PATIENT DATA FORM

PATIENT NAME: _____ MARITAL STATUS: M S D W

D.O.B: _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ EMPLOYER PH #: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

PRIMARY INSURED (If other than patient): _____DOB: _____

EMPLOYER NAME: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

I, _____, have received a copy of Helical Health, PLLC's Notice of Privacy Practices.

_____ _____

Patient/Guardian Signature Date

Pain Management Agreement

HAVE YOU HAD A NARCOTIC MEDICATION FILLED IN THE PAST YEAR? YES / NO

The purpose of this Agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines form any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines may not be replaced.

I agree to use _____(Pharmacy), located at

_____, telephone number_____, for filling prescriptions for all of my controlled medicines.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. If my pain is not well controlled, I will contact my doctor to discuss alternatives.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

This agreement is entered into on this _____ day of _____, _____.

Patient signature: _____ Physician signature: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
(TO BE COMPLETED AFTER DISCUSSING WITH PHYSICIAN)

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS.			
PATIENT/PLAN MEMBER NAME:	**BIRTH DATE:**	**SOCIAL SECURITY NO. (OPTIONAL)**	
PROVIDER'S/HEALTH PLAN'S NAME:	**RECIPIENT'S NAME:** **HELICAL HEALTH, PLLC (NIRAJ MEHTA, DO)**		
PROVIDER'S/HEALTH PLAN'S ADDRESS:	**ADDRESS 1:** **520 E. VINE STREET, #911**		
	ADDRESS 2:		
	CITY: KELLER	**STATE: TX**	**ZIP: 76248**

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING: (FILL IN THE DATE OR EVENT BUT NOT BOTH.)
DATE: **EVENT:**

PURPOSE OF DISCLOSURE:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

IS THIS REQUEST FOR PSYCHOTHERAPY NOTES? ☐ YES, THEN THIS IS THE ONLY ITEM YOU MAY REQUEST ON THIS AUTHORIZATION. YOU MUST SUBMIT ANOTHER AUTHORIZATION FOR OTHER ITEMS BELOW. ☐ NO, THEN YOU MAY CHECK AS MANY ITEMS BELOW AS YOU NEED.

DESCRIPTION:	DATE(S)	DESCRIPTION:	DATE(S)	DESCRIPTION:	DATE(S)
ALL PHI IN MEDICAL RECORD		OPERATIVE INFO		LABOR/DELIVERY SUMMARY	
ADMISSION FORM		CATH LAB		OB NURSING ASSESSMENT	
DICTATION REPORTS		SPECIAL TEST/THERAPY		POSTPARTEM FLOW SHEET	
PHYSICIAN REPORTS		RHYTHM STRIPS		ITEMIZED BILL	
INTAKE/OUTTAKE		NURSING INFO		UB-92:	
CLINICAL TEST		TRANSFER FORMS		OTHER:	
MEDICATION SHEETS		ER INFORMATION		OTHER:	

I ACKNOWLEDGE, AND HEREBY CONSENT TO SUCH, THAT THE RELEASED INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, PSYCHIATRIC, HIV TESTING, HIV RESULTS OR AIDS INFORMATION. _____ (INITIAL) IF NOT APPLICABLE, CHECK HERE. ☐

I UNDERSTAND THAT:

I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT IT IS STRICTLY VOLUNTARY.

MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, BUT IF I DO, IT WILL NOT HAVE ANY EFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION. FURTHER DETAILS MAY BE FOUND IN THE NOTICE OF PRIVACY PRACTICES.

IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR A HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE DISCLOSED.

I UNDERSTAND THAT I MAY SEE AND OBTAIN A COPY OF THE INFORMATION DESCRIBED ON THIS FORM, FOR A REASONABLE COPY FEE, IF I ASK FOR IT.

I GET A COPY OF THIS FORM AFTER I SIGN IT.

SECTION B: IS THE REQUEST OF PHI FOR THE PURPOSE OF MARKETING?
IF YES, THE HEALTH PLAN OR HEALTH CARE PROVIDER MUST COMPLETE SECTION B, IF NO SKIP TO SECTION C.

WILL THE RECIPIENT RECEIVE FINANCIAL OR IN-KIND COMPENSATION IN EXCHANGE FOR USING OR DISCLOSING THIS INFORMATION?
IF YES, DESCRIBE: ☐**YES** ☐**NO**

SECTION C: SIGNATURES

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED.

SIGNATURE OF PATIENT/PLAN MEMBER/GUARDIAN/PLAN MEMBER REPRESENTATIVE:	**DATE:**
PRINT NAME OF PATIENT/PLAN MEMBER REPRESENTATIVE:	**RELATIONSHIP TO PATIENT:**

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Helical Health, PLLC to use and/or disclose certain protected health information (PHI) about me to _____.
Name of entity to receive this information

This authorization permits Helical Health, PLLC to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

Changes to authorization need to be made in writing.

I do not have to sign this authorization in order to receive treatment from Helical Health, PLLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Helical Health, PLLC
520 E. VINE STREET, #911
KELLE, TX 76248

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient/Legal Guardian

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Helical Health, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Helical Health, PLLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Helical Health, PLLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Helical Health, PLLC's Privacy Officer at 520 E. Vine Street, #911, Keller, TX 76248.

With this consent, Helical Health, PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Helical Health, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Helical Health, PLLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Helical Health, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Helical Health, PLLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Helical Health, PLLC may decline to provide treatment to me.

_____	_____	_____
Signature of Patient or Legal Guardian	Patient or Legal Guardian Name	Date

HelicalHealth

ADVANCE DIRECTIVE QUESTIONNAIRE

You have certain rights under Federal and Texas law to make an Advance Directive, a document that allows you to make decisions concerning your medical care; to accept or refuse medical or surgical treatment; and to give instructions to the doctor regarding your health care when you are no longer able to communicate your desires. **If you have an Advance Directive, it is important for you to provide a copy of that document to your doctor.** If you do not have an Advance Directive, it is important for you to know what it is and how to make one.

PLEASE INDICATE IF YOU HAVE ANY ADVANCE DIRECTIVE(S):

- Living Will Yes No
- Durable Power of Attorney for Health Care Yes No
- Do Not Resuscitate Yes No
- Other, please describe _____

If you wish the physician to follow your Advance Directive, you must provide the Helical Health, PLLC with a copy.

PLEASE CONFIRM THE FOLLOWING: (INITIAL)

_____ I do not have an Advance Directive at this time.

IF YOU HAVE A LEGAL GUARDIAN, PLEASE ANSWER THE FOLLOWING:

Legal Guardian: _____

Name: _____

Address: _____ Phone: _____

If patient is unable to complete this form, please state reason: _____

CONSENT TO TREAT

I grant permission to the employees of Helical Health, PLLC to render routine outpatient care to carry out the orders of the physician. I understand that medicine and surgery is not an exact science and there is no guarantee that the outcome of my treatment will be what I want it to be.

ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER

I understand that Texas law provides and I agree, that if any HEALTH CARE worker is exposed to my blood or other bodily fluid, to allow Helical Health, PLLC to perform tests on my blood or other bodily fluid to determine the presence of any communicable disease; including but not limited to Hepatitis, Human Immunodeficiency Virus (which is the causative agent of AIDS) and syphilis. I understand that such testing is necessary to protect those who will be caring for me. I understand that the results of tests taken under these circumstances do not become a part of my medical record.

INSURANCE COVERAGE and FINANCIAL RESPONSIBILITY

Helical Health, PLLC cannot provide and bill for concierge services to patients with governmental insurance.

Helical Health, PLLC nor the patient will bill an insurance company for concierge services rendered by Helical Health, PLLC.

I understand that regardless of any assigned insurance benefits, I am responsible for the total charges for concierge services rendered by Helical Health, PLLC.

RELEASE OF INFORMATION

I authorize Helical Health, PLLC to release any medical information pertaining to my diagnosis and treatment through Helical Health, PLLC to representatives of local, state or federal agencies in accordance with the law. I further authorize release of this information to health care providers associated with my care outside of Helical Health, PLLC to facilitate further health care. All records concerning my care remain the property of Helical Health, PLLC. All records are confidential.

I request that this acknowledgement be in effect until revoked in writing for outpatient services rendered through Helical Health, PLLC.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient or Legal Guardian Patient's Name

Patient Name: _____

Who was your last physician? _____ Date last seen:_____

Family History: Please indicate which blood relative has had any of the following illnesses (include self):

High Blood Pressure_____ High Cholesterol_____
Heart disease or heart attack_____ Diabetes _____
Stroke_____ Cancer_____
Tuberculosis_____ Arthritis_____
Mental Illness_____ Kidney Disease_____
Glaucoma_____ Other_____

Hospital Admissions and Surgeries: Please list with Dates:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current Medications:

Name:	Strength (mg)	#taken per day	For what illness do you take it?

Allergies: Please list the medicines to which you are allergic and tell us what happens when you take it.

Medication: Reaction

_____ _____
_____ _____
_____ _____

Habits:

Do you smoke cigarettes?_____ How many packs per day? _____ How many years have you smoked? _____
Do you use chewing tobacco or snuff? _____ How many years have you chewed? _____ Do you drink beer, wine or mixed drinks? _____
How many drinks per day do you have? _____ How many years have you drank alcohol? ___ How many caffeinated drinks do you have each day? _____
Have you ever taken any street drugs?_____

What is the reason for your visit today? _____

Please check off any of the problems listed below if you have had them in the last 6 months:

___Decreased Hearing
___Vision Problems
___Dental/Gum Problems
___Hay Fever/Allergies
___Coughing up Blood
___Left Arm Pain
___Irregular Heartbeat
___Heart Attack/Angina
___Difficulty Swallowing
___Change in Bowel Habits
___Diarrhea
___Gall bladder Trouble
___Painful Urination
___Control in Urination
___Kidney Stones
___Pelvic Pain
___Chronic Fatigue
___Cancer (incl. Skin)
___Diabetes
___Tremor
___Arthritis/Joint Pain
___Foot Pain
___Eczema
___Nervousness
___Mental Illness

___Ringing in Ears
___Double Vision
___Sinus Problems
___Hoarseness
___Asthma/Wheezing
___High Blood Pressure
___High Cholesterol
___Constipation
___Heartburn/ Indigestion
___Leg Pain when Walking
___Diverticulosis
___Jaundice/Hepatitis
___Blood in Urine
___Weak Urine Stream
___Venereal Disease
___Erectile Dysfunction
___Unplanned Weight Loss
___Always Thirsty
___Thyroid Disease
___Muscle Weakness
___Back Pain
___Cold Feet
___Psoriasis
___Depression

___Daytime sleepiness
___Ear Infections
___Eye Pain
___Sore Throats
___Pneumonia
___Shortness of Breath
___Heart Murmur
___Swollen Ankles
___Varicose Veins
___Nausea/Vomiting
___Blood Clotting Problems
___Bloody/Tarry Stools
___Hernia
___Frequent Urination
___Urinary Urgency
___Feeling of Decreased Emptying
___Discharge from penis or Vagina
___Change in Sexual Drive or function
___Anemia
___Always Hungry
___Convulsions/Seizures
___Numbness
___Bone /Joint Injury

___Rashes
___Snoring
___Memory Loss
___Tattoos
___Dizzy Spells
___Nose Bleeds
___Neck swelling
___Bronchitis
___Chest Pain
___Palpitations
___Fainting Spells
___Loss of Appetite
___Peptic Ulcers
___Hemorrhoids
___Urine Infections
___Overnight Urination
___Easy Bruising
___Unplanned Weight Gain
___Stroke
___Headache
___Gout
___Hives
___Sleeping Difficulty
___Moodiness
___Blood transfusion

WOMEN ONLY

Last Menstrual Period: _____ Do your periods come every month? _____
How often?_____
Is your flow heavy medium light (Circle One)?
Do you get menstrual cramps? _____ How many days does your period usually last? ____
Do you have any pain or bleeding after sexual intercourse? _____
How many times have you been pregnant? _____
How many miscarriages or abortions have you had? _____
What is your method of birth control? _____
Do you get hot flashes? ____ Do you do self breast exams? ____ Date of last PAP?_____
Have you ever had an abnormal PAP?_____
When was your last mammogram? _____
Was it normal? _____

AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until _____, 20_____

I (we) the undersigned parent, parents or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any physician at Helical Health, PLLC It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions:

_____

_____

Signature of Father, Mother or Legal Guardian: _____ Date:_____

Address: _____ City: _____State: _____ Zip: _____

Parent contact information:

Father Name: _____ Home:_____ Work: _____

Mother Name: _____ Home:_____ Work: _____