Trinity Heritage Clinic

2204 Joe Battle Blvd. El Paso TX 79938 Tel:915-300-2276 Fax: 1-866-222-5219

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that my health condition may require diagnosis and treatment. I hereby voluntarily consent to such treatment, services, and procedures as ordered by my doctor, his consultants, associates and his assistants, or his designee. I also understand student nurses and others in professional training programs may be among the individuals who provide care to me.

I authorize Dr. Nwiloh and his assistants/designee to discuss my medical history, diagnosis, treatment, and prognosis as provided in the notice of privacy practices. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol, or chemical abuse. I have the right to add anyone or any organization that I do not wish to have my medical information by requesting in writing at any time.

I understand there are times when the law allows Dr. Nwiloh and his assistants/designee to release information regardless of whether I give my consent as outlined in the notice of privacy practices. For example, Dr. Nwiloh and his assistants/ designee may release information to doctors, nurses and other who provide me with health care or are prospective health care providers; to government agencies as authorized by law to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in document form.

I also understand and acknowledge that Texas law provides if any health care worker is exposed to my blood or other bodily fluid, Dr. Nwiloh and his assistants/designee may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of Dr. Nwiloh. I understand that the results of tests taken under these circumstances are confidential and do not become a part of my medical record.

I acknowledge that it may be difficult for the physician(s), his/her assistants, or his/her designee to personally communicate with the patient regarding laboratory/diagnostic test results, etc.It is the policy of Dr. Nwiloh’s Office to leave this information on the patient's telephone answering machine.

NO GUARANTEE: I acknowledge that the practice of medicine is not an exact science and that Dr. Nwiloh has made no guarantees or warranties to me as to the result of treatments or examination.

It is the policy of Dr. Nwiloh's Office not to release confidential medical information to patient’s family members. We cannot discuss your medical condition or release diagnostic test results to anyone without your consent. I hereby give consent that information regarding my medical condition, including laboratory and diagnostic test results can be given to:

a. _____ Relationship _____

b. _____ Relationship _____

c. _____ Relationship _____

_____ _____

Signature of Patient/Legally Authorized Representative Date

Trinity Heritage Clinic

DEMOGRAPHICS

Patient's Name (First, Middle, Last): _____Date of Birth: _____

Address: _____

City: _____ State: ____ Zip Code: _____ Email: _____

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

Sex: ☐ Male ☐ Female SS#: _____ Are you employed? ☐ Full Time ☐ Part-Time ☐ Retired ☐Disabled

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed How did you hear about us? _____

Ethnicity: ☐Asian ☐Black or African American ☐Caucasian ☐ Hispanic Other:_____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Pharmacy Name: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID#: _____

Name of Policy Holder: _____ DOB: _____ Group#: _____

Secondary Insurance: _____ Member ID#: _____

Name of Policy Holder: _____ DOB: _____ Group#: _____

OTHER HEALTH CARE PROVIDERS

	Type of Practitioner (e.g., PCP, Cardiologist, Podiatrist, etc)	Name	Office Use
1.			☐ ___
2.			☐ ___
3.			☐ ___
4.			☐ ___
5.			☐ ___
6.			
7.			
8.			

PERSONAL HISTORY

I HAVE NO PAST MEDICAL HISTORY ☐

EYES/EAR/NOSE/THROAT
- Cataracts ☐
- Glaucoma ☐
- Macular Degeneration ☐
- Hearing loss ☐
- Cold sores (canker sores) ☐

CARDIOVASCULAR
- Heart attack/Heart disease ☐
- Heart murmur ☐
- High blood pressure ☐
- Pacemaker ☐
- PAD (Peripheral artery disease) ☐

PULMONARY
- Asthma ☐
- COPD / Emphysema ☐
- Pneumonia ☐

GASTROINTESTINAL
- Colon polyps ☐
- Hemorrhoids ☐
- Diverticulosis ☐
- Liver disease ☐
- Reflux (GERD) ☐
- Ulcers (stomach, duodenal) ☐

GENITOURINARY
- Kidney/bladder infections ☐

MUSCULOSKELETAL/RHEUM
- Arthritis ☐
- Gout ☐

SKIN
- Eczema/Dry skin (circle one) ☐
- Psoriasis ☐

NEUROLOGIC
- Headaches ☐
- Seizures/Fits/Epilepsy ☐
- Stroke ☐

PSYCHIATRIC/DEPENDENCY
- ADD/ADHD ☐
- Alcohol/Drug Dependency ☐
- Anxiety ☐
- Bipolar Disorder ☐
- Depression ☐
- Eating disorder: anorexia/bulimia ☐
- Suicide attempt ☐

ENDOCRINE
- Diabetes (sugar) ☐
- Hyperthyroid (high thyroid) ☐
- Hypothyroid (low thyroid) ☐
- High cholesterol ☐
- Infertility (pregnancy problems) ☐
- Osteoporosis /Osteopenia ☐

BLOOD/LYMPHATIC/CANCER
- Anemia/Low blood counts ☐
- Blood clots ☐
- Cancer: (Type: _____) ☐
- Easy bleeding ☐
- Sickle cell anemia ☐
- Transfusion ☐

ALLERGIC/IMMUNOLOGIC
- Hay fever/Pollen allergy ☐

INFECTIONS
- AIDS/HIV ☐
- Genital infections (e.g., herpes, chlamydia/gonorrhea, warts) ☐
- Hepatitis: Select Type ☐
- Measles/Mumps/Rubella ☐
- Rheumatic fever ☐
- Shingles ☐
- Tuberculosis (TB) ☐

MEN ONLY
- Enlarged prostate (BPH) ☐
- Erectile dysfunction/impotence ☐
- Prostatitis ☐

WOMEN ONLY
- Menopausal symptoms ☐
- Abnormal uterine bleeding ☐
- Endometriosis ☐
- Premenstrual Syndrome (PMS) ☐

Other medical history: _____

Family History

	High Blood Pressure	Diabetes	High Cholesterol	Heart Disease/CAD	Heart Attack	Stroke	Depression/Anxiety/Bipolar	Cancer (please specify type)	Kidney disease	Alcohol/Drug dependency	COPD/Emphysema	Other
Father												
Mother												
Sister												
Brother												
PGM												
PGF												
MGM												
MGF												

MGM=Maternal Grandmother, MGF=Maternal Grandfather, PGM=Paternal Grandmother, PGF= Paternal Grandfather

MEDICATIONS

Please bring your medications in the bottles or a complete medication list to your appointment.

If there are more than 10 medications please attach a list.

Do you have problems remembering to take your medications? ☐ Yes ☐ No

	Medication Name	Dosage	Times Per Day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

MEDICATION ALLERGIES

NO KNOWN ALLERGIES ☐

	Medication Name	Reaction	Age When Occurred
1.			
2.			
3.			
4.			

Have you had any significant hospitalizations? If so, please specify:

	Reason for Hospitalization	Year
1.		
2.		
3.		

SURGICAL HISTORY

SURGICAL HISTORY	DATE	SURGICAL HISTORY	DATE
Angioplasty/Stent	_____	Gastric bypass	_____
CABG (Heart bypass)	_____	Heart Valve	_____
Defibrillator	_____	Hernia repair	_____
Appendectomy	_____	Hysterectomy	_____
Knee Replacement	_____	Mastectomy	_____
Hip Replacement	_____	Thyroidectomy	_____
Back Surgery	_____	Tonsillectomy	_____
Carpal tunnel release	_____	Pacemaker	_____
Cataract extraction	_____	Prostate surgery	_____
Fracture	_____	Biopsy (location)	_____
Gallbladder Removal	_____		

Other _____

SOCIAL HISTORY

Have you experienced a fall in past 12 months? ☐ Yes ☐ No If yes, how many times have you fallen? _____

Do you have a Living Will/Durable Power of Attorney? ☐ Yes ☐ No

If yes, please bring copies. If no, are you interested in completing one? ☐ Yes ☐ No

Living arrangements (check all that apply)

☐ I live with my spouse/partner ☐ I live alone ☐ I live alone but have friends who check on me regularly

☐ I have family close by who can help me ☐ Assisted Living/Group Home ☐ Nursing Home

Are you sexually active? ☐ Yes ☐ No ☐ Men Only ☐ Women Only ☐ Both Men and Women

# of partners in the last 12 months: ☐ 1 ☐ 2 ☐ 3 ☐ ≥3 Do you always use protection? ☐ Yes ☐ No

WOMEN ONLY

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

When was your last menstrual period? _____

Do you use contraception? ☐ Yes ☐ No If yes, what? _____

DEPRESSION SCREENING				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

ALCOHOL AND DRUG HISTORY					
In the past month… (circle the appropriate answers)					
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	≥ 4 times a week
How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	≥ 10
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Almost daily

Do you currently smoke?	Yes ◯	No ◯	How much? _____ cigarettes/day **OR** _____ packs/day How many years have you smoked this much? _____
Are you a former smoker?	Yes ◯	No ◯	I quit in _____ but smoked _____ packs a day for _____ yrs
Have you ever used street drugs?	Yes ◯	No ◯	What drugs? _____

Have you had any of the following? (*if yes, enter date to those that apply*)

Test	**Date**	**Test**	**Date**
Eye exam	_____	Tdap (Tetnus)	_____
Cholesterol Test	_____	Pneumovax	_____
Sleep study	_____	Prevnar 13	_____
Stool blood test	_____	Influenza (Flu Shot)	_____
Colonoscopy	_____	Zostavax (shingles shot)	_____
Bone Density	_____	Hepatitis B Vaccine	_____
Heart Stress Test	_____	Mammogram	_____
Prostate exam	_____	Pap Smear	_____
PSA Test	_____		

Other _____

Signature_____ Date:_____

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ADVANCE PRACTICE NURSE

CONSENT TO TREATMENT

Trinity Heritage Clinic has on staff an advance practice nurse to assist in the delivery of medical services.

The advance practice nurse is not a Doctor. An advance practice nurse is a registered nurse who has received advance education and training in the provision of health care. An advance nurse can diagnose, treat and monitor common acute and chronic diseases as well as prescribe maintenance care. In addition, the advance practice nurse may treat minor laceration and other minor injuries.

I have read, understood and consent to the services of an advance practice nurse for my health care needs. I also understand I may refuse to see the APN and request Dr. Nwiloh.

Trinity Heritage Clinic cuenta con una Enfermera Practica Avanzada para asistir en servicios medicos.

La Enfermera Practica Avanzada no es un Doctor. Una Enfermera Practica Avanzada es una enfermera registrada que recibio educacion y entranamiento avanzado en el area de salud. Una Enfermera Practica Avanzada puede diagnosticar, tratar, dar seguimiento y monitorear enfermedades cronicas communes, asi como recetar. Una Enfermera Practica Avanzada puede tartar laceraciones menores y otras lesiones pequenas.

He leido, entendido y doy mi consentimiento para ser atendido por una Enfermera Practica Avanzada para tratar mis necesidades de salud. Asi como tambien entiendo que puedo rehusarme a ver una Enfermera Practica Avanzada y pedir ser atendido por el Doctor Nwiloh.

Signature/Firma:_____ Date/Fecha:_____

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OFFICE POLICIES

Here are a few of our policies that we would like for you to be aware of:

Narcotics and controlled substances are no longer routinely prescribed by this office.

Check in Process:

1. Insurance card and a valid ID are required during check in process for every visit.
2. A Patient/Parent/Guardian must notify the office of changes in address, telephone number or insurance.
3. You are required to pay your past due balance or balances.
4. You will be responsible for payment for charges of services rendered if we are unable to verify benefits.
5. We accept cash, Visa, Mastercard, American Express, and Discover. (Payment is due at time of service)
6. Insurance companies require a collection of your co-pay or contracted percentage of services at **every** visit. If you have a deductible that has not been met, you will be required to pay for the visit at the contractual rate. If your insurance does not pay for a service, the charges will be the responsibility of the Patient/Parent/Guardian. We recommend that you always question your insurance company regarding your benefits and do not assume that everything is done in our office by your insurance carrier.

Appointments:

1. You must arrive 10-15 minutes prior to your appointment.
2. Rescheduling may be necessary if you are late for your appointment. We will try to work you in if time allows.
3. You are scheduled to be seen for only 15 minutes for an office visit and 20 to 25 minutes for a Physical/Wellness exam unless its determined by Dr.Nwiloh to extend your visit if additional time of care is needed.
4. If you are being worked into the schedule as a walk, you are only allowed one medical complaint. You will have to schedule an additional appointment for any additional medical concerns. Sick office visits are not considered routine follow up care, which require more time.
5. Wellness/Physical examinations cannot be scheduled on the say that you call. We reserve only a certain number of well examinations per day.
6. If you are scheduled for a physical/wellness exam and you have other medical issues aside from your physical/wellness exam you will have to copay for other issues due to seperate insurance filling. If you disagree with our policies, then you will have to reschedule for another office visit.
7. Appointment cancelled with less than 24hrs notice will be billed with the following fees: $25 fee for a cancelled office visit and $35 fee for a cancelled physical/wellness exam.
8. If you do not show up for an appointment there will be a $25 fee.

Financial Responsibilities

1. ALL DUE BALANCES MUST BE PAID PRIOR TO BEING SEEN, unless you have made financial arrangement with our office. (with the exception of emergency visits)
2. NO EXCEPTION for the following: Deductibles and Copay must be collected at the time of service.
3. Private Pay Patients will pay an estimated fee upfront. No Exception.

Others:

1. Medical records can be faxed to another physician free of charge for continuum of care and upon receipt of the medical records release. However, if the entire record is requested for changing of PCP or personal record a fee is applied.
2. Patients may obtain a copy of their medical record for a fee. Our office will provide patients their medical record in a for of an USB flash drive.Patients may also request paper copies; however, and additional fee may apply due to the volume of their medical records.
3. An excused absence for school or work will only be issued if you have been seen in the office for illness. Note must be obtained at the time of visit.
4. There will be a $25 fee for any paperwork that requires the physician's signature.
5. Due to HIPAA laws, patients must check in with the receptionist and are not allowed in the back of the office without consent.

_____ _____

Signature of Patient/ Legally Authorized representative Date

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Patient Consent for use of Email Communications Letter

To better serve our patients, this office has established a patient portal for some forms of communications. For routine matters that do not require immediate response, please provide us with your email. We will send you an invite to join our patient portal. Upon your acceptance via the email you can log on to your personal account with Trinity Heritage and contact us via email or view account balance, some labs, etc. Should you require urgent or immediate attention, this medium is not appropriate.

Communications relating to diagnose and treatment will be filled in your medical record.

This office is dedicated to keeping your medical record information confidential. Please provide us your personal email and not your work emails. Some companies consider email corporate property and your messages may be monitored. In addition, you should be aware that, although addressed to me, my staff and our colleagues would have access to this information. I understand that this office will not be responsible for information loss or delay, or beaches in confidentiality that are due to technical factors beyond office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email portal.

Carta de Consentimiento para el Uso del correo electronico como medio de Comunicacion

Con el fin de ofrecer un mejor servicio, esta oficina cuenta con un Portel de Internet como medio de comunicacion adicional con nuestros pacientes, para efectos que no requieran de una inmediata respuesta. Por favor proveanos con su correo electronico, le estaremos enviando una invitacion a nuestro Portal de Internet. Despues de aceptar nuestra invitacion podra acezar a su cuanta personal que tenga con Trinity Heritage Clinic. Por medio de dicha cuenta podra comunicarse con la oficina, ver el balance de su cuenta, resultados de laboratorio, etc. Es importante aclarar que si usted necesita atencion medica inmediata este no es un medio de comunicacion apropiado.

Cualquier informacion relacionada con diagnosticos o tratamientos seran incluidos en su expediente medico.

Esta oficina esta comprometida en mantener confidencial la informacion de su expediente medico. Por tal razon es importante que nos provea con un correo electronico personal y no de otra persona o de su trabajo ya que algunas companias consideran el correo electronico propiedad de la empresa y su correo puede ser monitoreado. Debe de estar enterado que el personal de esta oficina tiene acceso al portal y cualquiera de ellos podra responder a sus dudas.

Entiendo que esta oficina no sera responsable por informacion perdida o brechas en la confidencialidad relacionados con la tecnologia, ya que estan fuera del control de la oficina.

Entiendo y estoy de acuerdo con la Poliza de correo electronico arriba descrita.

Firmando esta poliza, usted declara estar acuerdo en que se envie cualquier informacion medica, por medio del Portal de internet.

Signature/Firma:_____ Date/Fecha:_____

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Medication Refill Guidelines.

1. Refills should be asked for at the time of your scheduled appointment. Allow 3-5 working days for medication orders. Only medication prescribed by a physician/provider in our practice will be reviewed.
2. When you need a medication refill, please call your pharmacy to verify if refills are available. If they don't have any refills they will contact us. This reduces the possibility of errors being made when filling your prescription.
3. Urgently needed medication refills should be called into the office.
4. Any Rx refill messages received after 3pm will not be reviewed until the next working day.
5. Pain medication and controlled substances can only be refilled during regular office appointments.
6. If an appointment is cancelled and not rescheduled or if you do not show up for appointment, only a 30 day medication refill will be provided.
7. Antibiotics will not be prescribed over the phone. If you feel you need antibiotics, you will need to be seen.

I acknowledge understanding this medication policy.

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1. Los Medicamentos deberían ser solicitados durante su visita medica. Denos de 3 a 5 días para curtir. Su receta. Recetas hechas únicamente por nuestra clínica serán revisadas o llendas.
2. Cuando necesite repuestos de su medicamento , favor de llamar a su farmacia primero, para revisar cuantos repuestos tiene. Ellos nos llamaran a poner la orden de repuestos. Esto elimina errores en su medicamento.
3. Medicamento que necesite urgentemente debería ser llamado a nuestra oficina.
4. Cualquier recado de repuesto de medicamento que sea llamado después de las 3 será trabajado hasta el próximo día.
5. Medicamento para dolor o controlado sera llenado unicamente durante su cita medica.
6. Si se cancela una cita y no se reprograma o si no se presenta a una cita, so se proporciona un reabastecimiento de medicamentos de 30 dias.
7. No se recetarán antibióticos por teléfono. Si siente que necesita un antibiótico, debera ser atendido.

Yo entiendo la póliza de medicamento.

Signature/Firma:_____Date/Fecha:_____

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I, _____ hereby consent to be photographed by Trinity Heritage Clinic for the purpose of Identification and medical treatment

I ____ have read and understand the HIPAA/Privacy Policy for Trinity Heritage Clinic

I ____ hereby assign my insurance benefits to be paid directly to the healthcare provider

I ____ authorize Trinity Heritage Clinic to release medical information required to process my claim

I ____ have read and understand the Financial Policy for Trinity Heritage Clinic

I ____ authorize Trinity Heritage Clinic to obtain/have access to my medication history

I ____ authorize my provider's office to contact me by mobile phone, including text message and leave a message/ voicemail and send an email if necessary

_____ _____ _____

Name Signature Date

_____ _____ _____

Witness Name Signature Date

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MEDICAL INFORMATION RELEASE FORM

(HIPAA PRIVACY PRACTICES RELEASE FORM)

Name:_____ Date of birth:_____

☐ I authorize the release of information from _____

Including: (circle selection)

All medical records, X-Ray, Labs, STD results, Mental Health records,

Other:_____

And/or examination rendered to me and claims information. This information may be release to:

Trinity Heritage Clinic

Victor Nwiloh, MD, 2004 Joe Battle Blvd Unit 204, El Paso, TX 79938, Tel 915-300-2276, Fax: 866-222-5219

My files may be released to my spouse:_____

Children:_____ Other:_____

This release of information will remain in effect until canceled by patient. I HAVE BEEN GIVEN THE HIPAA PRIVACY INFORMATION BEFORE ANY SERVICES HAVE BEEN RENDERED:

Nombre:_____ Fecha de Nacimiento:_____

Yo autorizo mi informacion medica de _____

Sea enviada al Doctor Nwiloh, Localizado en 2004 Joe Battle Blvd Unit 204, El Paso, Tx 79938, Tel: 915-300-2276,

Fax: 866-222-5219. Favor incluir: todo mi archive medico, resultado de laboratorio, reports sobre mi estado

mental.

Otros:_____

Mi archivo medico puede ser entregado a mi esposa(o):_____

Hijo(a):_____ Otros:_____

Esta autorizacion estara en efecto hasta que sea cancelada por el paciente. TRINITY HERITAGE CLINIC ME A DADO LA OPORTUNIDAD DE LEER LA INFORMACION DE PRIVACIDAD, ANTES DE OBTENER CUALQUIER SERVICIO MEDICO.

Signed:_____ Date:_____

Witness:_____ Date:_____