ELLENBECKER PERSONALIZED MEDICINE

Modern Care, Intentional Focus

PATIENT DEMOGRAPHIC INFORMATION

*Fields marked with * are required.*

PATIENT INFORMATION

Last Name*: _____ **First Name*:** _____ **Middle Initial:** _____

If minor, name of responsible parent: _____

Name you would like to appear on your health records: _____

Pronouns:

☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Date of Birth*: _____ **Social Security #*:** _____ **Driver's License #:** _____

Home Address*: _____

Apt/Suite #: _____ **City*:** _____ **State*:** _____ **ZIP*:** _____

Home #*: _____ **Mobile #*:** _____ **Preferred #:** ☐ Home ☐ Mobile

Email Address*: _____

Gender Identity:

☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Woman

☐ Genderqueer / Nonconforming ☐ Other: _____ ☐ Decline to Answer

Sexual Orientation:

☐ Straight / Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Queer / Pansexual / Questioning

☐ Other: _____ ☐ Don't Know ☐ Decline to Answer

Occupation: _____ **Employer:** _____

Employer Phone #: _____ **Employer Address:** _____

City: _____ **State:** _____ **ZIP:** _____

EDUCATION, LANGUAGE & DEMOGRAPHICS

Highest Level of Education: _____ **Preferred Language:** _____

Do You Need an Interpreter?: _____ **Ethnicity:** _____

Race: _____

Primary Care Physician*

Name: _____

Phone #: _____ **Address:** _____

City: _____ **State:** _____ **ZIP:** _____

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IF APPLICABLE — NAME OF SPOUSE / DOMESTIC PARTNER

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

IF PATIENT IS IN A NURSING OR ASSISTED LIVING FACILITY

Name of Facility*: _____ **Room #*:** _____

Address*: _____

City*: _____ **State*:** _____ **ZIP*:** _____

CONTACT INFO FOR RESPONSIBLE PARTY / SPOUSE / PARENT

If information is the same as above, leave blank.

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Social Security #: _____ **Relationship to Patient:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home #: _____ **Cell #:** _____

Email Address: _____

EMERGENCY CONTACTS

Please provide two contacts with different contact information.

Emergency Contact 1

Name: _____ **Relationship:** _____

Phone #: _____ **Address:** _____

City: _____ **State:** _____ **ZIP:** _____

Emergency Contact 2

Name: _____ **Relationship:** _____

Phone #: _____ **Address:** _____

City: _____ **State:** _____ **ZIP:** _____

INFORMATION SHARING

Who can we share your health information with? _____

_____

SIGNATURES

Patient Signature: _____ **Date:** _____

Patient Representative / Parent: _____ **Date:** _____

For patients requiring translation or verbal reading of this document, the reader/translator may document and sign below.

Reader / Translator: _____ **Date:** _____

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BILLING & INSURANCE INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

INSURANCE INFORMATION

Primary Insurer*

Insurer Name*: _____

Name of Insured*: _____

Insurance ID # / Group # / Other Information: _____

Secondary Insurer

Insurer Name: _____

Name of Insured: _____

Insurance ID # / Group # / Other Information: _____

Tertiary Insurer

Insurer Name: _____

Name of Insured: _____

Insurance ID # / Group # / Other Information: _____

Pharmacy Insurer

Insurer Name: _____

Name of Insured: _____

Insurance ID # / BIN # / PCN # / Group # / Other Information: _____

Patient Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

Physician to Be Seen: _____ **Date:** _____

Account Number Assigned: _____ **Initials:** _____

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GENERAL CONSENT TO TREAT

Including Financial Responsibility and Telehealth Consent

Patient Name: _____ **Date of Birth:** _____

CONSENT TO EXAMINATION AND TREATMENT

I voluntarily consent to examination, evaluation, and treatment by Beau Ellenbecker, DO and the staff of Ellenbecker Personalized Medicine. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me regarding the outcome of examination or treatment.

I understand that during the course of my care, routine procedures (such as blood draws, vaccinations, and point-of-care testing) may be performed, and that I will be informed of and asked to separately consent to any procedure requiring specific written consent.

I understand that I have the right to ask questions about my care, to refuse any recommended treatment, and to request a second opinion at any time.

FINANCIAL RESPONSIBILITY

I understand that my MDVIP membership fee covers the annual wellness program and enhanced access described in my membership agreement, and does not cover the cost of office visits, procedures, labs, or other medical services, which are billed separately to my insurance and/or to me directly.

I authorize Ellenbecker Personalized Medicine to file claims with my insurance carrier(s) on my behalf and to release any medical information necessary to process those claims. I understand that I am ultimately responsible for all charges not covered by insurance, including deductibles, co-payments, and co-insurance, and I agree to pay those amounts at or promptly after the time of service.

I authorize payment of medical benefits directly to Ellenbecker Personalized Medicine for services rendered.

TELEHEALTH CONSENT

I understand that telehealth involves the use of secure video, phone, or other electronic communication to enable my physician to provide care when I am not physically present in the office. I understand the following:

☐ Telehealth has potential benefits, including convenience and timely access to care, as well as limitations — my physician cannot perform a hands-on physical exam, and some conditions may require an in-person visit to be safely or accurately evaluated.

☐ My physician may determine at any time that my condition requires an in-person visit, and will direct me accordingly.

☐ As with any technology, there is a small risk that a telehealth session could be disrupted, delayed, or, despite reasonable safeguards, intercepted by an unauthorized party.

☐ The same confidentiality protections that apply to an in-office visit apply to a telehealth visit.

☐ I have the right to withhold or withdraw consent to telehealth at any time and request an in-person visit instead, without affecting my future care.

I voluntarily consent to receive care via telehealth under the terms described above.

ACKNOWLEDGMENT

I have read this form, or it has been read to me, and I have had the opportunity to ask questions. I understand and agree to its terms.

Patient (or Guardian) Signature: _____ **Date:** _____

Printed Name: _____

If signed by someone other than the patient:

Relationship to Patient: _____

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____

I. THE PATIENT

This form is for use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____ **Date of Birth:** _____

II. AUTHORIZATION

I authorize _____ ("Authorized Party") to use or disclose the following (check one):

- ☐ All of my medical-related information.
- ☐ My medical information ONLY related to: _____
- ☐ My medical-related information from _____ to _____.

Hereinafter known as the "Medical Records."

III. DISCLOSURE

The Authorized Party has my authorization to disclose my Medical Records to the following party:

Name: Beau Ellenbecker, DO PLLC — Ellenbecker Personalized Medicine
Address: 245 W SH 114, Suite 110, Southlake, TX 76092
Phone: **682.200.9960** **Fax:** **682.243.6215**
E-Mail: drbellenbeckerstaff@mdvip.com

IV. PURPOSE

The reason for this authorization is (check one):

- ☐ **General Purpose.** At my request (general).
- ☐ **Other:** _____

V. TERMINATION

This authorization will terminate (check one):

- ☐ Upon sending a written revocation to the Authorized Party.
- ☐ On the following date: _____

VI. ACKNOWLEDGMENT OF RIGHTS

I understand I have the right to revoke this authorization in writing at any time, except where uses or disclosures have already been made based on my original permission — I may not be able to revoke it if given to obtain insurance. I understand disclosed Medical Records may be re-disclosed by a recipient and no longer protected by HIPAA. I understand treatment may not be conditioned on my signing this authorization (unless treatment is sought solely to create records for a third party or a research study), and that I may refuse to sign. I will receive a copy of this authorization after signing; a copy is as valid as the original.

Signature of Patient: _____ **Date:** _____
Print Name: _____

(If the patient is unable to sign, complete the representative section below.)

The patient is unable to sign due to (check one):

- ☐ **Being a Minor.** Patient is ____ years old and considered a minor under state law.
- ☐ **Being Incapacitated.** Patient is incapacitated due to: _____

Signature of Representative: _____ **Date:** _____
Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian

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ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ **I consent** to have the above information released.

☐ **I do not consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____

II. HIV / AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given before this information can be released.

(check one)

☐ **I consent** to have the above information released.

☐ **I do not consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: _____

Ellenbecker Personalized Medicine is committed to protecting the privacy of your health information. This notice describes our legal duties and privacy practices with respect to your protected health information (PHI), and explains your rights regarding that information.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

For Treatment

We may use and disclose your health information to provide, coordinate, or manage your care and related services, including sharing information with other physicians, specialists, laboratories, pharmacies, or health care providers involved in your care.

For Payment

We may use and disclose your health information to bill and collect payment for the treatment and services you receive, including sharing information with your health insurance company to obtain reimbursement.

For Health Care Operations

We may use and disclose your health information for our own operations, including quality assessment and improvement, staff review, training, licensing, and general practice management and planning.

Appointment Reminders and Treatment Alternatives

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required or Permitted by Law

We may use or disclose your health information without your authorization when required by federal, state, or local law, including for public health activities, health oversight activities, judicial or administrative proceedings, law enforcement purposes, to avert a serious threat to health or safety, in connection with organ or tissue donation, for workers' compensation purposes, for certain research purposes under strict oversight, and for military, national security, or other specialized government functions.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other than as described above, we will not use or disclose your health information without your written authorization, including for purposes of marketing, sale of your health information, or disclosure of psychotherapy notes (if applicable). You may revoke a prior authorization, in writing, at any time, except to the extent we have already relied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- Right to Inspect and Copy — You may request to inspect and receive a copy of your health information, with limited exceptions. We may charge a reasonable fee for copies.
- Right to Request Amendment — You may request that we amend your health information if you believe it is incorrect or incomplete. We may deny your request under certain circumstances.
- Right to an Accounting of Disclosures — You may request a list of certain disclosures we have made of your health information.
- Right to Request Restrictions — You may request restrictions on how we use or disclose your health information for treatment, payment, or operations. We are not required to agree, except where you have paid out of pocket in full for a service and request that we not disclose that information to your health plan.
- Right to Request Confidential Communications — You may request that we communicate with you about your health information in a certain way or at a certain location (for example, by mail rather than phone).
- Right to a Paper Copy of This Notice — You may request a paper copy of this notice at any time, even if you agreed to receive it electronically.
- Right to Be Notified of a Breach — We will notify you if there is a breach of your unsecured health information.
- Right to Choose Someone to Act for You — If you have a personal representative or medical power of attorney, that person may exercise your rights and make choices about your health information.

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OUR DUTIES

We are required by law to maintain the privacy and security of your protected health information, to provide you with this notice of our legal duties and privacy practices, to abide by the terms of the notice currently in effect, and to notify you if a breach of your unsecured health information occurs.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice and to make the revised notice effective for health information we already have as well as any information we receive in the future. A copy of our current notice will be available at our office and, if applicable, on our website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the U.S. Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.

To File a Complaint With Our Practice

Ellenbecker Personalized Medicine, 245 W State Highway 114, Suite 110, Southlake, TX 76092 · Phone: 682.200.9960

To File a Complaint With the U.S. Department of Health and Human Services

Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, DC 20201 · Phone: 1-800-368-1019 · www.hhs.gov/ocr/privacy/hipaa/complaints

CONTACT INFORMATION

If you have questions about this notice or would like to exercise any of your rights, please contact our office:

Ellenbecker Personalized Medicine, 245 W State Highway 114, Suite 110, Southlake, TX 76092 · Phone: 682.200.9960

ACKNOWLEDGMENT OF RECEIPT

My signature below acknowledges that I have received a copy of this Notice of Privacy Practices. Signing this acknowledgment does not waive any of my privacy rights.

Patient (or Guardian) Signature: _____ **Date:** _____

Printed Name: _____