RENEW HEALTH 1850 Ave. D. Katy, Texas 77493 (281)391-6655

Patient Name_____DOB:_____ Date: _____

□ Male □Female Cell Phone: _____Email: _____

Employer Name:_____Position:_____

Best (2) two contact phone numbers: 1._____ 2._____

Check appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated

Patient's Address:_____City:_____State:_____ Zip:_____

Spouse or Patient's Guardian Name:_____

Whom may we thank for referring you? □Website □Patient □Referring Dr(_____) □Other:_____

Person to contact in case of an emergency:_____Phone:_____

If the patient is under 18, is ok to see and treat in the absence of parent/guardian. **□ *YES*** **□ *NO***

Responsible Party

Name of The Person responsible for this account:_____ DOB:_____

Relationship to Patient: □Parent □Grandparent □Guardian □Step-Child □ Other:_____

Address (if different than patient's):_____City/State/Zip:_____

Cell Phone:_____ Email:_____

Is the responsible person currently a patient at our office? □ Yes □ No

Does the patient have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured:_____DOB:_____

Employer of Insured:_____ Work Phone: _____

Insurance Company Name:_____Subscriber ID:_____

Patient's **Primary Care** Physician:_____Phone #_____

I agree that the above information is true and I authorize Renew Health, PLLC, to use this information to obtain service reimbursement. Additionally, I authorize Renew Health to administer exam, treatment and perform procedures as may be deemed necessary or advisable in my diagnosis-consent to treat. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing

Patient/Guardian Signature:_____Date:_____

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PATIENT HEALTH INFORMATION CONSENT

We may need to contact you regarding your care.

This is to acknowledge that you authorize Renew Health, PLLC to (***Check ALL that Apply):***

☐ Leave a detailed message on voice mail/machine

☐ Leave a call back person name and call back number only on voice mail/machine

☐ Call my workplace phone number and leave a call back number only for patient/guardian

☐ Call my workplace phone and ask for the patient/guardian directly

☐ Email (if office available) call back person name and call back number only

☐ Text (if office available) call back person name and call back number only

Authorization to release/disclose patients' PHI (personal health information)

List individual(s) or family members who have permission to obtain information about your care:

Name: _____ Relationship to patient:_____

Name: _____ Relationship to patient:_____

Name: _____ Relationship to patient:_____

Signature of Patient/Guardian:_____ Date: _____/_____/_____

Please note that it is your responsibility to inform us in writing if this information changes

HIPAA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

I understand that the patient's health information is private and confidential. I understand that Renew Health, PLLC, works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. Renew Health, PLLC, displays a copy of their "NOTICE OF PRIVACY PRACTICES" in the patient waiting area.

I understand that Renew Health, PLLC, may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where Renew Health, PLLC, is required by federal, state, or local law to release this information without my permission. One example would be in response to a warrant, summons, court order, subpoena or similar legal process.

Renew Health, PLLC, has a detailed document called the "NOTICE OF PRIVACY PRACTICES". It contains more information about the policies and practices protecting the patient's privacy including other potential disclosures and uses of patient's health information. I understand that I can receive a copy of this document at any time of my choosing.

Renew Health, PLLC, may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Renew Health, PLLC, will provide me with the most current "Notice of Privacy Practices". Within this Notice of Privacy Practices is contained a complete description of my privacy/ confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Renew Health, PLLC, has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Renew Health, PLLC, by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

Patient's Name: _____

Patient's Signature:_____**Date:** _____

Witness:_____ **Date:**_____

CONSENT FOR RELEASE OF INFORMATION
FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I hereby authorize Renew Health, PLLC, to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Renew Health, PLLC, can refuse to treat me.

I have been informed that Renew Health, PLLC, has prepared a notice ("Notice"), which more fully describes the uses, and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Renew Health, PLLC, in writing, but if I revoke my consent, such revocation will not affect any actions that Renew Health, PLLC ,took before receiving my revocation.

I understand that Renew Health, PLLC, has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Renew Health, PLLC, restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Renew Health, PLLC, does not have to agree to such restrictions, but that once such restrictions are agreed to, Renew Health, PLLC, must adhere to such restrictions.

_____
Date

_____
Signature of Patient or Patient's Representative

_____
Printed Name of Patient or Patient's Representative

_____
Relationship to Patient

FINANCIAL POLICY

Our Practice Financial Policy:

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience we accept Visa and MasterCard.

Your Insurance:

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will also bill your health plan for all services that we provide in the hospital.
Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patient:

For all services rendered to minor parties, the adult accompanying the patient is responsible for payment.

Missed Appointments:

In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee for any missed appointments or not cancelled at least on day prior. Please call us as early as possible if you know you will need to reschedule you appointment.

I have read and understand the financial policy service of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time.

Signed:_____**Date:**_____

Payment Policy

Insurance. We participate in most insurance plans, excluding any HMO or Medicaid Product. 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.

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.

Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable and necessary by your insurers. You must pay for these services in full at the time of visit.

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, you will be responsible for the balance of a claim.

Claims submission. We will submit your claims if we participate with your insurance plan. Your insurance company may need you to supply certain information directly to them. 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.

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

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.

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.

Signature of Patient /Legal Guardian_____ **Date:**_____

Please identify how your pain, stiffness or physical function is affecting your ability to perform the following life activities:

ACTIVITY:				**Today's Date: / / /**	
Carrying Groceries	☐No Pain	☐Uncomfortable	☐Painful	☐No Pain	☐ N/A
Sit to Stand	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Climbing Stairs	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Pet Care	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Driving	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Getting In/Out of Car	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Bending	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Household Chores	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Lifting Children	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Dressing	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Shaving	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Sexual Activities	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Sleep	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Using Stairs	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Getting off Toilet	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Walking	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Bathing Getting In/Out of Bath	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Sweeping/Vacuuming	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Dishes	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Laundry	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Yard Work	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Garbage	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Concentration- (Reading, Word Games)	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	☐ N/A
Other: _____	☐No Pain	☐Uncomfortable	☐Painful	☐Unable to Perform	

Details regarding current pain/discomfort:

What pain/discomfort brings you into our clinic today?

_____

What does this pain/discomfort stop you from doing?_____

How long have you suffered from this pain/discomfort?

(Days): _____ (Weeks): _____ (Months): _____ (Yrs): _____

What concerns you the most?

□ Not knowing what is wrong □ Depending on pain killers

□ Losing Mobility/function □ Risk of facing surgery

What would you like to achieve through treatment at our clinic?_____

Review of Systems: Have you *currently* or recently (in the past 3 months) experienced any of the following?

General: □ Weight Gain □ Weight Loss □ Fever □ Hair Loss □ Fatigue □ Weakness □ Other:

Eyes: □ Wears Glasses □ Wears Contacts □ Sensitivity to Light

Ears, Nose, Throat: □ Ringing in Ears □ Hearing Loss □ Ear Pain □ Runny Nose □ Sinus Pressure □ Pain or Difficulty Swallowing □ Growths in the Mouth □ Hoarseness □ TMJ

Cardiovascular: □ Chest Pain □ Palpitations □ Fainting □ Dizziness □ Varicose Veins □ Pain in Legs □ Swelling in Legs/Feet □ Shortness of Breath □ Pacemaker

Respiratory: □ Shortness of Breath while Walking □ Cough □ Asthma/Wheezing □ Chest Congestion

Gastrointestinal: □ Abdominal Pain □ Nausea □ Vomiting □ Diarrhea □ Hemorrhoids

Genitourinary: □ Discharge □ Painful Urination □ Frequent Urination □ Blood in Urine

Musculoskeletal: □ Back Pain □ Neck Pain □ Shoulder Pain □ Elbow Pain □ Wrist Pain □ Hand Pain □ Hip Pain □ Knee Pain □ Ankle Pain □ Foot Pain □ Tensions Headaches

□ Joint Stiffness (Location): _____

□ Muscle Spasms Location): _____

□ Numbness (Location): _____ □ Weakness (Location): _____

Skin: □ Bruising □ Rash □ Dry Skin □ Pigment Change □ Growths/Lesions

Neurologic: □ Stroke □ Headaches □ Migraines □ Unsteady Gait □ Memory Loss □ Weakness □ Numbness

Hematologic: □ Anemia □ Bruise Easily □ Ease of Bleeding □ Clotting Disorder

Endocrine: □ Diabetes □ Excessive Hunger □ Excessive Thirst □ Hair Loss/Hair Growth

Past Medical History: Mark the conditions you are currently being treated for or have ever been treated for in the past

General:

□ Cancer – Specify: _____
□ Diabetes – Type: _____
□ HIV / AIDS

Head/Eyes/Ears/Nose/Throat:

□ Glaucoma
□ Headaches
□ Head Injury
□ Hyperthyroidism
□ Hypothyroidism
□ Migraines

Cardiovascular/Hematologic:

□ Anemia
□ Bleeding Disorders
□ Coronary Artery Disease
□ Heart Attack
□ High Blood Pressure
□ Pacemaker/Defibrillator
□ Poor Circulation
□ Stroke

Respiratory:

□ Asthma
□ Bronchitis
□ COPD
□ Pneumonia
□ Tuberculosis

Gastrointestinal:

□ Irritable Bowel Syndrome
□ GERD / Acid Reflux
□ Gastrointestinal Bleeding
□ Constipation
□ Stomach Ulcers

Musculoskeletal:

□ Amputation
□ Bursitis
□ Carpal Tunnel Syndrome
□ Chronic Low Back Pain
□ Chronic Neck Pain
□ Chronic Joint Pain
□ Fibromyalgia
□ Herniated Disc
□ Joint Injury
□ Osteoarthritis
□ Osteoporosis
□ Rheumatoid Arthritis
□ Tennis Elbow

Genitourinary/Nephrology:

□ Bladder Infection(s)
□ Dialysis
□ Kidney Infection(s)
□ Urinary Incontinence

Hepatic:

□ Hepatitis A (Active/Inactive)
□ Hepatitis B (Active/Inactive)
□ Hepatitis C (Active/Inactive)

Neuropsychological:

□ Alcohol Abuse
□ Alzheimer Disease
□ Anxiety
□ Bipolar Disorder
□ Depression
□ Epilepsy
□ Prescription Drug Abuse
□ Multiple Sclerosis
□ Paralysis
□ Peripheral Neuropathy
□ Schizophrenia
□ Seizures
□ Complex Regional Pain Syndrome

Other Diagnosed Conditions:

_____
_____
_____

Females:

Are you currently pregnant?
Yes / No

Are you currently breastfeeding?
Yes / No

Past Surgical History: Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details/complications:

_____

_____

_____

☐ I HAVE NEVER HAD ANY SURGICAL PROCEDURES

Family History:

Mark all appropriate diagnoses as they pertain to your biological mother, father, and grandparents:

	Alcohol Problems	Cancer	Diabetes	Abnormal Bleeding	Heart Disease	High Blood Pressure	Kidney Disease	Liver Disease	Rheumatoid Arthritis	Stroke
Mother										
Father										
Grandparents										

Other medical problems: _____

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ☐ I AM ADOPTED (No Medical History Available)

Medications:

Please list ALL pain medications that you are taking currently:

_____

_____

Please list ALL pain medications you have taken in the past and are now NOT taking:

_____

_____

Please list ALL other medications you are currently taking:

_____

_____

_____

_____

Allergies: □ Yes □ No

If yes, please list all medications you are allergic to:

Medication Name	Allergic Reaction Type (What Happens)

Topical Allergies: □ Iodine □ Latex □ Tape □ Other: _____

Social History:

Are you currently working? ? □ Yes □ No; What is/was your occupation? _____

Tobacco Use: □ Denies tobacco use □ Current tobacco use

Type: _____ Year Begun: _____ Packs Per Day: ____ Still Smoking: Yes / No Year Quit: _____

Alcohol Use: □ Denies alcohol use □ Current alcohol use

Type: Beer / Wine / Liquor Frequency: Daily / Weekly / Occas. / Rare Drinks/day: _____ Drinks/week: _____

Illicit Drug Use: □ Denies illicit drug use □ Current illicit drug use

Type: _____ Frequency: Daily / Weekly / Occas. / Rare

Have you ever abused narcotic or prescription medications? □ Yes □ No; If so, which: _____

Are you currently in remission for alcohol or any other additions? □ Yes □ No □ Not Applicable

Exercise: □ None □ Light □ Moderate □ Heavy

Please specify current activities and frequency: _____

_____