Patient Forms

Basic Information

Full Name First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth / /

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number

Email

Social Security Number

Address Line 1

Address Line 2

City

State TX

Zip

Marital Status Select One

Maiden Last

Driver's License State TX

Driver's License #

Demographics

Sexual Orientation

Gender Identity

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity

Race

Language

Emergency Contact

Relationship to Contact

Full Name First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number

Email

Address Line 1

Address Line 2

City

State

Zip

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ **Home** ◯ **Mobile** ◯ **Work** **Phone Number** _____

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** ___ / ___ / ___

Policy ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company **Policy Number**

Insurance Plan **Insurance Phone Number**

Group Number

Insurance Company Address **Address Line 2**

City **State** **Zip**

Relationship to Secondary Policy Holder

If you are not the secondary policy holder, please fill out the following:

Full Name
First Middle Last

Sex Male Female Unknown **Date of Birth** / /

Insurance ID Number **Social Security Number**

Policy Holder Address **Address Line 2**

City **State** **Zip**

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us?

Integrative**Medical** OF COPPELL

PLEASE COMPLETE ALL QUESTIONS, CHECKING OFF ITEMS BELOW THAT APPLY TO YOU:

PAST MEDICAL PROBLEMS

☐ Diabetes ☐ Migraines ☐ Depression ☐ Anxiety ☐ Heart Disease
☐ Asthma ☐ Obesity ☐ Psychiatric ☐ Cancer/Tumor
☐ Osteoporosis ☐ Fibromyalgia

PRIOR SURGERIES

☐ Hernia ☐ C-Section ☐ Vasectomy ☐ Hysterectomy
☐ Back Surgery ☐ Gall Bladder ☐ Appendectomy
☐ Breast Augmentation ☐ Tonsillectomy

Other: _____

SOCIAL HISTORY

◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

With Whom do you live? _____ # of Children___

Date of Previous Physical:	**Family History:** *(Please List any of your blood relatives that have had medical conditions, along with a brief description of the forenamed condition)*
Previous Physician:	
Drug Allergies:	

LIFESTYLE QUESTIONS

Do You…? (Y/N)

Exercise Regularly? ◯ Y ◯ N Frequency:	**If current student, what year?**
Drink Alcohol? ◯ Y ◯ N Frequency:	**Take Daily Multivitamins?**
Smoke? ◯ Y ◯ N Want to Quit? ◯ Y ◯ N Occupation (Describe):	**Have regular eye/dental exams?**

670 N. MacArthur Blvd. Ste 100 Coppell, TX 75019 | Phone: (972)-745-4446 Fax: (972)745-2597

Integrative Medical of Coppell

PLEASE COMPLETE ALL QUESTIONS, CHECK ITEMS BELOW THAT APPLY TO YOU: (PAST AND PRESENT)

REVIEW OF SYMPTOMS

CONSTITUTIONAL
- weight loss ☐
- fever/chills ☐
- night sweats ☐

EYES
- vision loss ☐
- blurred vision ☐
- double vision ☐
- yellow sclera ☐

ENT
- hearing loss ☐
- ringing in the ears ☐
- congestion ☐
- runny nose ☐
- sore throat ☐
- oral ulcers ☐

CARDIOVASCULAR
- chest pain/pressure ☐
- chest discomfort ☐
- palpitations ☐
- Irregular heartbeat ☐

RESPIRATORY
- shortness of breath ☐
- cough ☐
- sputum production ☐
- coughing up blood ☐
- wheezing ☐

GASTROINTESTONAL
- abdominal pain ☐
- nausea/vomiting ☐
- constipation ☐
- diarrhea ☐
- anorexia ☐
- black stools ☐
- blood in stool ☐
- rectal bleeding ☐
- hemorrhoids ☐

MUSCOLOSKELETAL
- muscle pain ☐
- back pain ☐
- neck pain ☐
- joint pain/ stiffness ☐
- extremity swelling ☐

GENITOURINARY
- burning during urination ☐
- painful urination ☐
- frequent urination ☐
- blood in urine ☐
- urinary incontinence ☐
- weak urination flow ☐
- testicular swelling/pain ☐
- vaginal/penile discharge ☐

PSYCHIATRIC
- depression ☐
- anxiety ☐
- auditory/visual hallucinations ☐

NEUROLOGICAL
- headache ☐
- light headedness ☐
- blacking out ☐
- numbness/tingling of extremities ☐

HEMATOLOGIC
- anemia ☐
- easy bruising ☐

*Thank you for choosing Integrative Medical of Coppell to care for your medical needs. Please return **all** forms to our front desk staff*

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Name: _____ Date of Birth: _____

MEDICATION ALLERGIES (please list in this box)

MEDICATION LIST

Please list all medications you are currently taking/prescribed

	Medication Name	Strength	Form (Tablet, Capsule, Pump, Etc)	Directions	How long have you been taking this medication?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

PRESCRIPTION

IntegrativeMedical OF COPPELL

670 N MACARTHUR BLVD COPPELL TX 75019

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Integrative Medical recognizes the patient's right to confidentiality of protected health information ("PHI"). This form obtains permission to discuss and/or release information regarding your care at our practice to a person whom you designate as an authorized representative.

Authorization is optional- you may opt to not designate any authorized representatives.
If you intend for anyone else to schedule your appointments, manage your prescriptions, or receive billing/account/medical record information on your behalf, you must authorize them on this form.

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

The provider(s) and staff have my permission to:

☐ Leave a detailed message on my voicemail: (_____) - _____ - _____

☐ Send protected health information unencrypted to my personal email address:

EMAIL: _____

I AUTHORIZE INTEGRATIVE MEDICAL TO DISCLOSE MY PHI TO THE LISTED PERSON(S):

NAME:	PHONE NUMBER	RELATIONSHIP TO PATIENT

PROTECTED HEALTH INFORMATION DISCLOSURE

The provider(s) and staff have my permission to:

☐ Leave a detailed message with the person(s) listed above

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT IF THEY ARE NOT A COVERED ENTITY UNDER THE FEDERAL PRIVACY RULE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING INTEGRATIVE MEDICAL OF COPPELL IN WRITING, TO BE EFFECTIVE ON THE DATE NOTIFICATION IS RECEIVED. I AGREE THAT MY AUTHORIZATION IS VOLUNTARY.

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

IntegrativeMedical OF COPPELL

Agreement for Controlled Medications & Toxicology Screenings

The purpose of this document is to protect (you) the patient and to prevent any possible misunderstandings about certain medications we may prescribe through our office. The terms and explanations in this agreement are **non-negotiable** and are meant to help the patient and doctor comply with all pertinent laws, rules and regulations.

Controlled substance medications can have severe side effects such as drowsiness, vomiting, constipation and even death. Because of this, it is our goal to make sure these medications are monitored and prescribed as safely as possible. Toxicology screenings will be issued on a random basis at any of your office visits whether or not they specifically concern medication refills. This agreement will remain in effect as long as you are receiving a controlled substance.

(Controlled substances include, but are not limited to: Norco, Adderall, Concerta, Vyvanse, Xanax, Klonopin, Valium, Ambien, Ativan, Hycodan, Tussionex, Adipex, Lunesta, Testosterone and codeine products.)

I hereby agree to the following terms and conditions:

- Understand that managing and controlling the prescriptions is my sole responsibility. Lost, stolen or misplaced prescriptions will not be replaced. It is my responsibility to store the medication in safe location. If you plan to travel, only take what is necessary for the trip plus 2 to 3 days' medication in case you're unable to return on your schedule date.
- I agree to use prescribed medication only as directed by the doctor and will not attempt to alter my dosage or frequency unless directed by my Physician.
- it is my responsibility as the patient to make sure I request medication refills with in enough time to ensure I can obtain the new prescription before running out of my current fill. In the event it is time for me to come in for an office visit (with-in 90 days of most recent medication based office visit) I understand I will not receive any additional fills until I present in office.
- I will only use one pharmacy. If a pharmacy change must be made I will notify the Doctor immediately. I will use only one doctor's office for controlled substances.
- I will not use any non-prescribed medications, legal or illegal, while using medications prescribed by this doctor. I will not request nor accept any controlled substances from another Physician or other party while receiving medication from this doctor as it may endanger my health. Failure to comply will likely cause immediate termination as a patient. Failure to comply will likely cause immediate termination as a patient. If I am given a prescription from another Physician, I am to let this office know immediately. I will provide the names of the pharmacy and doctor's office if requested.
- I agree to NEVER share or give any prescribed controlled substance to another person.
- I agree to undergo urine drug testing as requested by my doctor. I understand that failure to undergo such testing may result in the immediate termination of all controlled prescription medications and/or discharge from this practice.
- My signature serves as an understanding and acceptance of the terms and conditions in this agreement.

Patient Name:_____**Date of Birth:** _____

Patient or Legal Guardian Signature:_____**Date:** _____

IntegrativeMedical OF COPPELL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization,
we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

No Show/Cancelation Policy: We require a 24 hour notice to cancel or reschedule appointments. A $35 fee will be charged for any appointments canceled or rescheduled less than 24 hours of the scheduled appointment time. A $50 fee will be charged for any well exam/physical appointments canceled or rescheduled less than 24 hours of the scheduled appointment time.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a nominal fee for each page and per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Derek Frye D.C. – OPA-C - Telephone: 972-745-4446 - Fax: 972-745-2597
Address: 670 N. MacArthur Blvd Suite 100, Coppell, TX 75019

Please sign below. Please note that by signing this form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices

_____ _____ _____

Patient Name *Patient Signature* *Date*