CLS HEALTH

Patient Demographic Information

Patient's Name:		Date:
DOB:	Age:	Sex: F M
Home Address:	Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated	
City:	State:	Zip:
Home Phone:	Cell #:	
Emergency Contact:	Phone #:	
Email Address:	Primary Care Physician:	
Employer Name:	Position:	
Primary Language:	Ethnicity: ☐ Hispanic or Latino ☐ non-Hispanic	

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Is this a work-related injury? Yes No

If you answered yes to the following question, please inform the front desk. Please be aware that your private health insurance will not cover any work-related injury.

Release of information

I allow release of medical information to the following: (Please check all that apply)

No one except myself: _____ Spouse: _____

Other: Name_____ Relation: _____

Pharmacy Information:

Pharmacy Name: Pharmacy phone number:

Responsible Party Information: Self: _____ Other: _____

Insurance policy holder:

Name: _____ DOB: _____ Relation: _____

Advanced Directive

___ I have a durable Power of Attorney or Advance Directive, and the decision maker's name is _____

___ I do not wish to discuss and advanced plan.

Signature: _____

CLS HEALTH

Patient Name: _____ Date of Birth: _____

What is the Reason for your appointment today: _____

SOCIAL HISTORY

Tobacco: Y N **Caffeine:** Y N **Alcohol:** Y N **Drug Use**: Y N **Exercise:** Y N

Diabetic Doctor_____ Phone: _____ Last Seen: _____

Cardiac Doctor: _____ Phone: _____ Last Seen: _____

Other Specialty/Name: _____ Phone: _____ Last Seen: _____

Height: _____ **Weight:** _____ **Shoe size:** _____

Describe Type of Pain:

☐ Dull ☐ Sharp ☐Shooting
☐ Burning ☐ Aching
☐ Throbbing ☐ Tingling
☐ Numbness ☐ Cramping
☐Other: _____

Location: ☐ Right ☐ Left ☐ Both

☐ Foot ☐ Ankle ☐ Leg

Onset: ☐ Slow ☐ Sudden ☐ Traumatic
Has Pain Become: ☐ Better ☐ Worse ☐ Stayed the same
Symptoms are worse:☐ Morning ☐ All Day ☐Evening ☐ Night

MEDICAL HISTORY

- ADD/ADHD
- Allergies/Hay Fever
- Anemia
- Anxiety
- Arthritis
- Asthma
- Autoimmune Disease (**Type):**
- _____
- **Blood Clots**
- Cancer, Type: _____
- Charcot Foot
- Congestive Heart Failure
- COPD
- Depression
- **Diabetes (circle)**
- **Type 1** or Type **2**
- Difficulty Healing
- Epilepsy/Seizures
- Fibromyalgia
- Gout
- Heart Disease/Heart Attack
- Hepatitis (circle) A**, B, C**
- High Blood Pressure
- High Cholesterol
- Immune Disease (HIV, AIDS)
- Kidney Disease
- Liver Disease
- Migraines
- Mitral Valve Prolapse
- Vascular Disease
- RSD/CRPS
- Shortness of Breath
- Stroke
- Thyroid Disorder

List any other medical problem not listed above: _____

***FEMALES:** Are you or might you be pregnant? Y N ***Have you ever had a reaction to local or general anesthesia? Y N

ALLERGY OR ADVERSE REACTION TO THE FOLLOWING: NICKEL____ TAPE/ADHESIVE_____ LATEX_____

MEDICATIONS ❑NONE

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

MEDICATION ALLERGIES: ❑NONE

1. _____ 3. _____ 6. _____
2. _____ 4. _____
5. _____

SURGERIES (PROCEDURE/YEAR) ❑NONE

7. _____ 9. _____ 11. _____
8. _____ 10. _____ 12. _____

CLS HEALTH

REVIEW OF SYSTEMS:

Please check any of the following that you are **currently** experiencing or have **recently** experienced:

Constitutional	____ Chills ____ Fatigue ___Fever ____Weakness ____Weight loss
Head	___Dizziness ___Fainting ____Headaches
Respiratory	___Asthma ___Short of breath ___Wheezing ___COPD ___Bronchitis ___TB
Cardiovascular	___Hair loss on Legs ___Leg or Foot Ulcers ___Vascular Graft/Stents ___Heart Murmur ___Cramps in legs or feet ___Replacement heart valve___Cold Feet ___History of heart attack
Gastrointestinal	___Liver disease ___Hepatitis ___Antacid Use ___Nausea ___Excessive thirst ___Gall Bladder Disease
Musculoskeletal	___Joint Stiffness ___Lower Back Pain ___Joint Implants ___Restricted Motion
Psychiatric	___Depression ___Anxiety ___Memory Loss
Skin	___Eczema ___Dryness ___Athletes Foot ___Keloid Scars ___Itching ___Ugly Toenails
Neurological	___Burning ___Fainting ___Strokes ___Unsteady Balance ___Numbness ___Tingling
Endocrine	___Sweats___ Thyroid
Hematologic/Lymph	___Bruises Easily ___Slow Healing Cuts ___Bleeds Easily ___Recent Chemo/Radiation ___Blood Clots

FAMILY HISTORY:

	List immediate family		List immediate family
___ Anemia	_____	___ Liver Disease	_____
___ Arthritis	_____	___ Skin issues	_____
___ Asthma	_____	___ Intellectual Disability	_____
___ Cancer	_____	___ Mitral Valve Prolapse	_____
___ Diabetes	_____	___ Multiple Sclerosis	_____
___ Gout	_____	___ Nail Disorders	_____
___ Heart Disease	_____	___ Nerve Disorders	_____
___ Hepatitis	_____	___ Obesity	_____
___ High Cholesterol	_____	___ Phlebitis	_____
___ Hypertension	_____	___ Skin problems	_____
___ HIV/AIDS	_____	___ Thyroid disorder	_____
___ Major Injury	_____	___ Stroke	_____
___ Kidney Disease	_____	___ Stomach/intest problem	_____
		___Varicose Veins	_____

BY SIGNING I CONSENT THAT ALL THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT/ LEGAL GUARDIAN **SIGNATURE** _____

CLS HEALTH

PATIENT CARE GUIDE

Welcome to CLS Health. Our mission is to provide you with high-quality, comprehensive healthcare services. To ensure a clear understanding of our practices and your responsibilities as a patient, we have created this comprehensive guide.

This guide covers various aspects of your care, including appointment procedures, privacy practices, financial responsibilities, and consent for treatment, among others. It provides detailed information regarding what you can expect from us and what we expect from you.

Please note that this guide is available upon request. For routine processes, we ask patients to sign the CLS Health Patient Acknowledgements & Agreements form, which summarizes the key points from this guide. By signing, you acknowledge that you have read, understand, and agree to the practices outlined therein and are aware that this care guide is available upon request.

SECTION 1: PATIENT CONSENT FOR TREATMENT

- Voluntary Consent: You consent to receive medical care as deemed necessary by the physicians, nurses, and other healthcare providers at CLS Health.

SECTION 2: FINANCIAL RESPONSIBILITY AND PAYMENT GUIDELINES

- Payment Obligations: We expect payments for services rendered by CLS Health at the time of service. This includes co-payments, deductibles, and co-insurance payments. You, as the patient or the designated guarantor, bear this responsibility.
- Referrals: If your insurance plan requires a referral, it is your responsibility to obtain it before your appointment.
- Appointment Cancellation and No-Show Policy: CLS Health may charge between $30-$200 as outlined in the CLS Health Financial & Office Policies, which you agree to by signing this form. This form can be made available to you by request.

SECTION 3: INSURANCE COVERAGE AND DIRECT PAYMENT AUTHORIZATION

- Insurance Understanding: It is your responsibility to understand the specifics of your insurance coverage, including which services are covered.
- Uncovered Services: You agree to be financially responsible for any charges for services not covered by your insurance policy.
- Insurance Benefit Payments: You authorize CLS Health to receive direct payment of any insurance benefits for services rendered to you or your dependents.

SECTION 4: INFORMATION DISCLOSURE AND ASSIGNMENT OF BENEFITS

- Medical Records Release: You consent to CLS Health sharing your medical records with specialists, consulting physicians, and other involved healthcare entities.
- Information Release for Claims Processing: You permit CLS Health to provide relevant medical and other information to insurance companies for claim processing.

SECTION 5: ACKNOWLEDGEMENT OF ADDITIONAL CHARGES FOR DIAGNOSTIC SERVICES

- You understand that services like lab tests, X-rays, and other diagnostic procedures might incur additional charges not covered by your insurance. You agree to be financially responsible for these charges.

SECTION 6: CONSENT FOR ELECTRONIC COMMUNICATIONS

- You consent to receive various communications concerning your healthcare, including but not limited to automated calls, artificial or pre-recorded messages, text messages, and promotional material on your registered mobile number.

SECTION 7: AUTHORIZATION FOR MINOR'S TREATMENT

- In cases where you can't accompany your minor child to the clinic, you give permission for designated adults (over the age of 18) to seek medical care for your child. You also authorize CLS Health to discuss and disclose details regarding your child's medical conditions, test results, appointments, insurance, and billing information with these designated individuals.

SECTION 8: OPTIONAL AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO THIRD PARTIES

- You authorize CLS Health to discuss or disclose details related to your medical condition, appointments, billing information, and insurance with additional contacts provided by you.

SECTION 9: PRIVACY PRACTICES AND DATA ACCESS BY CLS HEALTH SUBSIDIARIES

- You have received or had the opportunity to read the Notice of Privacy Practice

SECTION 10: AUTHORIZATION TO COLLECT MEDICATION HISTORY

- You authorize CLS Health to collect your medication history from various sources, including but not limited to, pharmacies, health insurers, and other healthcare providers. This information can include prescribed medications, over-the-counter drugs, dietary supplements, herbal remedies, and other treatments.

Understanding your medication history allows us to: Avoid harmful drug interactions.
Prevent duplicate therapies.
Identify medication non-adherence.
We assure you that your medication history, as part of your overall health information, is protected under federal and state law and will be used exclusively for the purpose of providing you with optimal medical care.

ACKNOWLEDGEMENT & AGREEMENTS

By signing, I acknowledge and agree to the following:

- I, as the responsible party, have entered the information in the patient registration form accurately and truthfully to the best of my knowledge.
- I have received or had the opportunity to read the CLS Health Patient Care Guide explaining my rights, responsibilities, and CLS Health's policies.
- I will seek clarification on any unclear details and can request the CLS Health Patient Care Guide at any time.
- I agree to the terms outlined in the CLS Health Patient Care Guide and acknowledge CLS Health will retain this form in my records.

Patient / Legal Guardian Name: _____ Signature: _____ Date: _____

CLS HEALTH

RELEASE MEDICAL RECORDS FROM:

Doctor/Hospital

Street Address

City, State, Zip Code

Phone Number/Fax Number

RELEASE MEDICAL RECORDS TO:

Name of Company/Doctor/Facility

Street Address

City, State, Zip Code

Phone Number/Fax Number

PATIENT INFORMATION:

Patient's Full Name

Date of Birth

Patient's Street Address

City, State, Zip Code

Contact Phone Number

Social Security Number

Release the Following Records:

____ All/Entire Medical Record ____ X-Rays (***charges will apply/CD must be pick up from office***)

____ Specific Medical Records: _____

____ Other: _____

Signature of Patient or Legal Guardian

Date

CLS HEALTH

Consent to Medical Treatment of a Minor

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

_____

_____

In order to comply with HIPAA guidelines and the Texas Family Code regarding medical treatment of a minor, it is necessary for you to complete the following information:

IT IS OUR POLICY THAT ONLY A NATURAL, ADOPTIVE PARENT OR LEGAL GUARDIAN IS AUTHORIZED TO CONSENT TO NON-EMERGENCY MEDICAL TREATMENT

If the parents are divorced, either parent can give consent for any emergency healthcare, including surgical procedures (Texas Family Code §153.074). The parent appointed as the child's sole managing conservator may give any other consent, including surgical procedures (Texas Family Code §153.132). The minor's parent or guardian may prefer to consent for some (or all) care in advance, instead of at the time of each specific visit.

I hereby authorize the following adults into whose care the minor has been entrusted to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment of the above-named patient deemed medically necessary by _____

MOTHER Name: _____ Ph #: _____

FATHER Name: _____ Ph #: _____

Name: _____ Relation: _____ Ph #: _____

Name: _____ Relation: _____ Ph #: _____

Name: _____ Relation: _____ Ph #: _____

Name: _____ Relation: _____ Ph #: _____

By signing below, I certify that I am the natural, adoptive parent or legal guardian of the above-mentioned patient. I am also aware that I may revoke this authorization by submitting a request in writing at any time.

Signed: _____ Date: _____

Printed Name: _____ DOB: _____

Relationship to minor: _____ SSN: _____