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Welcome Packet

Thank you for choosing Exceed Health Clinic for your healthcare needs! We are no longer an Urgent Care facility.

We are a Family Practice now!

Enclosed in this document is our New Patient Paperwork. We require all new patients to fill out all the forms in this packet before being seen. You can return these upon your appointment, fax them to us, or e-mail them to us. However, if you use e-mail, please be aware that e-mail is not the most secure way of transmitting personal data.

If you have any questions, please call 903-306-0001.

Thank you!

Exceed Health Clinic Staff

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3725 MALL DR TEXARKANA, TEXAS 75501
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Go to exceedhealthclinic.com for EASY online appointment access!

Ask us about our Membership Program!

Patient Information

Last Name First Name Middle Name
DOB(Date of Birth) SS# Male or Female
Address City ST Zip
Home Phone Cell Phone
Employer's Name Employer's Phone#
Emergency Contact Name Phone#
Marital Status: Single Married Widowed Divorced Separated (Females): Are you pregnant? Y N
Preferred Pharmacy Patient Email
Where did you hear about us?

Our office uses an automated calling system for appointment reminders, account notifications, and notifications of receipt of test results. If you DO NOT wish to receive communications via automated system, you must notify the receptionist so that this service can be turned off.

Please authorize (by circling) your choice(s) of communication and messages below.
(Please include the numbers or addresses above.)

Home Phone Cell Phone Work Phone E-Mail Address

PRIMARY INSURANCE INFORMATION

Plan Name ID# Group
Policy Holder's Name DOB SS#

SECONDARY INSURANCE INFORMATION

Plan Name ID# Group
Policy Holder's Name DOB SS#

The undersigned patient (or patient's representative) consents to allow EXCEED HEALTH CLINIC to provide medical care, testing, and treatment according to the judgement and diagnosis of the provider in attendance that are deemed necessary and advisable. This care may include additional testing such as laboratory tests, EKGs, X-rays, and other necessary test to ensure proper diagnosis and accurate treatment. Treatment may include administering medications (injections, IVs), surgical procedures (lancing abscesses, sutures, removal of skin anomalies, etc.), as well as papsmears, toenail removal, ear irrigations, and other invasive procedures. I understand that if, at any point, I do not wish to have such testing or treatment performed I am responsible for notifying the provider or nursing staff that I want to decline testing and/or treatment. I also understand that if I fail to notify the provider or nursing staff, I cannot hold the provider or clinic liable for any incurred charges from such testing or treatment. I understand that it is my responsibility to contact my insurance carrier prior to testing and/or treatment to determine coverage for such services.

Patient (or Guardian Signature)

Date



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MEDICAL HISTORY

Name: _____ DOB: _____ Age: _____

Allergies: _____

[] NKDA (No known drug allergies)

PATIENT PAST MEDICAL HISTORY

Do you have to have you ever been diagnosed with:

- ADD/ADHD, Allergies, Anemia, Angina, Anxiety Disorder, Arthritis, Asthma, Autism, Auto Immune, BPH, Bedwetting, Bipolar, Bladder/kidney problems, Blood disease, COPD, Cancer, Chicken Pox, Chronic Pain, Congenital Anomalies, Constipation, Coronary Artery Disease, DVT/blood clot, Depression, Developmental/Behavior, Diabetes Type 1, Diabetes Type 2, Diabetes Type 2-insulin, Diverticulitis, Diverticulosis, Erectile Dysfunction (ED), Ear/Hearing problems, Fibromyalgia, GERD, Gout, H-Pylori, Head Injury (concussion), Headaches, Heart problems/disease, Heart Attack, Hepatitis Type, High Cholesterol, Hypertension (Blood Pressure), Hyperthyroidism, Hypothyroidism, Liver disease, Lupus, Mental Illness, Muscle/Joint/Bone problems

****Cont. Past Medical History**

<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke	Surgeries: _____
<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Vision/Eye Problems	_____
<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Emphysema	Other: _____
<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Vascular disease	_____

<p>MEDICATIONS</p> <p>Please list current medications:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>OTHER PROVIDERS</p> <p>Please list other providers you may see:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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HEALTH HABITS

Mark all that apply:

Caffeine - small moderate heavy

Tobacco/Vape - packs per day _____ Dip-cans per day _____ Vape mg _____

***If you are not a smoker, have you ever smoked? Y Or N Date you quit _____

Alcohol - Frequency: _____ Street Drugs - Type _____ Frequency: _____



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FINANCIAL POLICY

We are committed to providing you the best possible care. Please understand that payment of your bill is considered part of your care. The following is a statement of our FINANCIAL POLICY which we require that you read and sign prior to any treatment. You are required to provide us with your most current billing information and notify us immediately of any changes.

*We accept cash, checks, credit cards, and money orders as form of payment.
There is a \$60.00 charge for every returned check.*

PPO/HMO AND OTHER MANAGED CARE

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, we are happy to file your insurance claims. However, you are responsible for paying all copayment, deductibles, coinsurance, and non-covered services. We are not a party to the contract between the patient and their insurance company and have our own contractual obligations with each of the insurance companies we participate with. Even with assignment of benefits, you are still ultimately responsible for all charges. Balances MUST be PAID IN FULL in 3 months or less.

PERSONAL INJURY (accidents)

We do NOT get involved with third-party claims such as motor vehicle accidents or Workman's Compensation.

SELF PAY

Payment of services is due at the time services are rendered.

DELINQUENT ACCOUNTS

Accounts that are not paid in full or satisfactory arrangements have not been made within 3 months (90 days) of the date services were rendered will be considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau, and/or to our attorney for further action. All collection fees are charged to the patient.

Please let us know if you have any questions. Sign and date below stating that you have read and understand our Financial Policy.

Signature

Date



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CONSENT TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI or HIPAA)

PATIENT NAME: _____ DOB _____ SSN _____

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, medical records and account information are, by law, very protected. EXCEED HEALTH CLINIC will only communicate or disclose your PHI to the person(s) listed below and only as designated below:

I grant permission to EXCEED HEALTH CLINIC to communicate information about my MEDICAL TREATMENT (PHI) and/or my MEDICAL ACCOUNT INFORMATION to the person(s) listed below:

NAME _____ RELATION TO PATIENT _____ [] TREATMENT [] ACCOUNT

NAME _____ RELATION TO PATIENT _____ [] TREATMENT [] ACCOUNT

I understand that myself or my legal representative may revoke this authorization at any time by providing written notice to EXCEED HEALTH CLINIC. I understand that information released to authorized individuals listed above may be disclosed to others via these recipients which may cause this information to no longer be protected by Federal and Texas privacy laws. I understand that this consent does not apply to release of information regarding my spouse, children or any other family member over the age of 18. I understand that the persons identified above must authorize their own individual consent for release and disclosure of their Protected Health Information (PHI). I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); treatment for drug and/or alcohol abuse; mental behavioral health or psychiatric treatments.

I have chosen to create a password to authorize release of PHI and I understand it is my responsibility to relay this password to the above listed authorized person(s).

[] Password: _____ (Optional)

[] I have read and understand the information on this form.

Signature _____

Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The notice of Privacy Practices for EXCEED HEALTH CLINIC has been made available for me to review. I understand that I may request a copy for myself of this notice or obtain a copy from their website exceedhealthclinic.com at any time. I also understand that I will receive notice of any changes made to the Privacy Practices for EXCEED HEALTH CLINIC when any changes are made or access the revised copy on the website provided above.

Signature _____

Date _____