PATIENT DEMOGRAPHICS

PATIENT INFORMATION

Patient Name: _____ Social Security Number: _____-_____-_____
Last First MI

DOB: _____/_____/_____ Sex: M_____ F_____ Marital Status: _____ Ethnicity: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's Occupation/Employer: _____ How did you hear about us? _____

Email: _____

PHARMACY NAME: _____ Location: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____/_____/_____ Sex: M_____ F_____

Social Security Number: _____-_____-_____ Relationship to Patient: _____

Employer: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____/_____/_____ Sex: M_____ F_____

Social Security Number: _____-_____-_____ Relationship to Patient: _____

Employer: _____

EMERGENCY CONTACTS

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

CONSENT AND AUTHORIZATION

I hereby give my consent for medical treatment. I further authorize the holder of medical or other information to release to my insurance carrier, government agency, or its intermediary any information for this or a related insurance claim. I request that payment of authorized benefits be made to this office that accepts assignment. I agree to pay all co pays/deductibles or other authorized charges not covered by my insurance carrier. I understand that I am responsible for notifying this office of any changes in insurance coverage or address.

Printed Name: _____

Signature: _____ **Date: _____**

ADULT HEALTH QUESTIONNAIRE

Patient Name: _____ DOB: _____/_____/_____

Family History (M/F/G)	**Prevention (Dates)**	**Advanced Directives**	**Please indicate specialists you have seen past 5 years**
Breast Cancer_____	Pap Smear_____	**Living Will:** ☐Yes ☐No	OB/GYN_____
Colon Cancer_____	Mammogram_____		Allergist_____
Prostate Cancer_____	Chest X-ray_____		Cardiologist_____
Other Cancer_____	EKG_____	**Durable Power of Attorney for Health Care:** ☐ Yes ☐ No	Ophthalmologist_____
Diabetes_____	Hearing Test_____		Surgeon_____
High BP_____	Eye Vision Test_____		Dermatologist_____
Heart Disease_____	Bone Density Test_____		Urologist_____
Stroke_____	Colon Cancer Screen_____		Gastroenterologist_____
Osteoporosis_____	Lab/Blood Test_____		Orthopedic_____
			Neurologist_____
			Other(s):

Drug Allergies (Please indicate and provide medication reaction)

None: ☐

Penicillin: ☐ Reaction: _____

Codeine: ☐ Reaction: _____

Sulfa: ☐ Reaction: _____

Other(s):

Current Medications with Strength / Dose (Include vitamin/herbal supplements

_____

_____

Past Medical History (check all symptoms/disease that apply to your **PAST HEALTH**)

_____ Osteoporosis	_____ Pneumonia	_____ Prostate Disease	_____ bone Fracture
_____ Glaucoma	_____ Tuberculosis	_____ Urinary Difficulties	_____ Chronic Headaches
_____ Hearing Difficulties	_____ Colon Disease	_____ Pelvic Pain	_____ Anxiety/Panic Attach
_____ Heart Disease	_____ Stomach Ulcers	_____ Abnormal Pap Smear	_____ Depression
_____ High blood Pressure	_____ Abdominal Pain	_____ Breast Disease	_____ Diabetes
_____ Chest Pain	_____ Indigestion	_____ Thyroid Disease	_____ Sexual Transmitted Disease
_____ Shortness of Breath	_____ Hernia	_____ Chronic Back Pain	_____ Cancer
_____ Chronic Cough	_____ Liver Disease	_____ Stroke	_____ Chronic Anemia
_____ Asthma/Emphysema	_____ Hepatitis	_____ Seizure/Epilepsy	_____ Abnormal Bleeding
_____ Fatigue			

Other(s):

Past Surgical History (Please indicate **YEAR** of Surgery)

_____ None	_____ Heart Bypass	_____ Gallbladder	_____ Hysterectomy	_____ Cataract
_____ Tonsillectomy	_____ Back/Spine	_____ Appendectomy	_____ Prostate	_____ Breast
_____ Hernia	_____ Colon	Other(s) (explain):		

Other Hospitalization(s)

Year: _____ Reason: _____ Hospital Name: _____

Year: _____ Reason: _____ Hospital Name: _____

Musculoskeletal (mark symptoms past/present)
_____ Low Back Pain
_____ Pain between Shoulder Blades
_____ Tension across top of Shoulders
_____ Neck Pain
_____ Hip Pain
_____ Leg Pain
_____ Foot Pain
_____ Shoulder Pain
_____ Arm Pain
_____ Hand Pain

Neurological
_____ Arm Numbness
_____ Hand Numbness
_____ Leg Numbness
_____ Foot Numbness
_____ Arm Weakness
_____ Hand Weakness
_____ Leg Weakness
_____ Foot Weakness
_____ Arm Burning
_____ Hand Burning
_____ Leg Burning
_____ Foot Burning

Caffeine
_____ None
_____ # cups/cans per day

Tobacco Use
_____ Non-Smoker
_____ Ex-Smoker
Year Quit _____
_____ Packs per day
For _____ years

Alcohol Use
_____ Non-Drinker
_____ Ex-Drinker
Year Quit _____
_____ # of Drinks per day
_____ # of Drinks per week

Digestive Symptoms
_____ Stomach Pains
_____ Constipation
_____ Diarrhea
_____ Reflux
_____ Gas
_____ Cramping
_____ Heartburn
_____ Bloating
_____ Vomiting
_____ Nausea

Vascular
_____ Cold Hands
_____ Cold Feet
_____ Swelling Hands
_____ Swelling Feet

Recreational Drug Use
_____ Never Use
_____ Previous Use of
_____ Currently use: _____

Any history of IV drug use? _____

Women Only

Date of last menstruation: _____ / _____ / _____
Period every _____ days
Heavy/Irregularity/Spotting/Pain/Discomfort? _____
Age at onset of menstruation: _____ Number of Births: _____
Pregnant or Breastfeeding? _____
Hot Flashes/Sweating at night? _____
Menstrual tension, pain, bloating, irritability or other symptoms at time of period? _____
Any blood in urine? _____
Any problems with control of urination? _____
Any bladder or kidney infection in past year? _____
Date of last pap and rectal exam? _____ / _____ / _____

Men Only

How many times do you urinate during the night? _____
Do you feel pain/burning with urination? _____
Any blood in Urine? _____
Has the force of your urination decreased? _____
Have you had any kidney, bladder or prostate infection within the past 12 months? _____
Do you have problems emptying your bladder completely? _____
Any difficulty with erection or ejaculation? _____
Any testicle pain or swelling? _____
Date of last prostate and rectal exam? ____ / ____/ ____

Have you ever had a blood transfusion? Yes ☐ No ☐

Indicate if you have, or have had, any symptom(s) in the following areas to a significant degree and briefly explain.

Skin _____ Back _____ Headache _____
Head/Neck _____ Intestinal _____ Difficulty Sleeping_____
Ears _____ Bladder _____ Depression _____
Nose _____ Bowel _____ Anxiety _____
Throat _____ Circulation _____ Other Pain/Discomfort:
Lungs _____ Change in Weight _____
Chest/Heart _____ Change in Energy Level _____
Breast _____ Dizziness _____

Religious/Cultural Beliefs
Do you have any religious/cultural practices which restrict the foods you eat or the medical treatment you receive?

Special Learning or Communication Needs?

CONSENT FOR TREATMENT & FINANCIAL POLICY ACKNOWLEDGEMENT

Consent for Services: I voluntarily consent to evaluation, treatment, diagnostic testing, labs, medication and other continued care which my physician, or her designees, deems medically necessary. By signing this consent, I also acknowledge and agree that in rendering care for me, my physician, and/or her designees, may choose to use products in which they have an ownership interest. I understand that I have a choice in the facilities and/or products used to provide treatment of my condition (s). I also understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination of treatment in this facility. I understand that I may be asked to present my insurance card and verify demographics at each visit.

FINANCIAL POLICY

Thank you for choosing Brazos Integrative Medicine! We are committed to providing quality healthcare to each of our patients in a way that is financially responsible for both our patients and our practice. Your clear understanding of our Financial Policy is important to our professional relationship.

BILLING YOUR INSURANCE

- You will be responsible for understanding details of your insurance coverage - including preventative care benefits, requirements for pre-authorization for procedures, annual deductibles and co-pays/co-insurance.
- You will be required to provide a current copy of your insurance card and notify us of any changes in insurance coverage. If we do not have current insurance billing information, the visit will be processed as "Self-Pay" (see below).
- All charges you incur are your responsibility regardless of your insurance coverage.
- You will be asked to pay for deductibles and co-pays at the time we provide the service to you.
- You will be asked to provide your insurance card and verify your address and phone number at each visit.

Our Responsibility is to assist you in understanding the provisions and limitations of your insurance company and to accurately file claims in a timely manner. We will verify benefits but cannot guarantee that your insurance will pay as quoted.

Your Responsibility is to be knowledgeable regarding your benefits, co-pays, deductible and co-insurance amounts. It is ultimately the patient's responsibility for payment of service provided even if insurance denies the claim or does not pay the expected amount. Please contact your insurance company directly to verify benefits if you have questions.

SELF PAY

For some patients that do not have insurance or for visits/services not covered by your carrier, you will be considered Self Pay. Some of the services offered may be considered experimental, therefore we will not bill to your insurance company. For these "non-billable" services, you will be responsible for the payment at the time of service.

- All patients that present without valid insurance information are considered a self-pay patient.
- All Self-Pay patients are required to pay at the time service is rendered.

Payment on unpaid balances is expected within 30 days. If you are unable to pay your balance in full, please contact our office to discuss payment plan options. A monthly payment is required to keep your account current.

We thank you for the opportunity to serve your healthcare needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY HEALTHCARE BENEFITS DIRECTLY TO MY HEALTHCARE PROVIDER.

I understand that the responsibility for payment for services provided in this office is mine, due and payable at the time services are rendered.

Printed Name: _____

Signature: _____ Date: _____

APPOINTMENT ATTENDANCE POLICY

Our office has identified that appointment no shows and late arrivals hamper our ability to successfully meet the treatment needs of our patients. We feel that each patient's reserved appointment time is important. A missed or late arrival greatly impacts your continued care.

Please read and sign the following document indicating that you are aware and will comply with the following policies:

- ⇨ We understand that situations occasionally arise that may make it impossible to attend a previously scheduled appointment. We kindly request that you notify our office by phone (245) 776-8008 no later than **24 hours in advance** if you are unable to attend your scheduled appointment. Prompt notification allows you to quickly reserve another appointment and enables another patient to take advantage of your original appointment.

Failure to comply with the required 24-hour notification will result in the following no show/cancellation fees:

- $25.00 - 1st missed office visit
- $50.00 - 2nd missed office visit
- $75.00 - 3rd missed office visit

_____ (Patient Initials)

There is a $100.00 no show/cancellation fee for Comprehensive Physical appointment.

_____ (Patient Initials)

- ⇨ We understand that situations occasionally arise that may it impossible to be prompt to a scheduled appointment. We kindly request that you notify our office by phone (254) 776-8008 if you anticipate a late arrival. Each appointment is scheduled by identifying the patient's individual needs and necessary treatment time. Often these needs cannot be met in a shortened time frame.

We cannot see a patient who arrives 15 minutes or more after their scheduled appointment time.

_____ (Patient Initials)

We will attempt to schedule you the same day, but only if we can do so without impact to another patient's reserved appointment time. Typically, the late arrival to an appointment will not be able to be accommodated that same day.

The appointment will need to be rescheduled and this becomes a missed appointment and therefore the above-mentioned fee applies.

_____ (Patient Initials)

_____

Patient Printed Name

_____ _____

Patient Signature Date

RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: _____ DOB: _____/_____/_____

The health information you may release subject to this authorization is as follows:

_____

_____

I authorize the release of my protected health information to the following person(s)/entity:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The reason or purpose for this release of information are as follows:

_____

_____

This authorization shall be in force and effective until the following event and / or date:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice.

318 Richland West Circle
Waco, Texas 76712

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Patient Printed Name or Personal Representative Date

_____ _____

Signature of Patient or Personal Representative Description of Personal Representative's Authority

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

I hereby authorize the release of information:

Patient Name	Date of Birth	Social Security Number

Release of records FROM:

Healthcare Provider / Provider / Facility	Telephone Number	Fax Number
Street Address	City, State	Zip Code

Please release requested information to: **LISA KIRK, DO**
318 RICHLAND WEST CIRCLE
WACO, TEXAS 76712
P: (254) 776-8008
F: (254) 776-6892

Please release the following information for these treatment dates: _____

Include this information (if applicable): ☐ Alcohol/Drug ☐ Genetics ☐ HIV/AIDS ☐ Mental Health

PURPOSE:

☐ **Attorney/Legal**	☐ **Continued Care**	☐ **Insurance**	☐ **Personal Use**
▫ Complete Records ▫ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) ▫ EKG/EEG/EMG reports ▫ Immunization records ▫ Laboratory reports ▫ Medication records ▫ Nursing notes ▫ Physician orders ▫ Progress notes ▫ Radiology reports **Other:**	▫ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) ▫ EKG/EEG/EMG reports ▫ Immunization records ▫ Laboratory reports ▫ Radiology reports **Other:**	▫ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) ▫ EKG/EEG/EMG reports ▫ Immunization records ▫ Laboratory reports ▫ Radiology reports **Other:**	▫ Complete Records ▫ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) ▫ Billing records ▫ EKG/EEG/EMG reports ▫ Immunization records ▫ Laboratory reports ▫ Medication records ▫ Nursing notes ▫ Physician orders ▫ Progress notes ▫ Radiology reports ▫ Radiology Images **Other:**

This protected health information is disclosed for the following purpose:

_____

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____
Patient Printed Name or Legal Authorized Representative

_____ _____
Signature of Patient or Legally Authorized Representative Date

Brazos INTEGRATIVE MEDICINE