ELITE HEALTHCARE
CENTER

**Thank you for choosing Elite Health LLC. To better serve you, please provide the following information:**

**Patient Information** **SSN:** _____

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____ Gender: _____ E-

Mail Address: _____ May we contact you by e-mail? Yes No

**Employer**

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

**Primary Care Physician**

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

**Emergency Contact**

Name: _____ Phone: _____ Relationship: _____

**Primary Policy Holder's Information/Responsible Party**

Policy Holder (Name): _____ Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Relation to Patient: _____ Policy Holder's SSN: _____ DOB: _____

Policy Number: _____ Group Number: _____

I authorize the release of information concerning my healthcare and treatment for the purposes of evaluating and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly, to the Physician. Elite Health LLC will file a claim with your insurance company for services performed. In the event of non-payment, I understand that I will be responsible for charges incurred today and any legal fees, collection fees, or other expenses incurred by Elite Health LLC in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

I give authorization to release my medical records to the following individuals:_____

_____ Date:_____

(Signature of patient)

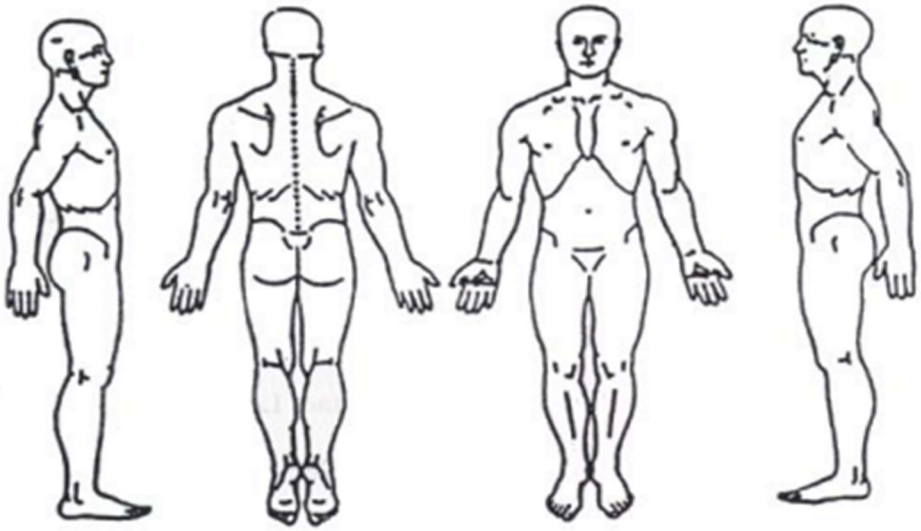
**MEDICAL HISTORY FORM**

(Please complete all **3** pages)

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

| **Chief Complaint:**<br>*(What brings you in today?)* | **Describe the pain:**<br>*(stabbing, tingling, etc.)* |
|---|---|
| **Onset:** ☐ Sudden ☐ Built up over several days ☐ Gradual over a long time | |
| **When did this problem start?** | **Is this due to an injury?** |

**On the diagram below, please circle any area(s) of pain or discomfort.**



**Medications:** (Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs

| **Medication** | **Dose** (mg) | **Times per Day** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **Medication** | **Dose** (mg) | **Times per Day** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Do you have allergies or reactions to medication?**_____

**Please describe:**_____

**Personal Medical History:** (Please indicate whether you have had any of the following medical problems

_____Cogentinal Heart Disease
Specify type:_____
_____Heart Attack
_____High Blood Pressure
_____High Cholesterol
_____Thyroid Problem
_____Stroke
_____Auto Immune Disease

_____Cancer
Specify type:_____
_____Bleeding/Clotting Disorder
_____ Renal Failure
_____ Diabetes
_____Gout
_____HIV/AIDS
_____Other:_____

**Surgical History:** (Please list all prior operations and dates)

| Operation | Date | Operation | Date |
|---|---|---|---|
| | | | |
| | | | |

## Social History

**Substances**

**Alcohol Use**

Do you drink alcohol? ☐ No ☐ Yes: #/week___

**Tobacco Use**

☐Cigarettes: Current Smoker, ____ Packs/Day, # of Years ____

☐ Quit, Date _____

☐ Never

**Drug Use**

☐Do you use recreational drugs?

**Exercise:** Do you exercise regularly?☐ No ☐ Yes

## Review of symptoms

**Blood/Lymphatic**
___Easy bruising/bleeding

**Cardiovascular**
___Chest pain/discomfort
___Leg pain with exercise
___Palputations

**Respiratory**
___Cough/Wheeze
___Difficulty breathing

**Musculoskeletal**
___Muscle/joint pain

**Eyes**
___Change in vision

**Gastrointestinal**
___Abdominal Pain
___blood in stool
___vomiting/diarrhea

**Psychiatric**
___Anxiety/Stress
___Depression
___Problems with sleep

**Other**
___:_____

**Skin**
___Rash

**Constitutional**
___Fever/chills/sweats
___Fatigue/weakness
___Excessive thirst/urination

**Neurological**
___Headaches
___Memory Loss
___Dizziness/loss of coordination

**Family History:** (Please indicate with a (X) family members who have had any of the following conditions)

| Medical Condition | Mom | Dad | Other |
|---|---|---|---|
| Heart Attack | | | |
| Hypertension | | | |
| High Cholesterol | | | |
| Kidney Diseases | | | |
| Lupus | | | |
| Osteoarthritis | | | |
| Osteoporosis | | | |
| Stroke | | | |
| Depression | | | |

| Medical Condition | Mom | Dad | Other |
|---|---|---|---|
| Arthritis | | | |
| Bleeding Problems | | | |
| Cancer | | | |
| Diabetes, Type 1 &2 | | | |
| Epilepsy (seizures) | | | |
| Thyroid Disorders | | | |
| Other: | | | |

## Patient Questionnaire

**Name: _____ Date: _____**

1. **Do you suffer from neck pain, with pain in your shoulder, arms or hands? NO YES**
2. **Do you have weakness/numbness/burning or reduced feeling in your shoulder, arms or hands? NO YES**
3. **Do you suffer from a loss of handgrip strength? NO YES**
4. **Do you suffer from back pain, with pain in your buttocks, legs or feet? NO YES**
5. **Do you have weakness, numbness, burning, or reduced feeling in your buttocks, legs or feet? NO YES**
6. **Do your hands, arms, legs or feet fall asleep NO YES**
7. **Do you suffer from cold hands or feet? NO YES**
8. **Do you have any issues with gait, coordination, dizziness, or balance? NO YES**
9. **Have you tried any medications such as anti-inflammatory and/or steroids? NO YES**
10. **Have you had an MRI of the spine or extremities? NO YES**
11. **Does pain wake you from sleep OR do you have pain that interferes with your sleep? NO YES**
12. **Have you been told you have arthritis and swelling in the spine or joints? NO YES**

# NOTICE OF INDIVIDUAL RIGHTS

As a patient, you have a number of rights with respect to your PHI, including:

- **The Right to Access, Copy or Inspect Your PHI.** This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee, as state law permits, to provide a copy of any medical information you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have forms available to request access to your PHI and we will provide a written response if we deny you access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect or obtain a copy of your medical information, you should contact our local privacy representative.
- **The Right to Amend Your PHI**. You have the right to ask us to amend written medical information we may have about you. We will generally amend your information within 60 days of your request and notify you upon amending the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is incorrect. If you wish to request an amendment of the medical information we have about you, please contact our local privacy representative to obtain an amendment request form.
- **The Right to Request an Accounting.** You may request an accounting from us of certain disclosures of your medical information we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share our health information with our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. If you wish to request an accounting, contact our privacy officer.
- **The Right to Request That We Restrict the Uses and Disclosures of Your PHI.** You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction that you may request and if we believe it is in your best interest to permit use and disclosure of your PHI, it will not be restricted.
- **The Right to Alternative Means of Communication.** You have the right to request or receive confidential communications from us by alternative means or at an alternative location by notifying us in writing.
- **The Right to Obtain a Paper Copy of the Notice on Request.** If you would like a paper copy of this Notice, you may contact us at the address listed below and we will provide you a paper copy of the Notice upon request.

**Revisions to the Notice:** We reserve the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our website, if we maintain one you can get a copy of the latest version of this Notice by contacting our privacy official.

**Your Legal Rights and Complaints:** You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to our privacy official.

*Privacy Official Contact Information: Swapnil Parikh*
(301) 231-5055 ext. 2006
Elite Health LLC
6010 Executive Blvd., Ste. 506, Rockville, MD 20852
Effective Date of the Notice: 2/7/2018

I understand that, unless otherwise stated above, Elite Health LLC may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. My signature below also grants Elite Health LLC and its business affiliates consent to use my PHI to contact me with educational and promotional items in the future via e-mail, U.S. Mail, telephone, fax and/or prerecorded messages. **ELITE HEALTH LLC WILL NEVER SELL OR "SPAM" MY PERSONAL CONTACT INFORMATION**. I understand Elite Health LLC has the right to change this notice at any time. I may obtain a current copy by contacting The Billing Office or the Facility.

Signature of Patient or Legal Representative: _____ Date: _____

If signed by legal representative, name and relationship to patient:_____

## CONSENT FOR SERVICES

The undersigned give consent for Elite Health LLC, its authorized representatives, its physicians, providers, and/or Independent Physician Contractors to provide appropriate medical services, including diagnostic and radiologic procedures, administration of medicines, and other treatment and care considered advisable or necessary by the patient's treating physicians and providers.

## PERSONAL PROPERTY AND VALUABLES

Personal property and valuables should be given to a family member. I understand that Elite Health LLC is not responsible for my personal property or valuables, such as money, credit cards, jewelry, luggage, clothing, dentures, eyeglasses, hearing aids, or other prosthetic devices.

## FINANCIAL OBLIGATION

In consideration of the services to be provided by Elite Health LLC, and its physicians, providers, and Independent Physician Contractors, the undersigned jointly and severally, agree to pay all charges, deductibles, copayments, and/or coinsurance amounts determined not paid or allowable by health insurance payors. Certain routine services and procedures, which are determined as necessary by the treating physician/provider, may not be covered by Medicare, Champus, Blue Cross and Blue Shield, and other third party payors. I/we agree to pay these non-covered services and/or procedures if ordered and performed by the treating physician/provider Elite Health LLC.

I/we agree to make payments according to Elite Health LLC credit terms. In the event I/we should default in payment of any of the above charges, then I/we agree to pay all reasonable costs of collection, including a reasonable attorney's fee as might be allowed by law, whether the account shall be referred to a collection agency or an attorney. I/we agree that Elite Health LLC and its representatives may contact me/us by telephone at any telephone number associated with my/our account. Elite Health LLC and its representatives may also contact me/us by sending text messages or emails, using any email address I/we provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

In the event that I/we cannot keep a scheduled appointment, I/we must provide Elite Health LLC with a minimum of 24-hours prior notice. In the event that the office is not open, I/we will leave a message with the after-hours answering service. Failure to provide sufficient notice will result in a $50 fee. This fee cannot be billed to insurance. A deposit may also be required to reserve future appointments.

## ASSIGNMENT OF BENEFITS

The undersigns assign payment of authorized insurance benefits otherwise payable to the policyholder, including Medicare and Champus benefits, directly to Elite Health LLC or its authorized representatives who provide services. I certify that all information is correct which has been given to apply to payment under Medicare, Champus, managed care, and Blue Cross and Blue Shield, and other third party programs.

## AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned authorize Elite Health LLC and its treating physicians/providers to furnish any medical and billing information about this account, including but not limited to the following:

(a) Insurance Billing – Information requested by the insurance company, Medicare, Champus, or other third party payors to support the claim submitted for payment of charges applicable to this account.
(b) Medical Necessity and Appropriateness of Services – Information requested by any utilization and/or Peer Review Organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services or to determine the benefits for related services.

This release allows disclosure about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, HIV, drug abuse, cancer registry treatment and follow-up and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. The revocation shall not pertain to information previously released.

Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

**I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONSENT.**

_____ _____

Signature of Patient or Patient's Representative Date

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.**

*PLEASE REVIEW IT CAREFULLY.*

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our facility. This record is necessary to provide you with quality care and to comply with certain legal requirements. Physicians (personal consultants, specialists) involved in your care may have different policies or notices regarding the doctor's use and disclosure of your medical information created and/or maintained in the doctor's office or clinic. Due to the nature of these services, we are required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. We are also required to abide by the terms of the version of this Notice currently in effect.

This notice will tell you about the ways in which we may use and disclose medical information about you, via any medium (written, oral, or electronic). We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to: Make sure that medical information that identifies you is kept private, give you this notice of our legal duties and privacy practices with respect to medical information about you; and maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI)

**Uses and Disclosures of PHI**: We may use PHI for the purposes of treatment, payment and health care operations, in most cases without your written permission. Examples of our use of your PHI:

**For Treatment:** This includes such things as obtaining verbal and written information about your medical condition and treatment from you and others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment and may transfer your PHI via telephone to the hospital or dispatch center.

**For Payment:** This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts. **For Health Care Operations:** This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions. **Other Permitted and Required Uses and Disclosures** such as for marketing or sale of your PHI to third parties, may be made only with your specific authorization. Once given, you may withdraw authorization at any time in writing.

**Use and Disclosure of PHI without Your Authorization.** We are permitted to use PHI without your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment, payment or health care operations activities of another health care provider who treats you; ▪

For health care and legal compliance activities;

- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence; ▪ For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the healthcare system; ▪ For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals;
- Use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.