

### PATIENT INFORMATION FORM

FIRST NAME		LAST NAME	
DOB	SEX <input type="radio"/> M <input type="radio"/> F	RACE <input type="radio"/> WHITE <input type="radio"/> AFRICAN AMERICAN <input type="radio"/> ASIAN <input type="radio"/> OTHER	
PRIMARY LANGUAGE		ETHNICITY <input type="radio"/> HISPANIC <input type="radio"/> NON-HISPANIC	
ADDRESS 1			
CITY		STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL	
WORK PHONE	ALT PHONE	SOCIAL SECURITY NUMBER	
MARITAL STATUS <input type="radio"/> S <input type="radio"/> M <input type="radio"/> W <input type="radio"/> D		SPOUSE'S NAME	
OCCUPATION			
EMPLOYER		EMPLOYER PHONE	
EMERGENCY CONTACT		PHONE	
RELATIONSHIP			
HOW DID YOU HEAR ABOUT US? <input type="radio"/> PHYSICIAN <input type="radio"/> INTERNET <input type="radio"/> RADIO <input type="radio"/> AD <input type="radio"/> FRIEND/FAMILY <input type="radio"/> OTHER			
REFERRING PHYSICIAN/FRIEND/FAMILY			
PRIMARY CARE PHYSICIAN			
PREFERRED PHARMACY		PHARMACY PHONE	
PHARMACY ADDRESS			

### MEDICARE INFORMATION

PATIENT'S NAME	DATE
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MEDICARE #	
DO YOU HAVE INSURANCE PRIMARY TO MEDICARE?	<input type="radio"/> Y <input type="radio"/> N
IF YES, PLEASE LIST	
MEDICARE SUPPLEMENT	ID
MEDICARE ADVANTAGE PLAN	ID
MEDICAID #	

### COMMERCIAL INSURANCE

PRIMARY INSURANCE	
ID	GROUP #
POLICY HOLDER <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> PARENT <input type="radio"/> OTHER	
POLICY HOLDER'S DOB	SSN
EMPLOYER	EMPLOYER'S PHONE

SECONDARY INSURANCE	
ID	GROUP #
POLICY HOLDER <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> PARENT <input type="radio"/> OTHER	
POLICY HOLDER'S DOB	SSN
EMPLOYER	EMPLOYER'S PHONE



1213 HERMANN DRIVE, SUITE 255, HOUSTON, TX 77004

P 713.955.1707 F 713.955.1699 W ALATEHEALTH.COM

## 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.

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PATIENT NAME (PRINT)

DATE

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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

## 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 more than 24 hours notice.

This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

**Office appointments and ultrasounds which are cancelled with less than 24 hours notification may be subject to a \$50 cancellation fee. Procedure cancellations require 2 day advance notification. Without notification, they may be subject to a \$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. Patients may also be subject to a **\$50 no-show fee for an office appointment or ultrasound and \$100 no-show fee for procedures.**

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.

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 (713-955-1708).

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

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PATIENT NAME (PRINT)

DATE

---

PATIENT SIGNATURE



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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. 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

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PATIENT NAME (PRINT)

DATE

---

PATIENT SIGNATURE



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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.

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PATIENT/RESPONSIBLE PARTY NAME (PRINT)

DATE

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PATIENT/RESPONSIBLE PARTY SIGNATURE



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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

PATIENT NAME (PRINT)

DATE

PATIENT SIGNATURE

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

## NEW PATIENT HISTORY FORM

NAME

---

DATE

PHONE

---

ADDRESS

DOB

---

I. HEIGHT

WEIGHT

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### II. ALLERGIES

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### III. PAST MEDICAL HISTORY

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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

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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 <input type="radio"/>	FATHER <input type="radio"/>	OTHER
II. HEART DISEASE	MOTHER <input type="radio"/>	FATHER <input type="radio"/>	OTHER
III. DIABETES	MOTHER <input type="radio"/>	FATHER <input type="radio"/>	OTHER
IV. AMPUTATION	MOTHER <input type="radio"/>	FATHER <input type="radio"/>	OTHER
V. FIBROIDS	MOTHER <input type="radio"/>	FATHER <input type="radio"/>	OTHER
VI. STROKE	MOTHER <input type="radio"/>	FATHER <input type="radio"/>	OTHER

### VI. SOCIAL HISTORY

I. SMOKING	YES <input type="radio"/>	NO <input type="radio"/>
IF YES, HOW MANY PACKS PER DAY, FOR HOW MANY YEARS ( ) PACKS ( ) YEARS		
II. ALCOHOL	YES <input type="radio"/>	NO <input type="radio"/>
III. ILLICIT DRUGS	YES <input type="radio"/>	NO <input type="radio"/>

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

#### CONSTITUTIONAL

FATIGUE	YES	NO
FEVER	YES	NO
LOSS OF APPETITE	YES	NO
NIGHT SWEATS	YES	NO
RIGORS	YES	NO
WEIGHT LOSS	YES	NO
WEIGHT GAIN	YES	NO
OTHER		

#### EYES

EYE PAIN	YES	NO
SUDDEN CHANGE IN VISION	YES	NO
OTHER		

#### CARDIOVASCULAR

CHEST PAIN	YES	NO
EDEMA	YES	NO
PALPITATION	YES	NO
OTHER		

#### GENITOURINARY

BLOOD IN URINE	YES	NO
DIFFICULTY STARTING URINE STREAM	YES	NO
FREQUENT URINATION	YES	NO
PAINFUL URINATION	YES	NO
OTHER		

#### INTEGUMENTARY

BREAST DISCHARGE	YES	NO
BREAST LUMP	YES	NO
BREAST PAIN	YES	NO
ITCHING	YES	NO
RASH	YES	NO
OTHER		

#### PSYCHIATRIC

ANXIETY DISORDER	YES	NO
DEPRESSION	YES	NO
PANIC ATTACK	YES	NO
SLEEP DISORDER	YES	NO
OTHER		

## NEW PATIENT HISTORY FORM

### VII. REVIEW OF SYSTEMS CONTINUED

**EARS-NOSE-MOUTH-THROAT**

BAD BREATH	YES	NO
EARS RINGING	YES	NO
HEARING LOSS	YES	NO
HOARSENESS	YES	NO
NOSE BLEEDS	YES	NO
POST NASAL DRIPS	YES	NO
SORE THROAT	YES	NO
OTHER		

**RESPIRATORY**

COUGH	YES	NO
SHORTNESS OF BREATH	YES	NO
WHEEZING	YES	NO
OTHER		

**GYNECOLOGY**

ABNORMAL VAGINAL BLEEDING	YES	NO
VAGINAL DISCHARGE	YES	NO
IS THERE ANY CHANCE THAT YOU COULD BE PREGANANT?	YES	NO
OTHER		

**MUSCULOSKELETAL**

BACK PAIN	YES	NO
JOINT PAIN	YES	NO
MORNING STIFFNESS	YES	NO
RAYNAUD'S	YES	NO
OTHER		

**NEUROLOGICAL**

WEAKNESS OF EITHER SIDE	YES	NO
ABNORMAL SKIN SENSATIONS OR SENSITIVITY	YES	NO
HEADACHES	YES	NO
OTHER		

**ENDOCRINE**

CHANGE IN HAIR PATTERN	YES	NO
DRY SKIN	YES	NO
HEAT/COLD INTOLERANCE	YES	NO
OTHER		

**HEMATOLOGIC/LYMPHATIC**

ANEMIA	YES	NO
BLEEDING/BRUISING TENDENCY	YES	NO
ENLARGED LYMPH NODES	YES	NO
OTHER		

**ALLERGIC/IMMUNOLOGIC**

CHRONIC NASAL CONGESTION	YES	NO
CHRONIC RUNNY NOSE	YES	NO
FREQUENT SNEEZING	YES	NO
WATERY/ITCHY EYES	YES	NO
OTHER		

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

- |                               |                                      |
|-------------------------------|--------------------------------------|
| <input type="radio"/> WEBSITE | <input type="radio"/> PHYSICIAN      |
| <input type="radio"/> RADIO   | <input type="radio"/> INSURANCE LIST |
| <input type="radio"/> TV      | <input type="radio"/> EVENT          |
| <input type="radio"/> FRIEND  | <input type="radio"/> OTHER:         |

PATIENT NAME (PRINT)	
PATIENT SIGNATURE	DATE