EL SHADDAI FAMILY CLINIC

1740 W Virginia St Suite #400 McKinney, TX 75609. Phone 469 252 0101 Fax 833 209 8503

Today's Date: ____/______/_____

Patient's Name: Last___________________________ First___________________ M.I._______

Date of Birth ____/______/_____ Age _____ Sex: M F Social Security _____-______-_____

Address ____

City _______________________ State ____________ Zip Code__________

Telephone (_____) _______-__________ Cell Phone (_____) _______-___________

E-mail _________________@______________.com

Emergency Contact Name ___________________ _____________________

Telephone (_____) _______-________ Relationship ______________________

If patient is a minor (age 18yrs or less), please continue to fill out

Mother's Name ______________________________ Date of Birth ____/______/_____

Social Security _____-______-_____ Cell Phone (_____) _______-_________

Work Phone (____) _______-____________

Father's Name ______________________________ Date of Birth ____/______/_____

Social Security _____-______-_____ Cell Phone (_____) _______-_________

Work Phone (____) ________-____________

Insurance

Primary Insurance: _____________ Insurance # __________________ Co-Pay __________

Secondary Insurance: __________________

Ins. Holder's Name _____________ DOB ____/____/____ SS # _____-______-_____

Phone & Contact Name/Info____

PLEASE GIVE YOUR PHOTO ID AND INSURANCE CARD(s) TO RECEPTIONIST

EL SHADDAI FAMILY CLINIC

1740 W Virginia St Suite #400 McKinney, TX 75609. Phone 469 252 0101 Fax 833 209 8503

El Shaddai Family Clinic (EFC) files primary insurance for services provided to patients with managed care organizations in which we participate. Co-payments, co-insurance services and deductibles are the responsibility of the patient and payable at the time of service. Managed care patients are billed for any remaining patient responsibilities after the insurance company has processed claims. Proof of insurance is not a guarantee of payment. Patients without insurance or covered under an insurance plan in which we do not participate are financially responsible for all charges incurred at the time of service. In the event that the insurance carrier erroneously denies payment for a service performed, it is the patient's responsibility to pursue action with the insurance carrier, as the policy is a legal contract between the patient and the insurance carrier. It is also the responsibility of the patient to be aware of the plan benefits and their right to the appeal process. Patients must verify plan participation with our office or the office visit is the patient's responsibility. I request release of payment information to EFC by third party payers, when required by coordination of benefits. Furthermore, I irrevocably assign any benefits available to me to EFC and I authorize payment of those benefits to EFC's providers.

ACCEPTANCE OF FINANCIAL TERMS

By signing this agreement, I accept the financial terms noted above and certify that the information contained on this form is true correct. Furthermore, I understand that it is my responsibility to present EFC with valid insurance information at each visit and inform EFC should any information on this form change at any time in the future.

Signature of Patient/LegalGuardian____Date____________

Authorization to Release Protected Health Information

By signing below, I hereby authorize EFC to disclose and release the relevant portion of my/my child's medical records from each occasion of treatment to any third party payer (or their representatives), or any other individual as may be necessary to obtain payment for the provider's services to me/my child, including for the purposes of coordination of benefits and prior authorizations. I also authorize the provider to disclose the medical information to other providers who are treating me/my child. Finally, I authorization the provider to release such information as is necessary for the provider to perform certain healthcare operations, such as utilization review by committee or my/my child's health insurance case manager or their designee and as required by federal, state, or local law. I understand that the information I am authorize to be disclose may contain references to psychiatric conditions, drug and alcohol abuse information, genetic testing information, and results of specific laboratory test, including HIV and AIDS diagnosis. As the party responsible for medical decision making or the patient/child represented in this medical record, I hereby give my consent to the provider and other healthcare employees of EFC to render both emergency and non –emergency healthcare services both in and out of my physical presence, and to perform all necessary diagnostic tests. I also assume full financial responsibility for any and all healthcare services provided to said patient/my child. A separate authorization form must be completed prior to releasing the patient records to the patient/guardian, other individuals or agencies. These requests are processed in order of receipt and up to two (2) working weeks. We do not process routine request for copies of medical records or the completion of health forms on a walk-in basis. We must receive, in writing, a request for records that includes the patient's name, date of birth, social security number, dates of record that are requested, plus to whom the records are to be faxed to. Records are also available for pick-up at the office location. **Please be aware, there is a fee associated with the duplication of medical records for patients transferring out of the practice. It is illegal to deny patient records or refuse the transfer of records due to an unpaid or past due account balance, however, records may be withheld for non-payment of the medical records fee. The fee is $35 for the first 20 pages and $.05 for each page thereafter.**

******Three No shows or Three cancellations of appointments will result in automatic termination of all EFC services******

By my signature below, I acknowledge that I have received the EFC Notice of Privacy Practices on or prior to any services being provided to me and agree to all of the above

Signature of Patient/Legal Guardian: ___________________________________Date_____________________

Relation to Patient: MOTHER FATHER SPOUSE LEGAL GUARDIAN

EL SHADDAI FAMILY CLINIC

1740 W Virginia St Suite #400 McKinney, TX 75609. Phone 469 252 0101 Fax 833 209 8503

PATIENT NAME:	**DOB:**
MEDICATION ALLERGIES:	**FOOD OR OTHER ALLERGIES**

CURRENT MEDICATIONS

NAME, DOSE, FREQUENCY	NAME, DOSE, FREQUENCY

PREVIOUS PRIMARY CARE PHYSICIAN: ______________________________ Phone # ____________________

PHARMACY ______________ ZIP CODE /Address ______________________ Phone #____________________

MEDICAL HISTORY (Circle which apply)

	SELF	MOM	DAD	SIBLING	Grand parent	others
Allergic Rhinitis/Hay Fever						
Anemia						
Arthritis						
Asthma						
Cancer						
Cataracts						
Depression/ Anxiety						
Mental Illness						
Diabetes						
Drug/Alcohol/Physical Abuse						
Emphysema						
Lung Problems						
Endometriosis						
Heart Disease						
Heart Attack						
High Blood Pressure						
High Cholesterol						
Irritable Bowel Syndrome						
Kidney Problems						
Migraines						
Peptic Ulcer / GI Problems						
Positive TB Test/Tuberculosis						
Sexually Transmitted Disease						
Seizures						
Stroke						
Thyroid Problems						
List any other problems below:						

EL SHADDAI FAMILY CLINIC

1740 W Virginia St Suite #400 McKinney, TX 75609. Phone 469 252 0101 Fax 833 209 8503

SURGERIES YEAR	Hospitalizations - Reason and year	IMMUNIZATIONS Answer Yes or No
		Flu shot? Year
		Pneumonia Shot? Year
		Tetanus? Year
		Have you had chicken pox?

ANNUAL PREVENTIVE EXAMS	OB/GYN HISTORY FOR WOMEN
Have you had a colonoscopy: yr	Menopaused? Yes No LMP:
Have you had a Bone density test: yr	Live children: Age of your children:
Have you had a stress test or EKG done: yr	No of pregnancies: Miscarriages/Abortions:
Have you had Prostate screening yr	Last PAP smear/ Well woman exam:
Have you ever had a positive test for Tuberculosis?	Have you had a Mammogram? yr:

SOCIAL HISTORY- circle your answer

Have you ever used tobacco products regularly? Yes No If yes, please continue below:
Tobacco Product # of years used? Amount each day Still Use?
Do you drink Alcohol Yes No Type? How many drinks / day or week?
Do you use any illegal drugs? Yes No If yes, please explain:

PERSONAL HISTORY

Your Occupation: Place Employed:
Level of Education: Hobbies:
Please circle if you experience any of the following symptoms , and if any present , please explain on the bottom of the page
General : weight loss fever chills.
Head/ Eyes/ Ear : headache, vision changes, hearing problems, itchy eyes, ringing in ears
Nose / throat: Running nose, seasonal allergy symptoms, sinus pain, sore throat
Neck: swelling or mass, difficulty swallowing, pain
Chest : shortness of breath, chest pain chest tightness when exercising
Abdomen: Pain, nausea , vomiting, diarrhea
Extremities/ Joints: weakness, pain or swelling
Genital : History of any STDs, abnormal discharge or any other concerns
Skin: any rashes or lesions
Psychiatry: Any depression or anxiety or suicidal thoughts
Other concerns:

EL SHADDAI FAMILY CLINIC
1740 W Virginia St Suite #400 McKinney, TX 75609. Phone 469 252 0101 Fax 833 209 8503

Authorization for Release of Medical Information

(Solicitud y Autorización para obtener información médica)

To release medical record information from the record of (A entregar el espediente medico de):

_______________________________________ _______________________________________

Patient/ Paciente (PRINT) Date of Birth/Fecha de Nacimiento

I authorize (Yo autorizo) : ____ Provider/Clinic

PHONE:________________________________ FAX: ____________________________

Information or medical records to be released by means of this authorization include the following:
(La información o expediente médico que se remitirán por medio de esta autorización incluye siguiente)

◯ Entire Medical Record/ Expediente Medico Complete

◯Office Visit/ Citas de Oficina

◯ Shot Record/ Expediente de Vacunas

◯Labs/ Resultados de Laboratorios

◯ Other/ Otra _________________________________

Please release the information to:
El Shaddai Family Clinic- Beena Paul MS APRN NP-C
1740 W Virginia St Ste 400 Mckinney TX 75609
Ph 469 252 0101 Fax 833 209 8503

I understand that my records cannot be disclosed without my written authorization, except as otherwise provided for by law. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that in any event this authorization shall expire automatically in one (1) year from date signed. I understand that photocopy or facsimile of this authorization is as valid as the original.

Entiendo que mis expedientes son confidenciales y que no pueden hacerse públicos sin mi autorización por escrito, excepto cuando lo autoriza la ley. Asimismo quedo enterado, que puedo revocar (cancelar) esta autorización a cualquier hora a menos de que ya se haya tomado acción basada en esta información, o en el evento, que esta autorización haya expirado automáticamente en una años. También entiendo que una copia fotostática o facsímil de esta autorización es tan válida como el original.

____

Patient/Parent/Legal Guardian Paciente/Padre Autorizado/Tutor Legal Signature/Firma Date/Fecha

1740 W Virginia St Suite #400 McKinney, TX 75609. Phone 469 252 0101 Fax 833 209 8503

El Shaddai Family Clinic has a Family Nurse Practitioner for delivery of your medical care. Our provider is board certified and is licensed in the state of Texas.

A Family nurse practitioner is an advanced practice registered nurse (APRN) who is prepared through advanced graduate education and clinical training that provides a wide range of health care services including diagnosis and management of common as well as complex medical conditions to individuals of all ages. They also promote health by appropriate screenings. And prescribing preventative therapies.

Nurse practitioners provide the coordination and management of care required in various health care delivery models.
Please note that as a medical office, emergencies can arise. Your wait may vary from 20-45 minutes. Rest assured that we are working diligently. We appreciate your patience.

I have read the above and hereby consent to the serves of a nurse practitioner for my health care needs

______________________________ ______________________________

Patients Name (Nombre) **Signature** (signatura) **Date** (fecha)

Beena Paul, MS APRN NP-C
Family Nurse Practitioner