Alate Health

1213 HERMANN DRIVE, SUITE 255, HOUSTON, TX 77004

**P** 713.955.1707 **F** 713.955.1699 **W** ALATEHEALTH.COM

# PATIENT INFORMATION FORM

| | | |
|---|---|---|
| FIRST NAME | | LAST NAME |
| DOB | SEX ◯ M ◯ F | RACE ◯ WHITE ◯ AFRICAN AMERICAN ◯ ASIAN ◯ OTHER |
| PRIMARY LANGUAGE | | ETHNICITY ◯ HISPANIC ◯ NON-HISPANIC |
| ADDRESS | | |
| CITY | STATE | ZIP |
| HOME PHONE | CELL PHONE | EMAIL |
| WORK PHONE | ALT PHONE | SOCIAL SECURITY NUMBER |
| MARITAL STATUS ◯ S ◯ M ◯ W ◯ D | | SPOUSE'S NAME |
| OCCUPATION | | |
| EMPLOYER | | EMPLOYER PHONE |
| EMERGENCY CONTACT | | PHONE |
| RELATIONSHIP | | |
| HOW DID YOU HEAR ABOUT US? ◯ PHYSICIAN ◯ INTERNET ◯ RADIO ◯ AD ◯ FRIEND/FAMILY ◯ OTHER | | |
| REFERRING PHYSICIAN/FRIEND/FAMILY | | |
| PRIMARY CARE PHYSICIAN | | PHONE |
| ADDRESS | | |
| PREFERRED PHARMACY | | PHARMACY PHONE |
| PHARMACY ADDRESS | | |

◯ I AGREE TO RECEIVE SMS FROM ALATE HEALTH. MESSAGE AND DATA RATES MAY APPLY.

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# MEDICARE INFORMATION

| PATIENT'S NAME | DATE |
|---|---|
| | |

| | | |
|---|---|---|
| MEDICARE # | | |
| DO YOU HAVE INSURANCE PRIMARY TO MEDICARE? | ◯ Y ◯ N | IF YES, PLEASE LIST |
| MEDICARE SUPPLEMENT | | ID |
| MEDICARE ADVANTAGE PLAN | | ID |
| MEDICAID # | | |

# COMMERCIAL INSURANCE

| PRIMARY INSURANCE | |
|---|---|
| ID | GROUP # |
| POLICY HOLDER ◯ SELF ◯ SPOUSE ◯ PARENT ◯ OTHER | |
| POLICY HOLDER'S DOB | SSN |
| EMPLOYER | EMPLOYER'S PHONE |

| SECONDARY INSURANCE | |
|---|---|
| ID | GROUP # |
| POLICY HOLDER ◯ SELF ◯ SPOUSE ◯ PARENT ◯ OTHER | |
| POLICY HOLDER'S DOB | SSN |
| EMPLOYER | EMPLOYER'S PHONE |

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## RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have received the Notice of Privacy Practices from Alate Health, which sets forth the ways in which my personal health information may be used or disclosed by Alate Health, and outlines my rights with respect to such information.

PATIENT NAME (PRINT) DATE

PATIENT SIGNATURE

## OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Alate Health to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, test results or medical care.

| NAME | |
|---|---|
| RELATIONSHIP | PHONE |

| NAME | |
|---|---|
| RELATIONSHIP | PHONE |

| NAME | |
|---|---|
| RELATIONSHIP | PHONE |

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# FINANCIAL POLICY

Thank you for choosing Alate Health for your care. We are committed to providing you with quality and affordable health care. In order to answer your questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

## 1. INSURANCE

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

## 2. CO-PAYMENTS AND DEDUCTIBLES

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

## 3. NON-COVERED SERVICES

Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

## 4. PROOF OF INSURANCE

All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

## 5. CLAIMS SUBMISSION

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

## 6. COVERAGE CHANGES

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

## 7. NONPAYMENT

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. We accept cash, checks, Mastercard, Visa, AMEX, Discover and Care Credit as forms of payment. The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash or credit only basis following any returned check. Should you have billing questions, contact our billing manager at 713-400-9478.

**THANK YOU FOR UNDERSTANDING OUR PAYMENT POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.**

I have read and understand the payment policy and agree to abide by its guidelines

PATIENT NAME (PRINT) DATE

PATIENT SIGNATURE

Alate Health

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# ASSIGNMENT OF BENEFITS FORM

## FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

## ASSIGNMENT OF BENEFITS

I hereby assign the benefits from any insurance or third party to Alate Health for medical services provided to me. I understand that Alate Health has the right to decline or accept assignment of such benefits. If these benefits are not assigned to Alate Health, I agree to forward to the practice, upon receipt, any insurance or third-party payments I receive for services rendered to me. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Alate Health medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Alate Health to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Alate Health on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

PATIENT/RESPONSIBLE PARTY NAME (PRINT) DATE

PATIENT/RESPONSIBLE PARTY SIGNATURE

Alate Health

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# CANCELLATION/NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide adequate notice to allow other patients the opportunity schedule within the appointment slot.

Office appointments and ultrasounds which are canceled with less than 24 hours notification may be subject to a $50 cancellation fee. Procedure cancellations will require the amount of notice and be subject to the cancellation fees indicated below:

**Peripheral Arterial Disease Treatment - 1 week notice, $250 cancellation fee**
**Fibroid Embolization - 1 week notice, $250 cancellation fee**
**Prostate Artery Embolization - 1 week notice, $250 cancellation fee**
**Venogram - 1 week notice $250 cancellation fee**
**Vein Treatments for legs - 3 days notice, $100 cancellation fee**

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as a **no-show**. Patients who no-show two (2) or more times in a 12 month period may be dismissed from the practice and denied future appointments.

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment for office visits and ultrasounds. Procedures will require a credit card on file at the time of scheduling and will be charged if cancellation is made without adequate notice as indicated above. If patient does not have a credit card to put on file, a cash or check deposit will need to be made at the time of scheduling. This will be refunded at the time the patient checks in for their procedure.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department (713-400-9478).

Please sign that you have read, understand and agree to this cancellation and no-show policy.

PATIENT SIGNATURE DATE

PATIENT NAME (PRINT)

Alate Health

1213 HERMANN DRIVE, SUITE 255, HOUSTON, TX 77004

**P** 713.955.1707 **F** 1.855.414.0010 **W** ALATEHEALTH.COM

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

| PATIENT NAME | DOB |
|---|---|
| SSN | |
| I HEREBY AUTHORIZE | |
| TO RELEASE HEALTHCARE INFORMATION OF THE ABOVE NAMED PATIENT TO<br><br>**ALATE HEALTH**<br>1213 HERMANN DRIVE, SUITE 255, HOUSTON, TX 77004 FAX: 713-955-1699 | |
| THIS REQUEST AND AUTHORIZATION APPLIES TO<br><br>○ **HEALTHCARE INFORMATION RELATED TO THE FOLLOWING TREATMENTS, CONDITIONS AND/OR DATES**<br><br>○ **ALL HEALTHCARE INFORMATION**<br>○ **OTHER** | |

**PATIENT SIGNATURE** **DATE**

*THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.*

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# NEW PATIENT HISTORY FORM

NAME

DATE PHONE

ADDRESS DOB

| | | | |
|---|---|---|---|
| **I.** | HEIGHT | WEIGHT | |
| **II.** | **ALLERGIES** | | |
| **III.** | **PAST MEDICAL HISTORY** | | |
| **A.** | ARTHRITIS | YES ◯ | NO ◯ |
| **B.** | KIDNEY DISEASE | YES ◯ | NO ◯ |
| **C.** | HEART ATTACK | YES ◯ | NO ◯ |
| | IF YES, DATE | | |
| **D.** | DIABETES | YES ◯ | NO ◯ |
| **E.** | HIGH BLOOD PRESSURE | YES ◯ | NO ◯ |
| **F.** | CONGESTIVE HEART FAILURE | YES ◯ | NO ◯ |
| **G.** | HEART DISEASE | YES ◯ | NO ◯ |
| **H.** | HEART VALVE DISEASE/REPLACEMENT | YES ◯ | NO ◯ |
| **I.** | HEART STENTS | YES ◯ | NO ◯ |
| | IF YES, DATE | | |
| **J.** | HEART MURMUR | YES ◯ | NO ◯ |
| **K.** | LUNG DISEASE | YES ◯ | NO ◯ |
| **L.** | SMOKING | YES ◯ | NO ◯ |
| **M.** | C-PAP MACHINE | YES ◯ | NO ◯ |
| **N.** | HEAVY SNORING | YES ◯ | NO ◯ |
| **IV.** | **SURGICAL HISTORY** | | |
| **I.** | SURGERY | DATE | |
| **II.** | SURGERY | DATE | |
| **III.** | SURGERY | DATE | |
| **IV.** | SURGERY | DATE | |
| **V.** | SURGERY | DATE | |
| **VI.** | SURGERY | DATE | |

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# NEW PATIENT HISTORY FORM

PATIENT'S NAME DATE

## V. FAMILY HISTORY

| | | | | |
|---|---|---|---|---|
| **I.** | CANCER | MOTHER ◯ | FATHER ◯ | OTHER |
| **II.** | HEART DISEASE | MOTHER ◯ | FATHER ◯ | OTHER |
| **III.** | DIABETES | MOTHER ◯ | FATHER ◯ | OTHER |
| **IV.** | AMPUTATION | MOTHER ◯ | FATHER ◯ | OTHER |
| **V.** | FIBROIDS | MOTHER ◯ | FATHER ◯ | OTHER |
| **VI.** | STROKE | MOTHER ◯ | FATHER ◯ | OTHER |

## VI. SOCIAL HISTORY

| | | | |
|---|---|---|---|
| **I.** | SMOKING | YES ◯ | NO ◯ |

IF YES, HOW MANY PACKS PER DAY, FOR HOW MANY YEARS ( ) PACKS ( )YEARS

| | | | |
|---|---|---|---|
| **II.** | ALCOHOL | YES ◯ | NO ◯ |
| **III.** | ILLICIT DRUGS | YES ◯ | NO ◯ |

## VII. REVIEW OF SYSTEMS *IF YOU ARE CURRENTLY EXPERIENCING PLEASE CIRCLE YES OR NO*

**GENERAL**

| | | |
|---|---|---|
| FEVER | Y | N |
| CHILLS | Y | N |
| SWEATS | Y | N |
| ANOREXIA | Y | N |
| FATIGUE | Y | N |
| WEAKNESS | Y | N |
| MALAISE | Y | N |
| WEIGHT LOSS | Y | N |
| SLEEP DISORDER | Y | N |

**EYES**

| | | |
|---|---|---|
| VISION LOSS IN 1 EYE | Y | N |
| DOUBLE VISION | Y | N |
| EYE IRRITATION | Y | N |
| VISION LOSS BOTH EYES | Y | N |
| EYE PAIN | Y | N |
| HALOS | Y | N |
| DISCHARGE | Y | N |
| LIGHT SENSITIVITY | Y | N |

**EARS-NOSE-THROAT**

| | | |
|---|---|---|
| RINGING IN THE EARS | Y | N |
| EAR DISCHARGE | Y | N |
| EAR ACHE | Y | N |
| DECREASED HEARING | Y | N |
| NASAL CONGESTION | Y | N |
| NOSEBLEEDS | Y | N |
| DIFFICULTY SWALLOWING | Y | N |
| HOARSENESS | Y | N |
| SORE THROAT | Y | N |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| DIFFICULTY BREATHING AT NIGHT | Y | N |
| NEAR FAINTING | Y | N |
| CHEST PAIN OR DISCOMFORT | Y | N |
| RACING/SKIPPING HEART BEATS | Y | N |
| FATIGUE | Y | N |
| LIGHTHEADEDNESS | Y | N |
| SHORTNESS OF BREATH WITH EXERTION | Y | N |
| PALPITATIONS | Y | N |
| SWELLING OF HANDS OR FEET | Y | N |
| DIFFICULTY BREATHING WHILE LYING DOWN | Y | N |
| FAINTING | Y | N |
| LEG CRAMPS WITH EXERTION | Y | N |
| BLUISH DISCOLORATION OF LIPS OR NAILS | Y | N |
| WEIGHT GAIN | Y | N |

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# NEW PATIENT HISTORY FORM

## VII. REVIEW OF SYSTEMS CONTINUED

**RESPIRATORY**

| | | |
|---|---|---|
| SLEEPING DISTURBANCES DUE TO BREATHING | Y | N |
| COUGH | Y | N |
| SHORTNESS OF BREATH | Y | N |
| COUGHING UP BLOOD | Y | N |
| CHEST DISCOMFORT | Y | N |
| WHEEZING | Y | N |
| EXCESSIVE SPUTUM | Y | N |
| EXCESSIVE SNORING | Y | N |

**GENITOURINARY**

| | | |
|---|---|---|
| FOUL URINARY DISCHARGE | Y | N |
| BLOOD IN URINE | Y | N |
| URINARY FREQUENCY | Y | N |
| INABILITY TO EMPTY BLADDER | Y | N |
| URINARY URGENCY | Y | N |
| KIDNEY PAIN | Y | N |
| TROUBLE STARTING URINARY STREAM | Y | N |
| PAINFUL URINATION | Y | N |
| INABILITY TO CONTROL BLADDER | Y | N |
| GENITAL SORES | Y | N |
| LACK OF SEXUAL DRIVE | Y | N |
| EXCESSIVE HEAVY PERIODS | Y | N |
| MISSED PERIODS | Y | N |
| UNUSUAL URINARY COLOR | Y | N |
| OTHER ABNORMAL VAGINAL BLEEDING | Y | N |
| PELVIC PAIN | Y | N |

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| MUSCLE CRAMPS | Y | N |
| JOINT PAIN | Y | N |
| JOINT SWELLING | Y | N |
| PRESENCE OF JOINT FLUID | Y | N |
| BACK PAIN | Y | N |
| STIFFNESS | Y | N |
| MUSCLE WEAKNESS | Y | N |
| ARTHRITIS | Y | N |
| GOUT | Y | N |
| LOSS OF STRENGTH | Y | N |
| MUSCLE ACHES | Y | N |

**SKIN**

| | | |
|---|---|---|
| EXCESSIVE PERSPIRATION | Y | N |
| NIGHT SWEATS | Y | N |
| SUSPICIOUS LESIONS | Y | N |
| CHANGES IN NAIL BEDS | Y | N |
| DRYNESS | Y | N |
| POOR WOUND HEALING | Y | N |
| UNUSUAL HAIR DISTRIBUTION | Y | N |
| SKIN CANCER | Y | N |
| ITCHING | Y | N |
| CHANGES IN COLOR OF SKIN | Y | N |
| FLUSHING | Y | N |
| RASH | Y | N |

**ENDOCRINE**

| | | |
|---|---|---|
| EXCESSIVE HUNGER | Y | N |
| COLD INTOLERANCE | Y | N |
| HEAT INTOLERANCE | Y | N |
| EXCESSIVE URINATION | Y | N |
| EXCESSIVE THIRST | Y | N |
| WEIGHT CHANGE | Y | N |

**HEMATOLOGIC**

| | | |
|---|---|---|
| ENLARGED LYMPH NODES | Y | N |
| BLEEDING | Y | N |
| SKIN DISCOLORATION | Y | N |
| ABNORMAL BRUISING | Y | N |
| FEVERS | Y | N |

**HOW DID YOU FIRST HEAR ABOUT US?**

- ○ WEBSITE
- ○ RADIO
- ○ TV
- ○ FRIEND
- ○ PHYSICIAN
- ○ INSURANCE LIST
- ○ EVENT
- ○ OTHER:

| PATIENT NAME (PRINT) | |
|---|---|
| PATIENT SIGNATURE | DATE |

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# PATIENT MEDICATION

| PATIENT NAME | |
|---|---|
| DATE | DOB |

**PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:**

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
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| PATIENT NAME | |
|---|---|
| DATE | DOB |

**TO HELP US COMMUNICATE WITH YOUR OTHER DOCTORS, PLEASE LIST THE INFORMATION BELOW FOR ALL OF THE DOCTORS WHOM YOU SEE AND WOULD LIKE TODAY'S OFFICE NOTES FAXED TO:**

| PHYSICIANS NAME | PHONE |
|---|---|
| PHYSICIANS NAME | PHONE |
| PHYSICIANS NAME | PHONE |

PATIENT SIGNATURE

DATE