All fields are required. Please print.

Patient Name: _____
(First) (MI) (Last) Date of Birth

Street Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____ Email address: _____

Social Security #: _____ Occupation: _____ Employer: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language: _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White

Preferred Pharmacy**:** _____ Pharmacy Phone/Zip Code: _____

Policy Holder Name: _____ **Policy Holder's Date of Birth:** _____

Insurance Company: _____ Insured ID: _____ Group Number: _____

Insurance Claims Address: _____ Insurance Phone Number:_____

Emergency contact/Permission to release info to: 1) _____ Phone: _____

2) _____ Phone: _____

Reason for Visit: _____ Referred by: _____

Areas of Interest:

☐ Wellness Exam/Programs	☐ ADD/ADHD Treatment	☐ Allergy Testing/Immunotherapy
☐ Female Hormone Therapy	☐ Male Hormone Therapy	☐ Physical Fitness/Personal Training
☐ Weight Loss Program	☐ HCG Program	☐ Detox
☐ Food Allergy Testing	☐ Botox/Dermal Fillers	☐ Skincare Consultation

Assignment of Insurance Benefits, Release of Protected Health Information, Consent for Treatment, Guaranty and Statement of Service

I hereby assign and authorize payment made directly to Bernice Gonzalez. M.D., P.A, dba Vital Life Wellness Center of all my covered health insurance benefits, including Medicare, Medi gap, Commercial all third party payors, or private managed care plans and insurance, whether payable directly to me by any or all third party payors. I understand my health insurance or third party payors may not cover part or all of the medical services rendered. I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and coinsurance regardless of reason given for non-payment. I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payors related to care rendered by Vital Life Wellness Center and agree that failure to do so will make me responsible for the entire billed charges. My assignment of benefits covers Vital Life Wellness Center for all services now rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits supersedes any previous assignment or agreements made with my insurance company and their related companies or any other third party payor to pay me directly. A copy of this form shall be considered valid as the original.

My Signature below indicates that I have been provided with a copy of the notice of privacy practices for Vital Life Wellness Center and Spa.

_____ _____
Signature of Patient –OR- Date

_____ _____
Legal Representative Relationship to Patient

VITAL LIFE
WELLNESS CENTER

New Patient Medical History

Name:_____ Age:_____ Date of Birth:_____ Sex: ☐ M ☐ F

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you authorize the release of medical information to anyone other than yourself? ☐ Y ☐ N

If yes, Name:_____ Relation:_____

Pharmacy Information: PREFERRED PHARMACY

Pharmacy Name/Location: _____ Phone: _____

Mail Order Pharmacy Name: _____

Address:_____

_____

Allergies to any medications, foods, dyes, or other substances? ☐ Y ☐ N
(If yes, please list allergy and type of reaction.)

_____ _____

_____ _____

_____ _____

_____ _____

Medications: Please include prescriptions, over-the-counter medications, vitamins, supplements, herbs, and eye drops.
(Please list the name, dose, and frequency.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Wellness History: Please list the date of last occurrence.

Bone density scan _____

Colonoscopy _____

Endoscopy _____

Electrocardiogram (EKG) _____

Male: Prostate exam _____

PSA _____

Female: Pap Smear _____

Mammogram _____

Breast exam _____

VITAL LIFE
WELLNESS CENTER

Last Menstrual Period _____

Past Medical History

Please check if you have had or currently have any of the following medical problems.

[ ] Anemia
[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Bladder problems: please specify below
[ ] Cancer, type:_____
Treatment:_____
[ ] Chest pain/Angina
[ ] Cholesterol, high
[ ] Depression
[ ] Diabetes
[ ] Eye disease: _____
[ ] Fractures:_____
[ ] Heart Disease
[ ] High blood pressure
[ ] Hypothyroidism
[ ] Hyperthyroidism
[ ] Kidney Disease
[ ] Liver problems: Please specify below.
[ ] Osteopenia
[ ] Osteoporosis
[ ] Peripheral vascular
[ ] Seizures
[ ] Stroke

Male: Benign Prostatic Hyperplasia

Female: Menstrual History
Age at onset: _____
Cycle every _____ days
Regular Irregular

Other:_____

Family History:
(Please list any diseases/illnesses that your parents, grandparents, or siblings have ever had.)

Father:_____
Health: ☐ Good ☐ Fair ☐ Poor ☐ Deceased

Mother:_____
Health: ☐ Good ☐ Fair ☐ Poor ☐ Deceased

Brother/s: _____
Health: ☐ Good ☐ Fair ☐ Poor ☐ Deceased

Sister/s: _____
Health: ☐ Good ☐ Fair ☐ Poor ☐ Deceased

Other: _____

_____ _____ _____

VITAL LIFE
WELLNESS CENTER

Patient Name | Date of Birth | Date

Surgical History:
(Please list and supply the dates of any surgeries.)

_____ _____

_____ _____

_____ _____

Hospitalizations (other than surgeries):
(Please include date of hospitalization, reason, and name of hospital.)

_____

_____

Prevention History:

Do you have advance directives? ☐ Y ☐ N

Do you use tobacco products? ☐ Y ☐ N What kind? _____ How often? _____

Do you drink alcoholic beverages? ☐ Y ☐ N Occasional How often? _____ How much? _____

Do you have a history of illicit/prescription drug abuse? ☐ Y ☐ N Explain: _____

Do you exercise regularly? ☐ Y ☐ N If yes, what type? _____

How often? _____

Do you have any dietary restrictions? ☐ Y ☐ N Explain: _____

Are you currently employed? ☐ Y ☐ N Occupation: _____

Education level: _____

Do your religious beliefs prevent you from obtaining certain medical care? ☐ Y ☐ N

If yes, please explain:_____

Do you wear your seatbelt? ☐ Y ☐ N

Do you use protective gear? ☐ Y ☐ N

Do you use sunscreen? ☐ Y ☐ N

Are you able to perform all activities of daily living (i.e. bathing, grooming, dressing, cooking) independently? ☐ Y ☐ N

If no, please explain:_____

_____ _____ _____
Patient Name | Date of Birth | Date

Notice of Privacy Practices Summary

Effective April 14, 2003

In 1996 Congress passed the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct (**HIPAA**). Included in this act is "**The Privacy Act**" which was approved August 14, 2002.

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

Who Will Follow This Notice?

This notice describes our practices and that of:

- Any health care professional authorized to enter information into your chart.
- All department and unites of each health care provider listed below.
- Any member of a volunteer group we allow to help you while you are a patient of the VLWC.
- All employees, staff and other personnel of the VLWC health care providers.
- All medical clinic and other health care providers owned and/or operated by a legal entity owned or controlled by VLWC.

The entities, sites and locations listed above are treated as a single affiliated covered entity, are referred to in this notice as the "VLWC," and follow the terms of this notice. These entities, sites and locations may share medical information with each other for treatment, payment or health care purposes and as otherwise allowed by Texas and federal law.

Duties of VLWC

VLWC is required by law to:

- Maintain the privacy of protected health information
- Provide patients with notice of its legal duties and privacy practices
- Abide by the terms of the Notice of Privacy Practices currently in effect
- Prominently display and make available Notice of Privacy Practices.

VLWC reserves the right to change the terms of its Notice of Privacy Practices as directed by HIPAA and to make the new notice provisions effective for all protected health information that it maintains.

Vital Life Wellness Center may own a part of a company which provides management services to its providers. I have the right to choose my own provider and I have the right to refuse to accept referral to any of these providers.

VLWC Permitted Uses & Disclosures of Your Protected Health Information

VLWC may use and disclose information about you (e.g. name, address, social security number) and your medical condition(s), including past, present and future, for the following purposes:

- Treatment: Such as disclosed information to a specialist, hospital, laboratory or pathologist to evaluate and address your medical needs (including amended information).
- Payment: For example, information disclosed to your insurance company to receive reimbursement for charges incurred regarding your medical care.
- Healthcare Operations: Information disclosed to evaluate and maintain the functions of VLWC (e.g. the quality of care it provides or to perform business analysis)

VITAL LIFE
WELLNESS CENTER

Notice of Privacy Practices Summary (Continued)

VLWC may use your protected health information to contact you regarding:

- Appointment reminders
- Lab and X-ray results
- Information about treatment alternatives
- Other health-related benefits and services that may be of interest to you

VLWC may also use and disclose your protected health information **without further consent** from you in the following circumstances:

- Public Health Agencies: For the purpose of reporting disease, vital statistics, or adverse effects from drugs, supplies or equipment.
- Serious Threats to Health/Safety: In cases of medical emergencies or instances where imminent and serious health or where safety threats exist.
- Deceased Patients: To coroners, medical examiners, funeral directors and organ donor officials.
- Law Enforcement: To law or military officials for the purposes of health delivery oversight, judicial or administrative proceedings, law enforcement and national security.
- Required By Law: To State officials for the purpose of management and financial audits, program monitoring and evaluation, licensure and certification.
- Healthcare Oversight: To the Department of Health and Human Services for purposes of compliance investigations and reviews.
- Research: To researchers when their research has been approved by an Institutional Review Board who reviews research proposals and established protocols to ensure the privacy of protected health information.
- Worker's Compensation: To Employers as required by Texas Worker's Compensation Laws in case of a work related injury.
- Victims of Abuse, Neglect or Domestic Violence: May be required to disclose medical information if there is evidence of abuse or neglect to appropriate enforcement agencies.
- Individuals Involved In Your Care or Payment for Your Care: To a friend or family member who is involved in your medical care.
- Military or Veterans: To a member of the armed forces as required by military command authorities.
- Lawsuits & Disputes: To a court or administrative representative regarding a lawsuit or dispute.
- Non-Routine Uses and Disclosures: Those uses and disclosures which exclude treatment, payment and health care purposes will be made ONLY with your written authorization of which you may revoke at any time.

Notice of Privacy Practices Summary (Continued)

YOUR PATIENT RIGHTS

Requests listed below must be submitted in WRITING to VLWC. Patient request forms are available by contacting your medical group directly or the VLWC Privacy Officer at 595-1019.

You Have The Right To:

- ***Request restrictions* or limits on certain uses and disclosures of your protected health information.** VLWC is not required to agree with your request. However, if we do, we will abide by your request except as required by law. Your request must 1) be in writing, 2) describe the information you wanted restricted, 3) state if the restriction is limited to our use or disclosure, and 4) state to whom the restriction applies.
- ***Request different ways for us to communicate with you* regarding your protected health information.** For example, you may prefer we contact a family member instead of you regarding your appointment reminders. This request must be made in writing.
- ***Inspect and copy* your protected health information.** VLWC will act upon your written request within 15 days of receipt, if records are onsite (30 days if offsite). If we deny your request, we will send you a written denial. In this case, you may request a review of the denial. A scheduled appointment is required for requests to inspect information. VLWC may charge you a fee to copy your records.
- ***Request an amendment* of your protected health information if you believe your health information is incorrect or incomplete**. You must submit the request in writing stating the requested amendment and reason for amendment. VLWC will act upon your request within 60 days of receipt. Your request may be denied, if VLWC believes the information is complete and accurate, or the information is not part of the medical information that you would be permitted to inspect or copy, or VLWC did not create the information.
- ***Object or agree to certain uses and disclosures* of your protected health information** that we may share about your condition with family members or a public agency in emergency situations. To object, please contact the VLWC Privacy Officer.
- ***Receive an accounting of any disclosures* that VLWC has made of your protected health information for non-routine purposes only**. This right applies to disclosures for purposes *other than treatment, payment or healthcare operations*. You may request a list of disclosures VLWC has made of your medical information for the six (6) years prior to your request. You may not request an accounting for dates of service prior to April 14, 2003. Your first request within a 12-month period is free, however VLWC may charge for additional requests within the same 12-month period. VLWC will act upon your request within 60 days of receipt.
- ***Receive a paper copy of this notice*,** upon request. You may also request a detailed listing of this notice.
- ***File a complaint* if you believe VLWC has violated your privacy rights.** You may file a complaint with the VLWC Privacy Officer, 2520 Broadway, Suite 100, San Antonio, TX 78215, (210) 595-1019, fax (210) 251-3194 or directly with the Secretary of the Department of Health and Human Services, Office of Civil Rights, 1301 Young St #1169, Dallas, TX 75202, (214) 767-4056, Fax (214) 767-0432, TDD (214) 767-8940.

_____ _____

Patient Signature Patient Name

_____ _____

Date of Birth Date

VITAL LIFE
WELLNESS CENTER

Physician Assistant/Nurse Practitioner Consent for Treatment

Vital Life Wellness Center has on staff a physician assistant/nurse practitioner to assist in the delivery of medical care.

A physician assistant/nurse practitioner is not a doctor. A physician assistant/nurse practitioner is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant/nurse practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant/nurse practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant/nurse practitioner for my health care needs, if I schedule a visit with that provider.

I understand that at any time I can refuse to see the physician assistant/nurse practitioner and request to see a physician.

_____ Printed Name of Patient	_____/_____/_____ Date of Birth
_____ Signature of Patient	_____ Date
_____ Printed Name of Legal Guardian/Representative and Relationship to Patient	_____ VLWC Staff Member's Signature
_____ Signature of Legal Guardian/Representative	_____ Date

Patient Health Contract

Thank you for choosing Vital Life Wellness Center for you healthcare needs. We appreciate the opportunity to serve you!

Acknowledgement of Receipt of Notice of Practices Summary

I have reviewed a copy of the Notice of Privacy Practices Summary for Vital Life Wellness Center. In signing below, I acknowledge that I have read the privacy summary and that Vital Life Wellness Center has given me the chance to discuss my concerns and questions about the privacy of my health information. I understand that patients may obtain a copy of the Notice of Privacy Practices Summary for their records at any time by calling 210.595.1019, or by requesting one at our office.

Patient Information

All patients must complete our New Patient Packet before being seen by our providers. Important information required to file an accurate claim with your insurance company includes the date of birth of the insured as well as a copy of your current insurance ID card and your photo ID. Without this information, we will not be able to file a claim on your behalf and full payment at the time of service will be expected.

Missed Appointments

YOU WILL INCUR A $35.00 CHARGE FOR ALL MISSED APPOINTMENTS. We do understand that emergencies occur. However, it is our policy that you will notify us 24 hours in advance if you are unable to attend your scheduled appointment. If you fail to notify us you will be charged a $35.00 Missed Appointment Fee. It is our policy to collect debit/credit card information to have on file in the event of a missed appointment without proper advance notice. Your information will be kept private and will only be used if you incur a Missed Appointment Fee. We will be unable to see you until your Missed Appointment Fee is paid. Repetitive missed appointments may be grounds for dismissal from the practice.

Financial Statement

All copays and deductibles required by insurance are due at the time of service. This arrangement is part of your contract with your insurance company.

Returned Checks

If your check is returned to the office due to insufficient funds, a $35.00 Returned Check Fee will be charged. The original charge plus the $35.00 Returned Check Fee must be received within 30 days of the date that the check was originally returned in order to avoid further late fees or a collection notice.

VITAL LIFE
WELLNESS CENTER

Patient Health Contract (Continued)

Consent for Release of Information

I consent to the release of information about my medical condition to myself and to any health care provider or office personnel involved with my current treatment. I understand that I may be contacted by an office representative who is conducting a quality-of-care review or study, and that information from my medical record has been made available to that representative.

Insurance Coverage

I understand that it is my responsibility to inform a Vital Life Wellness Center staff member if there has been any change to my insurance coverage since my last visit. I understand that **VLWC is not contracted with Affordable Care Act plans or Health Maintenance Organization plans.** If I am covered by an ACA or HMO plan, I agree to pay in full at the time of my VLWC service.

Non-Covered Services

You are responsible for services that are considered non-covered by your plan, services that are denied due to benefit limits or termination of coverage, and for deductible, co-insurance and/or co-pay balances not collected at the time of service. We understand that your personal situation may affect timely payment of your balance. So that we may assist you in the management of your account, we encourage you to discuss any financial problem you may be experiencing with a member of our Business Office at 210.595.1019. Payment plans and healthcare financing are available.

Consent for Treatment

I hereby authorize employees and agents of Vital Life Wellness Center (including physicians, physician assistants, nurse practitioners, and other VLWC employees) to render medical evaluations and care to me or the individual listed below. The duration of this consent is indefinite and continues until revoked in writing.

By signing below I agree that I have read and understand the above policies.

_____	_____/_____/_____
Printed Name of Patient	Date of Birth
_____	_____
Signature of Patient	Date
_____	_____
Printed Name of Legal Guardian/Representative	Relationship to Patient
_____	_____

Signature of Legal Guardian/Representative Date

Missed Appointment Fee Authorization

According to the **VLWC Patient Health Contract**, you will incur a $35.00 charge for all missed appointments.

It is our policy to collect debit/credit card information to have on file in the event of a missed appointment without proper advance notice. **Your information will be kept private and will only be used if you incur a Missed Appointment Fee.**

Please fill out the information below. Your signature will indicate that you have read, understood, and agree with the Missed Appointment policy as stated in our Patient Health Contract.

_____ _____/_____/_____
Printed Name of Patient Date of Birth

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Cardholder Name: _____

Credit Card Number:_____

Expiration Date: _____/_____/_____

_____ _____
Signature of Patient Today's Date

For internal use only:

☐ Entered in HPS

AMD 6-19-14