ELPIS
HEALTHCARE

NEW PATIENT FORM

Today's Date: _____

Patient Name: (Last), (First) (M.I.) _____

Date of Birth: _____ **Gender: Male [ ] Female [ ]**

S.S. Number: _____ **Employer:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: ( )_____ **Cell Phone: ( )**_____

Email: _____ **Occupation:** _____

Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Emergency Contact:_____ **Relationship:** _____**Phone #: ( )**_____

Pharmacy Name: _____ **City:** _____ **Phone #: ( )**_____

How did you learn about us? _____

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Primary Insurance information

Primary Card Holder's Name: _____

DOB: _____

Carrier Name: _____

Subscriber Name: Member ID#: _____

Group#: _____

Claims Address: _____

Carrier Contact #: _____

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Summary of Privacy Practices

SUMMARY OF PRIVACY PRACTICES & ASSIGNMENT OF BENEFITS:

The official Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information. Please refer to that Notice for further information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing/accreditation, and training of students. **Uses and Disclosures Base on your authorization:** Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. **Uses and Disclosures, Not requiring your authorization:** In the following circumstances, we may disclose your health information without your written authorization: 1.) to family members or close friends who are involved in your health care. 2.) For certain limited research purposes. 3.) For purposes of public health and safety. 4.) To Government agencies for purposes of their audits, investigations, and other oversight activities. 5.) To government authorities to prevent child abuse or domestic violence. 6.) To the FDA to report product defects or incidents. 7.) To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders. 8.) When required by court orders, search warrants, subpoenas and as otherwise required by law. **Patient Rights:** As our patient, you have the following rights: 1.) to have access to and/or a copy of your health information. 2.) To receive an accounting of certain disclosures we have made of your health information. 3.) To request restrictions as to how your health information is used or disclosed. 4.) To request that we amend your health information. 5.) To receive notice of our privacy practices.

I hereby authorize the above-named insurance company/companies to assign directly all benefits payable. I make this an irrevocable assignment of benefits. I understand that any insurance checks issued belong to ELPIS Healthcare PLLC, and/or their subsidiary companies, for services rendered and I agree to endorse them over should I receive them or otherwise repay any amounts paid to me. Failure to do so would result in legal action. I(we) am (are) aware that if payment is not made within a reasonable amount of time by the insurance carrier(s), that the and the matter is submitted to a collection agency/attorney, I (we) will be responsible for payment of all costs associated with that collection activity, including but not limited to reasonable attorney's fees, and court costs. I fully understand that once the account is being past due the practice reserves the right to begin adding interest at 1% per month simple interest, and if sent to collection, I (we) will be responsible for costs for collection agents and/or reasonable attorney's fees and/or costs of litigation.

ASSIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY: I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my

behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

CONSENT FOR TREATMENT:

At my request, the undersigned hereby voluntarily consents to undergo health screening tests performed by our medical provider. I understand that it is not possible to diagnose or define any disease or problem with a single test alone, and that a screening cannot detect every health problem. I understand that the test results will be reported directly to me. I further understand that it is my responsibility to consult the medical doctor for interpretation analysis, evaluation, and further explanation of my test results. I understand that the medical providers will only review instant results with patients. I understand that the medical provider or ordering physicians shall be liable for any claims including, but not limited to, any claim arising out of or related to, inaccurate, un-interpreted, misinterpreted or results not received and do hereby expressly forever release and discharge all claims, demands, injuries, damage, actions or cause of action.

I understand that the test results will become part of my medical record. I also understand that an insurance company may discover the results of this testing by obtaining a copy of my medical record in accordance with the terms of insurance policy(ies). I hereby consent to the release of my blood test results to me in a manner that I have chosen and my physician or any other health care provider I designate. I understand that my test results will only be provided to other third parties upon my express consent.

All of the above has been discussed with me and I have had an opportunity to have any questions answered that I have regarding my rights to Privacy. I understand possible but infrequent side effects include fainting, bacterial infection, or bruising (hematoma) at the puncture site are possible. In rare circumstances, I may be contacted for redraw due to poor lab sample. I understand some tests are for screening purposes only and are not diagnostic tests or substitutions for a more complete examination by a physician. Blood test results can fluctuate from day to day due to changes in the individual and from Laboratory variation. If any of my results fall outside normal ranges, I understand that I should see the physician for a follow up evaluation.

Media Release:

I hereby give my consent to all photographs, audio recordings, academic work, and/or video recordings taken of me. I understand that any such photographs, audio recordings, academic work, and/or video recordings become the property of the event producer and may be used with consent, for educational, instructional, or promotional purposes determined by the producer in broadcast and electronic media formats now existing or in the future created**. I also understand that I will be notified verbally, prior to any photographs, audio and/or video taken for final consent.**

I acknowledge that I have received, read, and understand the Summary of Privacy Practices and Health Screening Consent.

Signature:_____ **Printed Name:**_____ **Date:**_____

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Health History/Review of Systems

Please circle as each applies to you:

EARS/NOSE/THROAT

Vision/hearing problems: YES / NO
Chronic ear infections: YES / NO
Chronic sinus infections: YES / NO
Deviated septum: YES / NO

ENDOCRINE

Thyroid disease hypo/hyper? YES / NO
Diabetes Type I/II? YES / NO

PULMONARY

Emphysema: YES / NO
Asthma/wheezing: YES / NO
Shortness o f breath: YES / NO
NO Chronic bronchitis: YES / NO
NO COPD: YES / NO

CARDIOVASCULAR

Heart disease: YES / NO
Palpitations/irregular heartbeat: YES / NO
Hypertension/high blood pressure: YES / NO
Hypotension/low blood pressure: YES / NO
Anaphylactic Reaction: YES / NO
High cholesterol: YES / NO
History of MI: YES / NO
Congestive Heart Failure: YES / NO
Coronary Artery Disease: YES / NO
Blood clots YES / NO
Blood thinners YES / NO

GENITO-URINARY

Urinate frequently: YES / NO
Erectile dysfunction: YES / NO
Blood in urine: YES / NO

NEUROLOGICAL

Dizziness/vertigo: YES / NO
History of Stroke/CVA/TIA: YES / NO
Seizures: YES / NO
Headache/migraines YES / NO

DERMATOLOGIC

Skin rash: YES / NO
Itching: YES / NO
Sores tha t won't heal: YES / NO

MUSCULOSKELETAL

Joint swelling/pain: YES / NO
Spine or neck pain: YES / NO
Multiple sclerosis: YES / NO
Arthritis: YES / NO
Osteoporosis: YES / NO
Numbness/tingling: YES / NO
Gout: YES / NO

OTHER

Chronic fatigue: YES / NO
Sleep disturbances: YES / NO
Surgical History: YES / NO
Chemotherapy Treatments: YES / NO
Have you had a Mastectomy: YES / NO

GASTROINTESTINAL YES / NO (not listed)_____

GERD/heartburn:

Gluten intolerance/celiac: YES / NO (not listed)_____

Have you tried to lose weight without medications? YES / NO

If so, lost how many lbs.?_____**How long were you on program?** _____

Have you tried to los e weight with appetite suppressants? YES / NO

Are you pregnant or nursing? YES / NO

Do you have any leg pain when walking? YES / NO

What Brings you to the office today?

_____
_____
_____
_____

Please list any and all prior surgeries or hospitalizations:

Surgery Performed **Year**

_____
_____
_____
_____
_____

Hospitalizations: **Year:**

_____
_____
_____
_____
_____

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FAMILY HISTORY

	Father	Mother	Brother / Sister	Child 1	Child 2	Child 3	Child 4
Good Health							
Poor Health							
Allergies / Asthma							
Diabetes							
Heart Trouble							
High Blood Pressure							
Cancer							

4116 W Spring Creek Pkwy., Unit 400C, Plano, TX 75024 | O: (469) 983-5000 | F: (469) 983-5555
601 Westpark Way, Euless, TX 76040 | O: (817) 354-7070 | F: (817) 354-7073

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Social / Personal History (if yes please indicate quantity)

Do you smoke? YES / NO **If so, how many packs /day?** _____

Do you drink tea? YES / NO **If so, how many cups /day?** _____

Do you drink soda? YES / NO **If so, how many cans /day?** _____

Do you drink alcohol? YES / NO **If so, how many drinks /week?** _____

Do you drink coffee? YES / NO **If so, how many cups /day?** _____

Do you drink milk? YES / NO **If so, how many cups /day?** _____

Do you have any drug / medication allergies? YES / NO If yes, please list: _____

_____

_____

_____

_____

List All Current Medication(s):

_____

_____

_____

_____

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Allergy History

Do you suffer from seasonal allergy symptoms? YES / NO

Rate the severity of your allergy symptoms: Light / Moderate / Severe

Have you ever suffered from watery, itchy, red eyes or have any discharge? YES / NO Light / Moderate / Severe

Have you ever suffered from sneezing or similar airway obstructions? YES / NO Light / Moderate / Severe

Have you ever suffered from stuffy or runny nose, Itchy throat? YES / NO Light / Moderate / Severe

When do you flair up due to allergies?

Winter [ ] Spring [ ] Summer [ ] Fall [ ]

Do you currently take prescription or OTC Allergy medication? YES / NO

If yes, list medications? _____

How effective are the medications in controlling your allergy symptoms?

Effective [ ] Not effective [ ] Some-what effective [ ]

Please check each condition that your allergies have affected:

Missed Work [ ] Home life interrupted [ ] Missed family time [ ]

Other pertinent Allergy information:

_____

_____

_____

_____

Have you ever had a severe anaphylactic reaction (*swelling of the throat)* that required emergency medical attention or use of an Epi-pen? YES / NO

Are you allergic to aspirin? YES / NO

Are you moderate / severe asthmatic; who carries a rescue inhaler? YES / NO

Within the past year have you had an allergy scratch test? YES / NO

Within the past year have you had Immunotherapy medications made for you? YES / NO

Do you have a history of taking OTC allergy medications or allergy shots? YES / NO

If yes, what kind: _____

Are you pregnant or think you might be? YES / NO / Not Applicable

Are you taking any Beta Blockers? YES / NO

Are you taking any Anti-Depressants? YES / NO

Have you ever been told you were allergic to Penicillin? YES / NO

Elpis Healthcare

Food Sensitivity Survey

Patient Name: (Last), (First), (M)_____ **Date:**_____

Date of Birth:_____ **Gender: Male [ ] Female [ ] Height:**_____ **Weight:**_____

Please list all medications you are currently taking: _____

_____

Please complete the following food and chemical sensitivity questionnaire. **Circle each symptom based upon your experiences over the last 60 days**. This survey should be taken again after the completion of the Test, prior to reintroduction of "reactive" foods. Typically, 3-6 months after initial testing. This comparison will help to assess the success of the eating modification program.

Please circle the symptom s and rate the severity of the following:

Digestive Symptoms	Mild	Mod	Severe
Stomach Pains/Cramping	1	2	3
Constipation	1	2	3
Diarrhea	1	2	3
Reflux/Heartburn	1	2	3
Bloating	1	2	3
Gas	1	2	3
Nausea/Vomiting	1	2	3
Weight			
Inability to Lose Weight	1	2	3
Food Cravings	1	2	3
Water Retention	1	2	3
Sinus/Respiratory			
Stuffy/Runny Nose	1	2	3
Asthma	1	2	3
Chest Congestion	1	2	3
Chronic Cough	1	2	3
Wheezing	1	2	3
Frequent Sneezing	1	2	3
Head/Ears			
Migraines	1	2	3
Headaches	1	2	3

Emotional/Mental	Mild	Mod	Severe
Depression	1	2	3
Anxiety	1	2	3
Mood Swings	1	2	3
Irritability	1	2	3
Poor Concentration	1	2	3
Energy			
Fatigue	1	2	3
Hyperactivity	1	2	3
Lethargy	1	2	3
Restlessness	1	2	3
Skin Disorders			
Eczema	1	2	3
Dermatitis	1	2	3
Excessive Sweating	1	2	3
Rashes	1	2	3
Hives	1	2	3
Other Symptoms			
Joint Pain	1	2	3
Arthritis	1	2	3
Irregular Heartbeat	1	2	3
Chest Pains	1	2	3

Earaches	1	2	3	Muscle Aches	1	2	3
Ear Infection	1	2	3				
Ringing in Ears	1	2	3				
Eyes/Throat							
Itchy Eyes	1	2	3				
Watery Eyes	1	2	3				
Sore Throat	1	2	3				
Persistent Canker Sores	1	2	3				

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform us of any changes in my health history.

Signature:_____ **Printed Name:**_____ **Date:**_____

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NO-SHOW POLICY

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling 469.983.5000 or 817.354.7070, emailing info@elpis-healthcare.com.

If you do not show up for your appointment or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show.

No-Show appointments may be subject to a $50 fee.

No-show fees are the patient's sole responsibility and must be paid in full before your next appointment. If the no-show fee might prevent you from receiving necessary care, please contact us.
We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

If our office must cancel your appointment with less than 24 hours' notice, you may choose to meet with a different provider (if available) on the same day, to reschedule, or to cancel. In these circumstances, we will not charge you a cancellation fee.

If you have questions about our cancellation policy, or you're experiencing an emergency, please call 214-704-1438or email the practice manager at info@elpis-healthcare.com.

Patient Name: _____

Patient signature: _____

Date: _____

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HIPPA RELEASE FORM

Privacy regulations require us to have a release form signed by our patients so we may speak with family members, friends, and other relations regarding medical treatment and financial information. Each Person you wish to be considered an approved party to receive your medical or financial information and records on file must be listed individually by name (including a spouse or significant other).

Please print your name, relationship, and telephone number for each person when you authorize the release of your private health care information and account balances.

_____	_____	_____
Name	Relation	Phone #
_____	_____	_____
Name	Relation	Phone #
_____	_____	_____
Name	Relation	Phone #
_____	_____	_____
Name	Relation	Phone #
_____	_____	_____
Name	Relation	Phone #

This authorization will expire on ____ / ____ / _____ (please fill out the date if it is less than one year)

Patient Name: _____ Patient Signature: _____ Date: _____