HealthZone MD™
FAMILY AND SPORTS MEDICINE WELLNESS CENTER

Patient Registration Form

Name: _____

Date: M M / D D / Y Y Y Y

PATIENT INFORMATION

Last Name	First	MI	Sex ❑ Male ❑ Female
Birth Date M M / D D / Y Y Y Y	Age	SSN - -	Drivers License
Address	City	State	Zip
Home Phone #	Work #	Cell #	
Email		Preferred Method of Contact	
Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Domestic Partner			
Spouse's Name		Phone #	
Emergency Contact Name		Phone #	

INSURANCE

Primary Insurance	Policy #	Type of Network	Group #
Address	City	State	Zip
Insured's Name		Sex ❑ Male ❑ Female	
Insured's Employer		Phone #	
Birth Date M M / D D / Y Y Y Y	SSN - -	Relationship to Patient ❑ Self ❑ Spouse ❑ Dependent	
Insurance Address	City	State	Zip
Person Responsible for Payment	Relationship to Patient	Phone #	
Address	City	State	Zip

REFERRED BY

Physician	Magazine/Newspaper	Company
Friend	Health Fair/Community Event	Other

PHARMACY

Pharmacy Name		Phone #	
Address	City	State	Zip

PRIMARY CARE

Primary Care Physician Name		Phone #	
Address	City	State	Zip

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Symptoms & History Form

Name: _____

Date: M M / D D / Y Y Y Y

REVIEW OF SYMPTOMS

Please review and mark **ALL** items that have applied to you **within the last month** (including today)

General:	❑ Fever ❑ Chills ❑ Night Sweats ❑ Unexpected Weight Loss or Gain ❑ Fatigue ❑ Loss of Appetite
Skin:	❑ Rash ❑ Skin Lesions ❑ Abnormal Mole ❑ Jaundice ❑ Itching
Eyes:	❑ Eye Pain ❑ Double Vision ❑ Severe Redness
Ears:	❑ Ear Pain ❑ Difficulty Hearing ❑ Ringing in Ears ❑ Dizziness
Nose:	❑ Runny Nose ❑ Nasal Congestion ❑ Frequent Nose Bleeds ❑ Nasal/Sinus Pressure
Mouth/Throat:	❑ Sore Throat ❑ Difficulty Swallowing ❑ Bleeding Gums ❑ Sores in Mouth ❑ Tooth Pain ❑ Hoarseness
Chest/Heart:	❑ Chest Pain ❑ Racing/Pounding Heart ❑ Palpitations ❑ Shortness of Breath when Lying Down ❑ Lower Leg Swelling ❑ Fainting ❑ Calf Pain with Walking
Neck:	❑ Pain ❑ Swelling
Respiratory:	❑ Shortness of Breath ❑ Cough ❑ Wheezing ❑ Coughing up Blood
Stomach:	❑ Nausea/Vomiting ❑ Heartburn ❑ Abdominal Pain ❑ Vomiting Blood
Bowels:	❑ Diarrhea ❑ Constipation ❑ Black/Tarry/Bloody Stools ❑ Unusual Change in Stool Size/Shape/Color
Urinary Tract:	❑ Blood in Urine ❑ Increased Urination ❑ Difficulty Urinating ❑ Pain when Urinating ❑ Waking to Urinate
Musculoskeletal:	❑ Joint Pain ❑ Muscle Weakness ❑ Back Pain ❑ Swelling in Extremities ❑ Limited Range of Motion in Joints
Neurological:	❑ Seizures ❑ Problems with Coordination ❑ Memory/Sensory Issues ❑ Loss of Consciousness ❑ Numbness ❑ Weakness ❑ Tingling ❑ Dizziness ❑ Severe Headache
Endocrine:	❑ Fatigue ❑ Increased Thirst ❑ Cold Intolerance ❑ Heat Intolerance
Hematologic:	❑ Frequent Nose Bleeds ❑ Easy Bruising ❑ Easy Bleeding ❑ Swollen Hands/Feet ❑ Swollen Glands
Immunologic:	❑ Recurrent Infections ❑ Sneezing ❑ Itchy Eyes
Psychiatric:	❑ Depression/Anxiety ❑ Mood Swings ❑ Emotional Changes ❑ Substance Abuse ❑ Suicide Attempts

❑ No to all

PAST MEDICAL HISTORY

❑ Anemia	❑ Hernia
❑ Anxiety Disorder	❑ Hypertension
❑ Arthritis	❑ Hyperthyroidism
❑ Asthma	❑ Hypothyroidism
❑ Bleeding Disorder	❑ Kidney Disease
❑ Blood Clot	❑ Leg or Foot Ulcers
❑ Cancer	❑ Liver Disease
❑ Coronary Artery Disease	❑ Lung Disease
❑ Depression	❑ Migraines
❑ Diabetes	❑ Osteoporosis
❑ GERD/Reflux	❑ Pacemaker
❑ Gastrointestinal Ulcers	❑ Peripheral Vascular Disease
❑ Gout	❑ Pulmonary Embolism
❑ HIV or AIDS	❑ Rheumatoid Arthritis
❑ Heart Attack	❑ Seizures/Epilepsy
❑ Heart Disease	❑ Stroke
❑ Heart Problems	❑ Tuberculosis
❑ Hepatitis	❑ Other: _____

❑ No to all

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Patient General Health Form

Name: _____

Date: M M / D D / Y Y Y Y

GENERAL INFO

Height	Weight	Are You Pregnant? ❑ No ❑ Yes: _____ months	Living Arrangement ❑ Alone ❑ With Others
Employer	Occupation	School/Team	Team/Sport
Exercise Level ❑ None ❑ Occasional ❑ Moderate ❑ Heavy		Hand Dominance	Sporting Activities
Use of tobacco products ❑ Never ❑ In the Past ❑ Currently; _____packs/day		Illicit Drug Use ❑ No ❑ Yes; Type(s):_____	
Alcohol Consumption ❑ Never ❑ Occasional ❑ Moderate ❑ Heavy _____drinks/week			

ALLERGIES

Are you allergic to any medications? ❑ No ❑ Yes

Medication	Reaction	Medication	Reaction
Medication	Reaction	Medication	Reaction

PREVIOUS SURGERY

Please list any surgeries or hospitalizations you have had in the past ❑ None

Surgery/Illness	Hospital	Year
Surgery/Illness	Hospital	Year
Surgery/Illness	Hospital	Year

CURRENT MEDICATIONS

Please list all current medications ❑ None

Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed

FAMILY HISTORY

Family Member	Health Issue	☐ Deceased
Family Member	Health Issue	☐ Deceased
Family Member	Health Issue	☐ Deceased

SIGNATURE

I certify that the facts contained on this form are true and complete to the best of my knowledge.

_____	_____	_____
Signature	Printed Name	Date

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Patient Financial Responsibility Form

Date: M M / D D / Y Y Y Y

FINANCIAL RESPONSIBILITY

I understand that payment in full is expected at the time services are rendered. If prior arrangements have been made, CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center {HZFSM MD}) may bill my insurance company for the estimated portion. This is a courtesy to me, and I am responsible for the total payment of all charges regardless of insurance coverage.

Since some insurance carriers may delay payment of claims, I may be called upon for payment if CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center {HZFSM MD}) has not received payment within 60 days of billing. If CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center {HZFSM MD}) receives any subsequent payment from my insurance company, then a credit balance will be promptly refunded to me.

I understand that my insurance is a contract between me, my employer and the insurance company. CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center {HZFSM MD}) is not a party to that contract and cannot be responsible for negotiating payment.

I hereby authorize my insurance benefits to be paid directly to CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center {HZFSM MD}) realizing I am responsible for payment as stated above.
I hereby authorize CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center (HZFSM MD}) to release medical information pertaining to my claim to my insurance company, third party payors and/or my attorney. There is a fee for copying medical records.
Unless otherwise specified, I authorize CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center (HZFSM MD}) to access the national pharmacy database for my medication history.

Signature _____ Date _____

MEDICAL RELEASE

I hereby authorize CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center {HZFSM MD}) to release medical information pertaining to my claim to my insurance company, third party payor and/or my attorney. There is a fee for copying medical records.

Signature _____ Date _____

PRIVACY PRACTICE

I have read the Privacy Practice documented by CHUKWUEMEKA NNABUIFE DO PLLC (DBA: HealthZone MD Family and Sports Medicine Wellness Center {HZFSM MD}).

Signature _____ Date _____

Print

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[HealthZone MD Family and Sports Medicine Wellness Center]			
Patient Last Name (Type)	Patient First Name (type)	MI	Type Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice

_____ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

_____ (**Patient/Representative initials)** Some messages relevant to your visit may be sent regardless of explicit consent, including instructions or communications directly related to your care. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. For other types of communications, I consent to receiving, by telephone call, text message, or voicemail transmission, communications by or on behalf of the practice/clinic at the email, telephone number or text address I have provided in my patient record. I also consent to receiving such communications to any email, text address or telephone number forwarded or transferred from that address or telephone number. Other healthcare communications may include, but are not limited to, healthcare communications to family or designated representatives regarding my treatment or condition, reminder messages to me regarding appointments for medical care, communications regarding insurance or billing or requests for feedback about my visit via satisfaction surveys and/or public-facing reviews. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system for the selection or dialing of telephone numbers or the playing of prerecorded messages and may be made by the practice/clinic or someone calling on their behalf even if my phone number is listed on any federal or state "do not call" registry. To the extent these instructions and other communications could be deemed telephonic sales calls, solicitations, or advertisements, I consent to receiving them. I understand that I am not required to consent directly or indirectly to communications in order to receive healthcare services.

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for

your convenience to all our affiliated locations that share an electronic health record in which you have a relationship. My consent to access the location's Electronic Health Record's Patient Portal shall be considered separate and apart from the consent in this form *(section: Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications).*

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility.

without specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Communications about my Healthcare

I agree for the Provider, or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

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Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other Healthzone MD Family and Sports Medicine Wellness Center or affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

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info@HealthZoneMD.com
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A photocopy of this consent shall be considered as valid as the original.

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER any insurance or other third-party benefits available for health care services provided to me. I understand HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER) I agree to forward all health Insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe. I expressly agree and consent that HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER or EBO Servicer

And collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or HEALTHZONE MD FAMILY AND SPORTS MEDICINE WELLNESS CENTER or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient/patient representative signature: _____ **Date:** _____ **Patient Consent for Financial Communications**

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FAMILY AND SPORTS MEDICINE WELLNESS CENTER

Financial Agreement

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- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
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Patient/patient representative signature:_____ **Date:**_____

If you are not the patient, please identify your relationship with the patient. Circle or mark relationship(s) from list below: Spouse Guarantor

Parent Healthcare Power of Attorney

Legal Guardian Other (please specify)

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281-256-8879
info@HealthZoneMD.com
607 Park Grove Drive Suite A, Katy, TX 77450

A photocopy of this consent shall be considered as valid as the original.

HealthZone MD
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Agreement of Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to, prior to any treatment.

- Fees are payable when services are rendered. We accept cash, checks, credit cards and pre-approved insurance for which we are a contracted provider and are the designated primary care provider (PCP) or Specialist.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and preauthorization.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information. Including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility.
- We will ask to and make a copy of your ID card and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance.
- It is the responsibility of each patient to know the details of his or her insurance plan, in addition to any lapses in insurance coverage. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, certain procedures, lab work, DME, hospitalizations or supplies, that are not covered by your plan; we may bill you directly for those charges. If your current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.
- The office bills only for services performed by our providers.
- If another provider's name is listed as your PCP, you will be asked to change the name to Chukwuemeka Nnabuife MD,DO, before you are seen. Please bring your insurance card to EVERY visit.
- If an account is not paid in full within 90 days, a 25% collection processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing no additional appointment will be made for delinquent accounts until they are brought current.
- Checks returned for any reason. Will be assessed a $35.00 service fee. In addition to the amount of the check.
- We attempt to contact every patient to remind them of their appointment; However, Health Zone MD family and sports medicine wellness center reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the. Appointment. The current no-show fee is $35.00 and it's subject to change without notice.

I have read the financial policies contained above and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full. I hereby authorize the physician to release any, and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company and nearby authorized payment of the insurance benefits directly to the physicians for any services rendered that are not paid for directly by myself. BY SIGNING BELOW, I ACKNOWLEDE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES.I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM

Patient Financial Responsibility including collections, no-show policy. Office Policies and procedures.

_____ _____

Signature of Patient/ Responsible Party Date

_____ _____

Name of Patient/ Responsible Party (Please print) Relationship to Patient

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