night, on holidays or weekends. I will no request refills from on-call physician.

I have been informed that I may not take other drugs such as tranquilizers, sedatives, or antihistamines without first consulting with my physician. I understand that I should not mix my medications with alcohol. The combination use of the above drugs may produce profound sedation, respiratory depression, and in worst cases, death.

Failure to abide by these parameters will be grounds for termination of the prescription of narcotics by Dr. _____ and may result in **termination** from this practice.

Medication: _____ Dosage: _____ Monthly Quantity: _____
Pharmacy: _____ Telephone #: _____

I have read, understand and agree to follow the rules of this agreement. I authorize a copy of this agreement to be released to my pharmacist.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____



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Preferred Pharmacy: _____

LIST OF CURRENT MEDICATIONS

Medication:	Strength:	How often do you take?	Reason for taking:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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