Edward Holt, DO P.A

Patient Information

Name: _____ Age: _____ Date of Birth: _____ Social Security Number: _____

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

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician: _____ Employer: _____ Occupation: _____

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

Marital Status: (circle one) Single Married Divorced Widowed

Race: American Indian Asian Black Hispanic White Other _____

How did you hear about our office? _____

Pharmacy Name and City: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SPOUSE INFORMATION

Name: _____ Social Security Number: _____ Date of Birth: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

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

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ ID#: _____ Group#: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship to patient: _____

Secondary Insurance Co. Name: _____ ID#: _____ Group#: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship to patient: _____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release all information contained in my financial and medical records to my insurance company or health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered. I permit a copy of this authorization to use in place of the original.

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Edward L. Holt, DO, P.A. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am totally fully responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities and ultimately responsible for payment in full if my insurance company does not pay in a timely manner.

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

I have read each of the statements above and authorize, understand and agree to each statement.

Patient's Signature: _____ **Date:** _____

Edward Holt, DO P.A

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received and/or reviewed a copy of Edward I> Holt, DO, P.A. Notice of Privacy Practices.

Signature of Patient_____ Date: _____

Blood Component Policy

The patient has been fully informed (advised) regarding the policies of Edward Lee Holt, DO, P.A. concerning policies of blood product therapy. When confronted with hemorrhage or anemia, the physician will respect the patient's religious beliefs and will replace blood volume with non-blood products whenever possible. However, in life-threatening situations, when blood and blood product therapy is felt essential, the patient has been informed that it is the policy of this doctor to follow standard medical practice and administer all available therapy, including blood products, to sustain health or life. When these policies are in opposition with the patient's beliefs or desires, she has been advised to arrange medical care elsewhere.

Patient's Signature _____ **Witness:** _____ **Date:** _____

Borderline Abnormal Pap Smear Testing

After having borderline abnormal pap results, Dr. Holt will routinely check for HPV (Human Papillomavirus) to determine the best treatment plan. Some insurance companies do not cover this test. It is your responsibility to check on coverage. I understand I will be responsible for any charges not covered by my insurance.

_____ Yes, I agree to HPV testing. _____ No, I decline HPV testing.

Patient's Signature _____ **Witness:** _____ **Date:** _____

Authorization for Medical Testing and Consent Release of Information

As of January 1, 1996, state law requires that all pregnant patients be tested for HIV. The law also allows for you to refuse such testing. Studies have shown that if pregnant women with HIV are identified and treated early in the pregnancy, there is significantly decreased risk of transmitting the virus to the unborn child. Therefore, we recommend the testing. You also have the right to have anonymous testing performed at the Health Department.

I hereby request and give my voluntary consent to Dr. Edward Lee Holt, his employees, and agents to administer such diagnostic procedures necessary to identify the presence in my system of *Human Immunodeficiency Virus (HIV)* for the purpose of determining whether I may have or be susceptible to *Acquired Immune Deficiency Syndrome (AIDS)*. I am aware the HIV and AIDS test results are confidential, and may only be released or disclosed under specific circumstances. I hereby authorize and consent to the release and disclosure of any HIV/AIDS test result, as that term is defined in the Texas Health and Safety Act Ann.s81.10(5)(Vernon 1990), to the following persons or entities:

1. The physician or other person who conducts the test.
2. A physician, nurse, or other healthcare professional who has a legitimate need to know the test result for his/her own protection and for the patient's health and welfare.
3. Any local, state, or federal health authority, if reporting is required under applicable law or regulation.
4. Any health insurance company, health maintenance organization, or other third party health care payer from or through whom payment for such procedures may be directly or indirectly made.

I further release Dr. Edward Lee Holt and any healthcare provider from any and all liability in connection with the medical testing to be conducted pursuant to this authorization and the lease and disclosure of any test result.

I hereby certify that I have read, been informed of the reasoning for being tested, and fully understand the above authorization, and that I have requested/declined the administration of the above said diagnostic procedure and executed my authorization voluntarily and of my own free will.

_____ Yes, I agree to testing. _____ No, I decline to testing.

Patient's Signature _____ **Witness:** _____ **Date:** _____

Edward Holt, DO P.A

REVIEW OF SYSTEMS

Please check any of the following symptoms that apply to you currently.

Constitutional

___Change in appetite
___ Decreased Libido
___ Fatigue
___ Night Sweats
___ Weight Loss
___Change in height
___ Difficulty Sleeping
___ Fever
___ Weight Gain

Eyes

___Blurred Vision
___Glasses/Contacts
___Visions Changes
___ Double Visions
___ Spots before eyes

Ears, Nose, & Throat

___Congestion
___Difficulty Swallowing
___ Hearing Problems
___ Neck Mass
___Nose Bleeds/Gums
___Ringing in the Ears
___ Seasonal Allergies
___Sore Throat
___ Dental Problems
___ Earaches
___ Mouth Sores
___ Neck Stiffness/Pain
___ Recurrent Ear
___ Runny Nose
___ Sinus Problems

Cardiovascular

___ Chest Pain
___Leg swelling
___Varicose Veins
___Difficulty breathing w/ exertion
___Difficulty breathing when lying flat
___Leg Pain
___Irregular Heart Beat

Respiratory

___Chronic cough
___Painful breathing
___Snoring
___Coughing up blood
___Shortness of breath
___Wheezing

Gastrointestinal

___Abdominal mass
___Black Stools Bloody Stools
___Diarrhea
___Incontinence of stool/gas
___Jaundice
___Nausea/Vomiting
___Abdominal pain
___Constipation
___Hemorrhoids
___Indigestion
___Rectal Pain

Genitourinary

___Abnormal bleeding
___Blood in Urine
___Frequent Bladder Infections
___Frequent Urination
___Incomplete Emptying
___Infertility
___Painful Intercourse
___Pain with Urination
___Urgency to Urinate
___Vaginal Dryness
___ Vaginal Discharge
___ Absence of Periods
___DES exposure
___Fibroids
___History of Endometriosis
___Urinary Incontinence
___ Pain with Urination
___Painful Periods
___Premenstrual Syndrome
___ Pelvic Pain
___ Vaginal Itching

Musculoskeletal

___Back Pain
___Joint swelling
___Muscle Weakness
___ Joint Pain/Stiffness
___ Muscle Pain

Skin

___Acne
___ Dry Skin
___Enlarged Lymph Nodes
___Rash
___Discoloration
___Easy Bruising
___ Itching Moles
___Sores

Breasts

___Breast Mass
___Nipple Discharge/Blood
___Breast Pain/Swelling

Neurologic

___Difficulty Walking
___Headaches
___Numbness
___Tremor
___Dizziness
___Memory Problems
___Seizures

Psychiatric

___Anxiety
___Frequent Crying
___Depression

Endocrine

___Abnormal Hair Growth
___Deepening of Voice
___Intolerance
___ Abnormal Thirst
___Hair Loss
___Hot Flashes

Edward Holt, DO P.A

Patient's Confidentiality Instructions

Patient Name: _____ DOB: _____

It is important for us to honor the confidentiality between patient and physician.

PLEASE CHECK YOUR PREFERENCE BELOW.

_____ You may discuss my medical information ONLY with me.

_____ I give my permission to discuss my medical information with the following people:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

YES or NO You may leave medical information (test results) on my voicemail:

HOME#:_____ CELL #:_____

Patient Signature:_____ Date:_____

Edward Holt, DO P.A

Consent for Drug and Alcohol Testing

There are many health risks associated with the use of alcohol, drug/substances during pregnancy. In order to assist you in obtaining the best possible care during your pregnancy and to provide you with referrals counseling and drug treatment, we are requesting that you sign the consent for drug /substance and alcohol testing; your doctor will test you during each trimester of your pregnancy.

The following are some of the risks associated with illicit and pharmaceutical drugs and/or alcohol use during pregnancy:

***BABIES BORN TO WOMEN WHO DRINK ALCOHOL AND/OR TAKE DRUGS MAY BE BORN WITH MENTAL RETARDATION, HAVE PHYSICAL AND FACIAL ABNORMALITIES, GROWTH DIFICIENCIES AND PERMANENT DEVELOPMENTAL PROBLEMS.**

***THE USE OF ALCOHOL AND/OR DRUGS DURING PREGNANCY CAN SLOW THE GROWTH OF THE BABY CAUSING PREMATURE DELIVERY AND RESLTING IN LOW BIRTHWIEGHT.**

***BABIES THAT ARE BORN TO MOTHERS THAT HAVE USED DRUGS/substances during the pregnancy can bge born with signs of withdrawl.**

With my signature I consent to test for alcohol and drug/substances and acknowledge receipt of information regarding the risks involving using alcohol and / or drug/substances during my pregnancy. A copy of this consent can be given to me.

Patient's signature:_____ Date:_____

Witness Signature: _____ Date: _____

PATIENT INTAKE HISTORY

Name: _____ DOB: _____

General Medical History: (Please circle the ones that apply)

Alcohol / Drug
Anemia
Arrhythmia
Arthritis
Asthma
Blood Disorder
Blood Clots
Blood Transfusions
Bowel Problems
Broken Bones
Cancer
Cataracts
Chicken Pox
Collagen Disease
Depression / Anxiety
Diabetes
Eating Disorder
Gallbladder Disease
Glaucoma
Headaches
Heart Disease
Heart Murmur
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Joint/Back Pain
Kidney Infections
Kidney Stones
Lung Disease
Osteoporosis
Pneumonia
Reflux/Ulcers
Pneumatic Fever
Seizures/ Epilepsy
Sickle Cell
Stroke
Thyroid Disease
Tuberculosis

Edward Holt, DO P.A

SURGERIES: (List **ALL** past surgeries or injury history)

1._____ 3._____

2._____ 4._____

MEDICATIONS: (List **ALL** medications that you take regularly or have taken recently, including all non-prescription drugs)

1._____ 3._____

2._____ 4._____

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If YES, list which ones and reaction)

_____

_____

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	Method Type	Duration of Use	Complications
Present	_____	_____	_____
Previous	_____	_____	_____
	_____	_____	_____

OBSTETRIC HISTORY: (List all pregnancies, date, and outcomes.)

Date	Weight	Sex	Place of Delivery	Type of Delivery	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FAMILY HISTORY: (List family members (father, mother, sister, brother, etc.) with any health problems.)

_____

_____

SOCIAL HISTORY:

Have you ever smoked? ☐ Yes ☐ No How many/day? _____ How many years? _____

Alcohol: ☐ Yes ☐ No How many drinks/day? _____ Per week? _____

Do you exercise regularly? ☐ Yes ☐ No Have you ever used recreational drugs? ☐ Yes ☐ No Specify: _____ Please quantify your caffeine intake: _____ Have you ever been sexually abused, threatened or hurt by anyone? ☐ Yes ☐ No

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY:

First Day of your last menstrual period _____ Age first started period: _____ Usual number of days from one period to the next: _____

Usual # of days of flow: _____ Are your periods: ☐ Light ☐ Moderate ☐ Heavy Any menstrual abnormalities? _____

Any excessive bleeding or spotting between cycles? ☐ Yes ☐ No Cramps with periods ☐ Yes ☐ No

SEXUAL HISTORY:

Have you ever had sex? ☐ Yes ☐ No Are you currently sexually active? ☐ Yes ☐ No # of lifetime sexual partners? ____

Any history of STDs? _____ Are your sexual partners: ☐ Men ☐ Women ☐ Both ☐ Not applicable

PAP SMEARS:

Last pelvic exam: _____ When was your last PAP test: _____ Have you ever had an abnormal pap? ☐ Yes ☐ No

Do you do regular self-breast exams? _____ Date of last mammogram? ___/___/___ Date of last colonoscopy: ___/___/___

Edward L. Holt, DO, P.A.
OBSTETRICAL DEPOSIT & PAYMENT AGREEMENT

FINANCIAL POLICY

1. Your insurance will be filed as a courtesy to you; however, you are responsible for the entire bill. All co-pays, unmet deductible and other patient responsible services must be paid on the day of the visit. If your insurance carrier applies the billed charges t your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. If y do not have insurance, payment in full will be expected at the time of the visit.
2. In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days) then you may become responsible for the bill.
3. If your insurance plan requires a referral or prior authorization, you must present this along with insurance ID at each visit. If y do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
4. If payment is not received within a reasonable amount of time from the guarantor or if we receive returned mail as undeliverat we will place your account with an outside collection agency.
5. Returned checks will be subject to a returned check fee.
6. A fee may be charged for missed appointments. Two No Show appointments with no advanced notice from the patient may re in termination from the practice. Being 10 minutes or more late for an appointment may result in rescheduling your appointm
7. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.
8. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney r agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned agrees to be responsible for charges n covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
9. **NOTICE OF PRIVACY:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.
   - ☐ I decline the Notice of Privacy Practices

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ Date: _____

Signature of Patient, Legal Representative for health care services, if other than Patient

_____

Relationship of Representative. Reason individual is unable to sign, i.e. minor or legally incompetent

Patient Name: _____ DOB: _____

2203 West Lampasas, Suite 210. Ennis, TX 75119. Tel: 972.875.2112 Fax: 972.875.6112

Welcome to Dr. Holt's Office

Office Policy effective 10/1/2011

- Absolutely **NO CHILDREN** over the age of twelve (12) months. Failure to comply with policy may result in rescheduling your appointment.
- Only one (1) guest is allowed in the exam room with each patient.
- No food or drinks are allowed in the office.
- Please turn off your cell phones in the Exam Room.

This policy helps to protect the health and safety of our patients.

Patient Signature: _____ Date: _____

Genetic Screening Questionnaire

Name _____ **Race** _____ **Age** _____

Father of Child _____ **Race** _____ **Age** _____

First day of your last menstrual period _____

How many times have you been pregnant, including this time? _____

How many miscarriages have you had? _____

Have you ever had a stillborn child? Yes ____ No ____

Have any of your children died? Yes ____ No ____

Do you have a child with a birth defect? Yes ____ No ____

Have you been exposed to drugs, X-rays, alcohol, or tobacco use during this pregnancy? Yes ____ No ____

If the baby's father has children by another woman, did she have miscarriages, a stillbirth, or children with birth defects? Yes ____ No ____

Are you or the father of Eastern European Jewish origin? Yes ____ No ____

Are you or the father Black? Yes ____ No ____

Are you or the father Greek or Italian? Yes ____ No ____

Are you and the father blood relatives? Yes ____ No ____

Check any of the following disorders that occur in your family or the family of the baby's father

_____Birth defects

_____Childhood/Infancy Deaths

_____Mental Retardation

_____Down's Syndrome

_____Spina Bifida

_____Hydrocephalus

_____Sickle Cell Trait of Disease

_____Polycystic Kidney Disease

_____Tay-Sachs Carrier of Disease

_____Galactosemia

_____Hemophilia (bleeding disorder)

_____Person under 35 with heart disease

_____Person under 35 with emphysema

_____Any disorder or disease that "runs" in the family. What? _____

_____Huntington's Chorea

_____Porphyria

_____Cleft lip or palate

_____Heart defects

_____Blindness

_____Deafness

_____Dwarfism

_____Cystic Fibrosis

_____Thalassemia

_____Phenylketonuria PKU

_____Muscular Dystrophy

_____Diabetes

Edward L. Holt, DO, P.A.
OBSTETRICAL DEPOSIT & PAYMENT AGREEMENT

PRIVATE PAY AGREEMENT

I understand that Dr. Holt is accepting me as a private pay patient for the period of _____, and I will be responsible for paying any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

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Edward L. Holt, DO, P.A.
OBSTETRICAL DEPOSIT & PAYMENT AGREEMENT

AGREEMENT FOR NON-COVERED SERVICES

UNDER ALL

CHIP PERINATE INSURANCE PLANS

RESPONSIBILITY OF PAYMENT

The following services and procedures are NOT COVERED under the Chip Perinate Insurance plan. This list is not all inclusive. Consult your member services department for more information.

- Inpatient and outpatient treatments, *other than* prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth.
- Services related to preterm, false, or other labor *not* resulting in delivery.
- Nursing care services
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate (ex. High blood pressure or diabetes pertaining to the mother).
- Mammography screening

PAYMENT FOR ANY SERVICES AND PROCEDURES THAT ARE NOT PAYABLE BY THE INSURANCE COMPANY WILL BE THE RESPONSIBILITY OF THE UNDERSIGNED PATIENT.

- I understand that I may receive medical services from Dr. Holt that are not covered benefits of my insurance plan.
- I understand that I am responsible to pay for any services received that are not covered benefits of my insurance plan.
- I understand that after a claim has been submitted to my insurance carrier, if (1) the claim is denied for any reason; OR (2) there is additional patient liability (i.e. deductible, co-insurance, or non-covered charges, etc.) the balance is my responsibility.
- I understand that I may establish a payment plan to pay for non-covered medical services.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Employee Initials: _____

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