



Lifeline

Family Health & Wellness

S. Latrice Totsch, DNP, MBA, APRN, FNP-C

9330 Poppy Dr. Ste. 500

Dallas, Texas 75218

469-384-7781

NEW PATIENT PAPERWORK



Lifeline

Family Health & Wellness

Primary Care that puts YOU first

Lifeline Family Health and Wellness is dedicated to providing exceptional patient-centered care. We offer various services for people of all ages and backgrounds, including preventive care, chronic disease management, mental health, and more. At our clinic, we prioritize the patient's needs and work alongside them to create personalized treatment plans that address their concerns.

Our medical clinic is more than just a place to receive medical treatment - it's where patients feel supported, heard, and empowered to take control of their health.

With our personalized approach to healthcare and commitment to patient satisfaction, our medical clinic is ideal for anyone looking for the highest quality of care.



Lifeline

Family Health & Wellness

CANCELLATION/NO SHOW POLICY

We acknowledge that patients may occasionally need to reschedule an appointment. Please know that we are reserving that time for you to see the provider. If it is necessary to cancel the appointment, patients are required to call or leave a message at least **TWO hours** before their appointment time.

"No Show" is defined as failing to arrive for a scheduled appointment. A 10-minute grace period is provided for appointments except for annual physicals.

If the patient does not cancel their appointment within two hours or "no-show", they will be assessed a **\$20.00 fee**.

EXCESSIVE CANCELLATIONS AND/OR NO SHOWS could lead to the ability to only schedule same-day appointments OR discharge from the practice.

MEDICATION REFILLS

Please notify the office of refill requests promptly. Approval of your refill request can take up to **48-72 hours**. Contact the pharmacy accordingly. Medication refills will be addressed during regular business hours. Prescriptions will **not** be refilled on Saturdays, Sundays, or holidays. **An office visit may be required before prescriptions are refilled.**

MESSAGES

When leaving a telephone message, please allow **48 business hours** for a return call from one of our office staff. If your needs must be addressed sooner, please schedule an office visit at any time during office hours with the provider. **In an urgent or emergency medical situation, please call 911.**

Please allow **72 hours** to complete the requested forms and letters.

AFTER HOURS POLICY

This notice is to inform you that you will be responsible for the payment for any **after-hours calls** made to contact the provider at Lifeline Family Health & Wellness. The fee for after-hours calls is **\$30** and will be due before your next appointment.

If you have a life-threatening medical emergency after hours, please call 911 or go to your nearest emergency room.

BILLING AND COLLECTIONS

Payment is due at the time services are rendered. Copays and deductible percentages will be collected accordingly. If the patient has a remaining deductible or balance, a statement will be mailed. This is due within 30 days of receipt. Payments can be made in the office or on the website under the "Patient Resources" tab. Patients may not carry a balance of greater than \$100. They will be asked to pay the overage or the complete balance before their next appointment. Outstanding balances greater than 90 days must be paid in full before the patient will be seen. These balances are subject to collections if they remain unpaid. Payment plans are available upon request. Lifeline Family Health and Wellness reserves the right to dismiss a patient from the practice for refusal to pay. For questions about balances or the Explanation of Benefits (EOB), you can email the billing manager, Diana, at insurance@lifelinefamilyhealth.com.

Initials: _____



Lifeline

Family Health & Wellness

PATIENT INFORMATION

PERSONAL INFORMATION

Full Name :

Preferred Name :

Date Of Birth : ____ / ____ / ____

Gender/Sex : Male Female Non-binary Transgender (Also check M/F) Prefer Not To Respond

Address, City, Zip Code : _____

Phone Number : _____ E-Mail : _____

Social Security Number (optional) : _____

Status : Single Married Divorced Other

Occupation : _____ Are You A Retiree ? : Yes No

How did you hear about us? : _____

INSURANCE INFORMATION

Insurance Carrier : _____ Insurance Plan : _____

Contact Number : _____ Policy Number : _____

Group Number : _____

Subscriber's Name, Relationship : _____

Date of Birth of Policy Holder : _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ Home Number : _____

Relationship : _____ Mobile Number : _____

Permission to release information to this person? Yes No

I authorize release of information to the following individuals: _____

Date: _____ Signature: _____ Print name: _____

Full Name :

Date Of Birth : / /



Lifeline

Family Health & Wellness

MEDICAL HISTORY

CURRENT HEALTH

Please check ALL conditions you currently have (with diagnosis date) :

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer/Type: _____ | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Nerve Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis / tendonitis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Skin Conditions: _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dementia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Vitamin Deficiencies |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Other: _____ |

Surgical History: (hospitalizations, procedures)

Family Member	FAMILY HISTORY
Mother	
Father	
Children	
Siblings	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

Full Name :

Date Of Birth : / /



Lifeline
Family Health & Wellness

MEDICATION LIST

Please list any medications , vitamins and supplements you are currently taking and the dosage:

Medication	Dosage	Directions

Allergies (Food/Drug) :

Date: _____ Initials: _____

S. Latrice Totsch, DNP, MBA, APRN, FNP-C
9330 Poppy Dr. Ste. 500
Dallas, Texas 75218
P: (469) 384-7781
F: (469) 277-3000



MEDICAL RECORDS RELEASE FORM

CONSENT

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

REQUESTED RECORDS

Name of Person or Facility: _____

Practice Address: _____

Phone: _____

Fax: _____

Please select all the records that apply to your request:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> EKG, EEG, EMG | <input type="checkbox"/> Medication Record |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Urgent Care | <input type="checkbox"/> Doctor Consults | _____ |

Please select the reason for your request:

- | | | | |
|---|---|------------------------------------|--|
| <input type="checkbox"/> Continued Patient Care | <input type="checkbox"/> Attorney / Legal | <input type="checkbox"/> Insurance | <input type="checkbox"/> Social Service / Disability |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Personal | <input type="checkbox"/> Other: | _____ |

Please select how you would like to receive your request:

- | | |
|--|------------------------------|
| <input type="checkbox"/> Mail to Address | <input type="checkbox"/> Fax |
|--|------------------------------|

Date: _____ Signature: _____

Print Name: _____

HIPAA CONSENT FORM

I, _____ (Patient Name), UNDERSTAND THAT AS A CLIENT OF **LIFELINE FAMILY HEALTH & WELLNESS**, MY PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW **LIFELINE FAMILY HEALTH & WELLNESS'S** NOTICE OF PRIVACY PRACTICES BEFORE SIGNING THIS CONSENT FORM. I UNDERSTAND THAT **LIFELINE FAMILY HEALTH & WELLNESS** RESERVES THE RIGHT TO REVISE ITS NOTICE OF PRIVACY PRACTICES AND THAT I WILL BE GIVEN A COPY OF ANY REVISED NOTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW MY PHI IS USED AND DISCLOSED, BUT THAT **LIFELINE FAMILY HEALTH & WELLNESS** IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS. THE **LIFELINE FAMILY HEALTH & WELLNESS** CAN ALSO AGREE TO REQUESTED RESTRICTIONS REGARDING MY PHI PROVIDED THAT THE RESTRICTIONS ARE COMPLIANT WITH ALL APPLICABLE LAWS AND REGULATIONS. I HAVE READ AND UNDERSTAND FEDERAL LAW CODE 45 CFR § 164.512 WHICH OUTLINES THE CIRCUMSTANCES UNDER WHICH PHI CAN BE DISCLOSED AND WITHOUT MY CONSENT.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME, BUT THAT REVOCATION WILL NOT AFFECT ANY DISCLOSURES ALREADY MADE BY **LIFELINE FAMILY HEALTH & WELLNESS** IN RELIANCE ON THIS CONSENT. TO CANCEL MY CONSENT, I MUST WRITE A LETTER TO **LIFELINE FAMILY HEALTH & WELLNESS** THAT STATES THAT I AM REVOKING MY CONSENT TO MY PHI FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS. THE LETTER MUST BE SIGNED AND DATED. IF I DO DECIDE TO CANCEL CONSENT TO ALL MY PHI, I UNDERSTAND THAT **LIFELINE FAMILY HEALTH & WELLNESS** IS NO LONGER OBLIGATED TO PROVIDE SERVICES TO ME.

I UNDERSTAND THAT I HAVE THE RIGHT TO FILE A COMPLAINT WITH **LIFELINE FAMILY HEALTH & WELLNESS** AND WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IF I BELIEVE MY PRIVACY RIGHTS HAVE BEEN VIOLATED.

I HAVE READ AND UNDERSTAND THE ABOVE AND HEREBY GIVE MY CONSENT FOR **LIFELINE FAMILY HEALTH & WELLNESS** TO USE AND DISCLOSE MY PHI AS DESCRIBED ABOVE.

DATE : _____

X _____
SIGNATURE OF CLIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

PRINT NAME OF LEGALLY AUTHORIZED REPRESENTATIVE

RELATIONSHIP BETWEEN CLIENT AND AUTHORIZED REPRESENTATIVE

Lifeline Family Health & Wellness

9330 Poppy Dr. Ste. 500 Dallas, Texas 75218
P: 469-384-7781 F: 469-277-3000