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

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CANCELLATION/NO SHOW POLICY

We acknowledge that patients may occasionally need to reschedule an appointment. Please understand 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 with the exception of annual physicals.

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

MEDICATION REFILLS

Please notify the office of refill requests in a timely manner. 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 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.

Initials: _____

MINOR PATIENT INFORMATION

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PERSONAL INFORMATION

Full Name :

Preferred Name :

Name of Parent 1/Guardian :

Name of Parent 2/Guardian :

Date Of Birth : _____ / _____ / _____

Gender : ☐ 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) : _____

Name of School : _____ **Grade** : _____

How did you hear about us? : _____

INSURANCE INFORMATION

Insurance Carrier : _____ **Insurance Plan** : _____

Contact Number : _____ **Policy Number** : _____

Group Number : _____

Subscriber's Name, Relationship : _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Home Number** : _____

Relationship : _____ **Mobile Number** : _____

Date: _____ **Signature:** _____

Print name: _____

Full Name :

Date Of Birth : / /

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MEDICAL HISTORY

CURRENT HEALTH

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

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

Surgical History:

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

Full Name :

Date Of Birth : / /

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MEDICATION LIST

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

Medication	Dosage	Directions

Allergies (Food/Drug) :

Date: _____ **Initials:** _____

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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:

- ☐ Clinic Notes
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Radiology Reports
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Urgent Care
- ☐ Operative Reports
- ☐ EKG, EEG, EMG
- ☐ Emergency Room
- ☐ Doctor Consults
- ☐ Physician Orders
- ☐ Medication Record
- ☐ Other: _____

Please select the reason for your request:

- ☐ Continued Patient Care
- ☐ Worker's Compensation
- ☐ Attorney / Legal
- ☐ Personal
- ☐ Insurance
- ☐ Other: _____
- ☐ Social Service / Disability

Please select how you would like to receive your request:

- ☐ Mail to Address
- ☐ Fax

Date: _____ **Signature:** _____

Print Name: _____

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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

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