PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last*) ____

Date of Birth: ________________ Age: ________ Male / Female Marital Status: S M W D

Address: ____

Phone Number ______________ Social Security # ____________________ Driver's License # __________

E-Mail Address: ____

Employer ____ Phone: ______________

Employer Address: ____

Referring Physician: ____

Preferred Pharmacy: ____

Responsible Party

Name: ____

Relationship to Patient: ____

Address: ____

Phone Number: ________________ Social Security # ____________________

Employer: ____

Phone Number: ____________ Employer Address: ______________________________

Emergency Contact: ____ Phone Number: ____________

Relationship: ________________ HIPPA Information: YES/NO

Insurance Information

Insurance Company: ____

Phone Number: ________________ Address: ____

Group # ______________________________ Certificate or ID # ____________________________

Insured's Name: ______________________________ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer ______________________________ Phone Number: ________________

Employer Address: ____

Insured's Social Security # ____________________ Date of Birth ____________________ Male / Female

I hereby assign, transfer, and set over to AlphaHealth Licensed Healthcare Providers at AlphaHealth Medical Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

CANCELLATION / NO SHOW POLICY FOR DOCTOR/ULTRASOUND APPOINTMENT

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment with the provider is not cancelled at least 24 hours in advance,

you will be charged a **$25 Fee.**

All Ultrasound appointments not cancelled at least 24 hours in advance, will be charged a **$50 Fee.**

After **three (3)** No Showed Appointments you may be discharged from the office.

Patient Signature: ____ Date: ______________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: ____________________________________

Date of Birth: ____________________________________

Social Security Number: ____________________________

I acknowledge that I have been provided with a written copy of his/her AlphaHealth Licensed Healthcare Providers Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

____ ____________________________

Patient Signature Date

____ ____________________________

Personal Representative Signature (if applicable) Relationship to Patient

PATIENT CONSENT TO TREAT

I hereby give my consent to AlphaHealth Licensed Healthcare Providers and authorize her/him to provide my medical treatment. I understand that AlphaHealth Licensed Healthcare Providers will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize AlphaHealth Licensed Healthcare Providers to perform any additional or different treatment that is thought necessary if, in an emergency, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient Name: ______________________________

Patient Signature: ____________________________ Date: ___________________

Parent/Guardian Signature (for minor): _____________________ Relationship: ___________

Signature of Treating Provider: ___________________________ Date: _______________

Telemedicine Consent Form

Introduction

Telemedicine involves the use of electronic communication to enable healthcare providers at different locations. This information may be diagnosis, therapy, follow-up and/or education and may include any of the following

- Patient Medical Records
- Medical Images
- Live two-way audio & video

Electronic system used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improve access to medical care by enabling a patient to remain in his/her home
- Obtaining expertise of a distant doctor

I certify that this form has been fully explained to me. I have read it or had it read to me. I understand and agree to its contents. I am consenting to participating in the telemedicine examination. I authorize AlphaHealth Medical Associates doctors, nurses, and or other providers involved to perform procedures that may be necessary for my current medical condition.

Name Printed: ____

Signature: ____

Date: ____

HIPPA Medical Release Form

Patient Name: ____

Date of Birth: ____

Today's Date: ____

I _________________________________, give permission to AlphaHealth
(Patient Name)
Medical Associates to release my medical information, including test results, past medical history, appointment dates, to: **(Who Can receive this information) Family Members, Other Providers providing care.**

1.) Name: ______________________ Contact Number:_________________

Relationship/Specialist:__________________

2.) Name: ______________________ Contact Number:_________________

Relationship/Specialist:__________________

3.) Name: ______________________ Contact Number:_________________

Relationship/Specialist:__________________

4.) Name: ______________________ Contact Number:_________________

Relationship/Specialist:__________________

Patients Signature: _________________________________ **Date**:______________________

I understand I may revoke this authorization at any time, provided that the revocation is submitted in writing to the privacy officer at the practice.

1014 E. Wheatland Rd Duncanville, TX 75116 Ph: 214-550-2330-Duncanville
255 W. Lebanon Rd Ste#116 Frisco, TX 75036 Ph: 469-405-0500-Frisco
7505 Glenview Dr Suite: 151 North Richland Hills, TX 76180 Ph: 817-284-9922-NRH
1251 E. Redbird Lane Ste: A Dallas, TX 75241 Ph: 214-377-0608- Redbird

Patient Name: ________________________ **DOB:** ______________ **Last Four Of SSN:** __________

Name and complete mailing address of the person to receive your records is required to process this request.

Send copy of records to: **Send Copy of records From:**

AlphaHealth Medical Associates

Duncanville Fax: 214-550-2331 /Frisco Fax: 469-405-0501

NRH Fax: 817-284-9926/Redbird Fax: 214-432-1426

I understand that if the recipient authorized to receive the information is not a covered entitiy, e.g. Insurance Company or non-healthcare provider, the released informtion may no longer be protected by Federal & State regulations

The following information is requested and may be released:

All Records: _____ Lab Reports: ______

Progress Notes:____ Radioogy Reports:_____

ER Discharge Summary:_____ Medications:_____

Medical Summary:____ EKG Report:_____

Reason for Request: PCP Change: _______ Continuation of Care: ______

I hereby give my express consent to release all medical records regarding my treatment , including psychological or psychiatric treatment, drug abuse, Human Immunodeficiency Virus (HIV) infection including Acquired Immunodeficiency Syndrome (AIDS) or test for HIV or sexually transmitted disease (STD) by circling one or all of the above.

Description of the Purpose /or Disclosure: I understanf that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire the authorization to be in effect until . I further understand that I may revoke this authorization at any time by notifying Waterstone Wellness, inwriting. I understand that copies of records are subject to a $25.00 minimum fee.

____

Signature of Patient/Representative **Date** **Phone Number**

MEDICAL HISTORY

Patient Name: ____ Age: _______________________

Please check off all that apply to you.

__Heart Disease

___Heart Murmur

___Rheumatic Fever

___Asthma

___COPD

___Pneumonia

___High Blood Pressure

___Stroke

___Blood Clot in vein

___Rheumatological Disease

___Sleep Apnea

___Sickle Cell Disease

___Blood Transfusion

___Diabetes

___Cancer

If so what kind? _______

___Migraine

___Congenital Disease

___Seizures

___Epilepsy

___Liver Disease

___Hepatitis

___Mononucleosis

___Gallbladder Disease

___STD

___Kidney Disease

___Mood Disorder

___Depression

___Anxiety

___ADHD/ADD

___Chronic Pain

___Arthritis

___Osteoporosis

___Osteopenia

___Insomnia

___Anemia

___Thyroid Disorder

___Tuberculosis

Other: __________________

Surgical Procedures / Hospitalizations Month/Year

____ ______________

____ ______________

____ ______________

____ ______________

Family History

Do any of the following conditions run in your family? If so, please list your relationship to them.

Mother's Age: ____________________________ Father's Age: ______________________________

Condition	Relationship	Alive?
______ Stroke		
______ Heart Attack/ Disease		
______ High Cholesterol		
______ High Blood Pressure		
______ Cancer		
What Kind of Cancer?		
______ Diabetes		
______ Genetic Condition		
______ Breast Disease		
_______ My Family has NO Health Conditions		

Social History

Do you smoke? _____ Yes ______ No _______ Former Smoker
If yes, how many times per day? _______
Do you drink alcohol? ______ Yes _______ No
If yes, how many drinks per week? ________
Have you taken any illegal drugs? ______ Yes ______ No
If yes, which one? ____________________________

What date if ever, did you last have the following?

___ Routine Blood Work
___ Flu Vaccine
___ Covid Vaccine
___ Last Menstrual Cycle
___ Pap (Women 18+)
___ Mammogram (Women 40+)
___ Colonoscopy/Cologuard (45+)
___ Prostate Screening (Men 50+)
___ Shingles Vaccine (50+)
___ Bone Density Screening (65+)
___ Pneumonia Vaccine (65+)
___ Last Fall (65+)
___ Vasectomy (Males)
___ Hysterectomy (Women)
___Diabetic Eye Exam

Medication List

MEDICATION LIST			**ALLERGIES**	
Medication Name	Dose	Frequency	Food/Drug Name	Reaction