Health Rx Wellness

Kristina Doolittle, APRN | Jayme Taylor, APRN, CSOWM

# NEW PATIENT MEDICAL HISTORY FORM

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____ Phone:
(Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____ Pharmacy: _____

## Medication/Allergy History

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

_____ _____ _____ _____

_____ _____ _____ _____

Allergies:
(Medications)_____
(Food)_____

## System Review (Check all that apply)

| | | | |
|---|---|---|---|
| ❑ Recent Weight loss more than 10lbs | | ❑ Recent Weight gain more than 10lb | |
| ❑ Acne | ❑ Constipation | ❑ Cough | ❑ Chest pain |
| ❑ Skin rash | ❑ Abdominal pain | ❑ Snoring | ❑ Palpitations |
| ❑ Anxiety | ❑ Diarrhea | ❑ Difficulty breathing when flat | ❑ Fainting/Blacking out |
| ❑ Depression | ❑ Indigestion | ❑ Shortness of breath | ❑ Swelling ankles/extremities |
| ❑ Inability to concentrate | ❑ Increased appetite | ❑ Difficulty swallowing | ❑ Dizziness |
| ❑ Loss of interest | ❑ Decreased appetite | ❑ Weakness/low energy | ❑ Seizures |
| ❑ Mood changes | ❑ Food intolerance | ❑ Urinary frequency/urgency | ❑ Headache |
| ❑ Insomnia | ❑ Nausea/vomiting | ❑ Nighttime urination | ❑ Back pain |
| ❑ Memory loss | ❑ Gas and bloating | ❑ Slow urine flow | ❑ Muscle aches/pain |
| ❑ Cold/heat intolerance | ❑ Blood in stool | ❑ Joint pain | ❑ Blood clots |

## Family History

| | | | |
|---|---|---|---|
| Other (check all that apply): | ❑ High Blood Pressure | ❑ Heart Disease | ❑ High Cholesterol |
| ❑ High Triglycerides | ❑ Stroke | ❑ Thyroid Problems | ❑ Anxiety |
| ❑ Diabetes | ❑ Depression | ❑ Bipolar Disorder | |
| ❑ Cancer (type/s):_____ | | ❑ Other:_____ | |

**Social History**

Smoking: □ Never □ Current smoker (_____ packs/day) □ Past smoker (quit _____ years ago)
Alcohol: □ Never □ Occasional □ Regularly (_____ drinks per day) Prior treatment for alcoholism? Y / N
Drugs: □ Never □ Current □ Past □ Type of drugs: _____
Marijuana: □ Never □ Current user (_____ times/day)
Marital Status: _____

**Medical History**

Exercise type:_____ Duration: _____ hours _____ minutes Number of times per week: _____
Does anything limit you from exercising? _____
How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):

| | | | |
|---|---|---|---|
| ▢ Heart Attack | ▢ Angina | ▢ Gallbladder Stones | ▢ Sleep Apnea |
| ▢ High Blood Pressure | ▢ Stroke | ▢ Indigestion/Reflux | ▢ Thyroid |
| ▢ High Cholesterol | ▢ Diabetes | ▢ Celiac Disease | ▢ Anxiety |
| ▢ High Triglycerides | ▢Gout | ▢ Pancreatitis | ▢ Depression |
| ▢ Infertility | ▢ Arthritis | ▢ PCOS | ▢ Bipolar |
| ▢ Glaucoma | ▢ Cancer (type/s): _____ | | |

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):

| | | | |
|---|---|---|---|
| ▢ Gastric Bypass | ▢ Gastric Banding | ▢ Gastric Sleeve | ▢ Gallbladder |
| ▢ Heart Bypass | ▢ Hysterectomy | ▢ Other: _____ | |

**Gynecologic History** (Female)

Age periods started? _____ Age periods ended _____ Periods are: Regular / Irregular Heavy / Normal / Light
Number of pregnancies: _____ Number of children: _____ Age of first pregnancy: _____ Age of last pregnancy: _____

| | | |
|---|---|---|
| ▢ Absence of periods | ▢ Hot flashes | ▢ Change in bladder habits |
| ▢ Facial hair | ▢ Abnormal/excessive menstruation | |

Comments: _____
_____
_____

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# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient name: (First) _____ (Last) _____
Date of birth: _____/_____/_____ SSN: _____
Address: _____ (City) _____ (State) _____ (Zip) _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.* 2. *The following individual or organization is authorized to make the disclosure.*

Practice Name: _____
Address: _____ (City) _____ (State) _____ (Zip) _____

1. The type and amount of information to be used or disclosed is as follows:

□ Complete health records □ Lab results/X-ray reports

□ Physical exam □ Consultation reports

□ Immunization record □ Other (please specify): _____

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. *This information may be disclosed to and used by Rx Health & Wellness for the purpose of* _____

3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____

4. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Rx Health & Wellness.

_____ _____

Patient's Name (printed) Date

_____

Patient Signature *(or signature of person with authority to consent for patient)*

Kristina Doolittle, APRN | Jayme Taylor, APRN, CSOWM
11560 N 135th East Ave Ste 101
Owasso OK, 74055
Ph:(918)553-1188 Fx:(855)873-6538

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# RX HEALTH & WELLNESS PATIENT AGREEMENT

## Authorization for Medical Treatment

Office Practice/Clinic personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment, and to record, film and/or photograph for treatment, performance improvement or education, deemed necessary or advisable until the update patient agreement is signed or this form is revoked by me or my representative. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

## Disclosure of Information

I understand that my medical records and billing information are made and retained by this office and are accessible to office personnel. Office personnel may use or disclose medical information for operations, functions and to any other physician or health care personnel involved in continuum of care. Safeguards are in place to ensure improper access. This office and its medical staff are authorized to disclose all or part of my medical record to insurance carrier, workers compensation carrier, or self-insured employer group liable for any of the office charges and to any health care provider who is or may be involved in my care. Oklahoma/Kansas law requires that this office advise you that information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug, substance or alcohol abuse. By signing this agreement, you are consenting to such disclosure. Office personnel may release my general condition to family/friends that inquire about me by name.

## Assignment of Insurance Benefits

I agree that physician benefits otherwise payable to the insured are to be made payable to the providers responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to rules of coordination of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash or credit card at the time of service.

## Precertification Policy

I understand that the office will assist with precertification requirements but will NOT assume responsibility for any precertification or any impact which it may have on insurance payment.

## Financial Responsibility

As consideration for services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this office.

## Certification

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this patient agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this patient agreement. A photocopy of this agreement has the same effect as an original.

| Patient or Representative | Relationship to Patient | Date Signed | Witness |
|---|---|---|---|
| | | | |

| Patient Name- Printed | Date of Birth | Account Number |
|---|---|---|
| | | |

## Release of Protected Health Information

Information may be released to the following individual(s)

| Name/Relationship | Phone Number | Name/Relationship | Phone Number |
|---|---|---|---|
| | | | |

## Acknowledgment of Notice of Privacy Practices

**A complete description of how your medical information will be used and disclosed by this office is in our Notice of Privacy Practices, which is available to you upon request. A copy is also posted inside the office.**

**I have received a copy of Notice of Privacy Practices**

| Patient or Representative | Relationship to Patient | Date Signed | Witness |
|---|---|---|---|
| | | | |

**Kristina Doolittle, APRN | Jayme Taylor, APRN, CSOWM**

**AGREEMENT FOR OFF LABEL AND LONG-TERM CONTROLLED SUBSTANCE PRESCRIPTIONS**

Patient name: _____ Date of birth: _____

**Obesity Controlled**

**NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT RX HEALTH & WELLNESS WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND RX HEALTH & WELLNESS DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.**

Some anti-obesity medications are considered "controlled medications." By law, a controlled medication can only be prescribed from one facility at a time; therefore I agree that only Rx Health & Wellness will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my provider(s) at Rx Health & Wellness and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contraindicated with certain medical histories, allergies, or other medication use**. I agree that I will be honest in disclosing this information and will notify my provider(s) at Rx Health & Wellness of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by Rx Health & Wellness. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered "off label" or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my provider(s) at Rx Health & Wellness are experienced specialist(s) in obesity medicine who will, at times, elect or choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my provider(s) at Rx Health & Wellness.

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification. I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

**Off Label Medications**

Other than controlled medications used outside FDA approved scheduling, I understand that my provider at Rx Health and Wellness may choose to use medications for weight loss that may not have their FDA approval for weight loss. This is considered off label. I understand that my provider is specialty trained to determine what medications may benefit me based on my diseases processes and specific weight loss needs and understand that sometimes this means utilizing FDA approved medications for weight loss which may not be an FDA approved diagnosis for these medications. Examples include diabetic medications that are used off label such as medications like Metformin. GLP medications such as Ozempic, Victoza, and Trulicity. Compounded GLP medications such as semaglutide salt formulations and tirzepatide. SGLT medications such as Farxiga and Jardiance, as well as other classes of medications deemed appropriate by my Rx Health and Wellness provider.

**Controlled Medications Outside Obesity**

The use of _____ (print names of medication) may cause addiction and is only one part of the treatment for: _____ (print name of condition-e.g., pain, anxiety, etc.).

The goals of this medicine are:

- to improve my ability to work and function at home.
- to help my _____ (print name of condition-e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.
- to attempt de-escalation of dosing as determined by provider.

I have been told that:

1. If I drink alcohol or use street drugs I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my provider (e.g., primary care, physical therapy, mental
- I agree to give a blood or urine sample, if asked, to test for drug use.

### Refills

Refills will be made only during regular office hours Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine**.** I will not come to Clinic for my refill until I am called by the nurse. **I must keep track of my medications. No early or emergency refills may be made. No exceptions will be made.**

### Pharmacy

I will only use one pharmacy to get my medicine. My provider may talk with the pharmacist about my medicines. The name of my pharmacy is _____.

### Prescriptions from Other Doctors

If I see another provider who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Provider Visit in the original bottle, even if there are no pills left.

### Privacy

While I am taking this medicine, my provider may need to contact other providers or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

### Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my provider, and I understand the above rules.

### Provider Responsibilities

As your provider, I agree to perform regular checks to see how well the medicine is working. | agree to provide care for you based on status as patient even if you are no longer getting controlled medicines from me.

| _____ | _____ | _____ |
|---|---|---|
| **Patient name** | **Patient's signature** | **Date** |

| _____ | _____ | _____ |
|---|---|---|
| **Provider name** | **Provider's signature** | **Date** |

This document has been discussed with and signed by the provider and patient. (A signed copy will be scanned into the patient's chart and a copy given to the patient.)

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# No-Show and Conclusion of the PCP-Patient Relationship Policy

**Please note, this is just a notice of actions that could lead to termination from our practice. This is not a notification of termination.**

It is the policy of Rx Health and Wellness to maintain a therapeutic and trusting relationship with all patients. When such a relationship has not been formed or the relationship with a patient is no longer proceeding in an effective manner, the attending provider may terminate his/her relationship with the patient which would include ALL members of the patient's family and it would also include being seen by any other provider in this practice. Any such termination shall be carried out within the bounds of applicable state and federal laws, rules, regulations and professional guidelines such as the American Medical Association guidelines, and this policy. Termination of the relationship may occur with the goal of assuring appropriate continuity of care for the patient. When a patient cancels appointments, procedures or other scheduled care on a repetitive basis without cause or enough notice, quality and continuity of care are adversely impacted, office schedules are disrupted, and it impedes other patient(s) appointments. In order to decrease the incidence of such cases, a "No-Show fee of $60.00" may be assessed and/or when indicated, which can result in the physician/patient relationship to be terminated.

**Causes for Termination**

The physician or his/her designee identifies a patient with whom the physician-patient relationship has been affected negatively or is no longer therapeutic. The types of circumstances that can result in termination include, but are not limited to, the following:

- Repeated noncompliance with therapies or treatments essential to the patient's safety as deemed medically necessary by the physician or other attending healthcare provider ("Provider")
- Failure to meet financial obligations to Rx Health & Wellness regarding care provided or to cooperate with payment processes consistent with Rx Health & Wellness payment policies
- Consistent or repeated failure to keep appointments without good cause and/or without notice of intent to cancel appointments prior to 24 hrs of the scheduled appointment time
- Threatening, violent, abusive or patterns or repetitive rude or offensive behavior directed at a Provider, other Rx Health & Wellness staff, or other patients or visitors
- Attempts by the patient to use the relationship to illegally or improperly obtain controlled substances for non-therapeutic purposes, abuse of controlled substances or otherwise refusing to obtain treatment for controlled substance abuse or addiction, seeking multiple prescriptions from different physicians or diverting controlled substances
- The patient elects to terminate or expresses a desire to terminate the relationship

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It is the desire of Rx Health & Wellness to do our best to have the best applicable care for all our patient's healthcare needs so we can keep the provider/patient relationship trustworthy and respectful.

I,_____ have read the above policy statement and agree to act within the guidelines stated. Additionally, I understand that should I no-show my appointment that I am responsible for the total visit cost of that appointment which is equal to $60. In which case, I give permission for Rx Health & Wellness to debit the card on file for this fee.

_____ _____

Patient / Representative Signature Date

_____ _____

Witness Signature Date

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## No Show Policy

Due to the limited spaces available on each provider schedule it is necessary that patients that are scheduled show up at their designated times. Patients have until 24 hours prior to their appointment time to cancel their appointment. We do understand that things happen and therefore in some cases we will overlook same day reschedules, unless these become a pattern for patients. Each appointment that is scheduled and no-showed is an appointment that could have been utilized by another patient. Therefore, our policy is that patients that no-show their appointments will be charged the full cash price of the missed appointment (see pricing below). **This will be billed to the credit/debit/HSA card on file for that patient.** Signing this agreement verifies that you understand this policy and your responsibility as the patient to cancel your appointment in a timely fashion should you not be able to make it to your scheduled appointment. Furthermore, patients that are more than 7 minutes late for their appointment will be considered a "no show," unless otherwise approved by the clinic but limited to 1 waived NS fee per calendar year.

I,_____have read the above policy statement and agree to cancel all scheduled appointments prior to 24 hours of the appointment time. Additionally, I understand that should I no-show my appointment that I am responsible for the total visit cost of that appointment. In which case, I give permission for Rx Health & Wellness to debit the card on file for this fee.

| | |
|---|---|
| Office Visit with RN | $40 |
| Office Visit Provider | $80 |
| Medical Nutrition Therapy | $80 |

**Credit/Debit Card #: _____**

**Expiration Date:_____/_____**

_____ _____

**Patient or Responsible Party Signature** **Date**

_____ _____

**Witness** **Date**

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## PATIENT DEMOGRAPHICS

Legal name: (First) _____(Last) _____MI:_____

Name you prefer to be called:_____

Date of birth: _____/_____/_____ Age:_____ SSN:_____

Address: _____

(City) _____ (State) _____ (Zip) _____

Home Phone: _____Cell Phone:_____

Email Address: _____

Sex: Male Female Transgenter (F to M) Transgender (M to F) Gender queer

Choose not to disclose Other gender category not listed:_____

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Employment Status: Full-time Part-time Unemployed Disabled Retired Military

Employment Information

Employer:_____ Occupation:_____

Employer Address: _____

(City) _____ (State) _____ (Zip) _____

Work Phone: _____ Ext:_____

Emergency Contact:

Name: Relationship:_____ Phone:_____

Primary Care Provider: _____ Phone:_____

Pharmacy and Labs:

Preferred Pharmacy:_____

Address:_____ Phone:_____

Preferred Lab:_____

Address:_____ Phone:_____

Insurance:

Primary Insurance:_____

Secondary Insurance:_____

Medication Benefits:_____

Please present your insurance card to the staff at the front desk

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11560 N 135th East Ave Ste 101
Owasso OK, 74055
Ph:(918)553-1188 Fx:(855)873-6538

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