ACHIEVE HEALTH

RYAN NOLEN, D.O.

NEW PATIENT HEALTH HISTORY

How did you find out about Achieve Health? _____

YOUR PERSONAL INFORMATION

NAME: _____ REFERRED BY: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____

STATE/ ZIP _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____.

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

CELL PHONE: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

COMPANY: _____ ID/ POLICY NUMBER: _____

GROUP NUMBER: _____ PHONE: _____

SUBSCRIBER'S NAME. _____. DOB: _____

SECONDARY INSURANCE

COMPANY: _____ ID/ POLICY NUMBER: _____

GROUP NUMBER: _____ PHONE: _____

SELF- PAY

_____. **I do not have medical insurance and will be paying cash for today's office visit**

YOUR MEDICAL HISTORY

PHARMACY INFORMATION

NAME: _____ ADDRESS: _____

PHONE: _____ ZIP CODE: _____

ALLERGIES

Do You Have ANY Drug Allergies? (Please Circle One) YES NO

If YES, Please List the Name of the Medication and Your Reaction to That Medication

1. _____ REACTION: _____
2. _____ REACTION: _____
3. _____ REACTION: _____
4. _____ REACTION: _____

MEDICATIONS

Please List ALL Prescriptions, Over- the –Counter, Vitamins, and Herbal Supplements Below

	Medication	Dosage	Time Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

PREVENTIVE CARE

PLEASE NOTATE THE DATES OF YOUR LAST:

COVID Vaccines #1 _____ **#2** _____ **1st Booster** _____ **2nd Booster:** _____

Physical. _____ **Colon- Cancer Screening.** _____

Stress Test. _____ **Bone Density.** _____

Mammogram. _____ **PAP Smear.** _____

Prostate Exam. _____ **PSA Lab Test.** _____

PAST MEDICAL HISTORY

[Circle All That Apply]

Alcoholism	Bleeding problems	Orthopedic Issues	Stomach Issues.	Sleep Apnea
Anemia	Cancer: _____.	High Blood Pressure	Kidney Stones	Heart Attack
Anxiety	Crohn's Disease	High Cholesterol	Kidney Disease.	Seizures
Heart Palpitations	COPD/ Emphysema	Hiatal Hernia	Liver Disease	Stroke
Arthritis/ Rheumatoid	Dementia	Hepatitis	Lupus	Thyroid
Asthma	Depression	HIV	Infections	Urinary
Bipolar	DVT (blood clot)	GERD (acid reflux)	Parkinson's Disease	
Bladder problems	Diabetes: 1 or 2	Glaucoma	Pulmonary Embolism	
	Diverticulitis	Macular Degeneration.	Psoriasis	
	Heart Disease	Neuropathy	Irritable Bowel	

OTHER: _____

SURGICAL HISTORY

Date:	Type of Surgery:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY. [Circle All That Apply]

FATHER: Living Age: _____ Deceased Age: _____

Alcoholism	Bipolar	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes: 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/ Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid
Arthritis	Dementia	Heart Disease	Migraines	Heart Attack

OTHER: _____

_____

MOTHER: Living Age: _____ Deceased Age: _____

Alcoholism	Bipolar	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes: 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/ Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid
Arthritis	Dementia	Heart Disease	Migraines	Heart Attack

OTHER: _____

_____

OTHER FAMILY MEMBERS WITH ANY SIGNIFICANT HEALTH CONCERNS:

_____

_____

_____

_____

_____

SOCIAL. HISTORY

(CIRCLE ALL THAT APPLY)

Marital Status: Single Married Divorced Widowed

Number and Ages of your children: _____

Occupation: _____

Education Level: (Circle the Highest Completed Degree)

High School Vocational College Masters/ Doctorate

Smoking/ Tobacco Use:

Do you currently Smoke/ Chew tobacco products? YES. NO. If so, how much? _____

Do you currently drink alcohol? YES. NO. If "yes", How would you describe yourself?

SOCIAL (3-4 drinks/ week). MODERATE (7-10 drinks/ week). HIGH (More than 10 drinks/ week)

Do you currently use Recreational Drug? YES NO

Type: _____

Sexually Active: No Yes

CARE TEAM MEMBERS

(Cardiologist, Mental Health Provider, Kidney Doctor, Chiropractor, Physical Therapist

1. Name. _____. Phone: _____
   Address. _____
   Specialty. _____

2. Name. _____. Phone: _____
   Address. _____
   Specialty. _____

3. Name. _____. Phone: _____
   Address. _____
   Specialty. _____

Financial Agreement and Notice For No-Show Appointments

UPDATED: January 2023

Achieve Health Internal Medicine is NOT your typical corporate physician's office. We DO NOT double-book our appointments so that you only get 15 minutes with Dr. Nolen. We offer a more personal experience for you, reserving an appointment block 30 min. to 1 hour in length. If you do not call to 2 business days in advance to reschedule, that appointment block is lost for someone else that could have used that time and it is a loss of revenue for Dr. Nolen.

Moving forward, YOU WILL BE RESPONSIBLE FOR AN OFFICE VISIT FEE OF $125, IF WE DO NOT GET A CALL FROM YOU TO CANCEL OR RESCHEDULE YOUR APPOINTMENT 2 BUSINESS DAYS IN ADVANCE, NOT INCLUDING WEEKEND DAYS. We understand that unforeseen emergencies can occur, and each individual case will be considered.

A current credit card MUST be on file and updated as the information changes. THIS IS NOW A REQUIREMENT FOR ALL PATIENTS. We do virtual visits as well and this allows us to charge your credit card at the time of your virtual appointment.

We request that payment be made for your office visit at the time of that visit. We do not file insurance and then bill the client. We accept all Major Credit Cards, Health Savings Cards and Cash.

A charge may incur for requests of physical copies of your medical records. We will FAX your records to another physician at no charge. Transferring records may take up to 1 week.

PLEASE CIRCLE: MC VISA DISCOVER AMEX

CREDIT CARD NUMBER: _____

CVV CODE. _____ EXPIRATION DATE. _____

We hope this implementation will help our office run more efficiently and help us to continue to offer the level of care we want to provide. You deserve our time, please respect Dr. Nolen's time.

Thank you for your understanding and cooperation.

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____. DATE. _____

Communication of PIH (Personal Health Information)

CONSENT TO RECEIVE ELECTRONIC COMMUNICATION FROM DR. NOLEN AND HIS STAFF

*** Please Initial each item ***

_____. **Consent to receive electronic communication from Dr Nolen's office.** I agree that Dr Nolen and his staff may communicate with me about my personal health information, scheduling, billing, or other important issues regarding my care via email, cell phone, home phone, work phone (if provided to our office) and fax.

_____. **Other family members involved in my care.** I give Dr. Nolen and his staff permission to communicate with other family members/ friends regarding my care. This includes, but is not limited to: office visits/ scheduling, lab reports, diagnostic testing reports, treatment plans and billing/ insurance issues.

Name: _____. Relation: _____

Name: _____. Relation: _____

_____. **Referrals to other physicians or agencies that require medical records in order to perform their business.** I give Dr. Nolen and his staff permission to disclose my complete health record, but not limited to, diagnosis, lab / imaging test results, treatment plans, and billing records for all of my conditions, to those involved in my care.

Signature of patient or legal guardian: _____

Print name of patient or legal guardian: _____

Date: _____

Authorization for Disclosure of Medical Records to Dr. Nolen/ Achieve Health

PATIENT NAME. _____

PREVIOUS/ OTHER NAMES USED. _____

PATIENT ADDRESS. _____

DATE OF BIRTH. _____

I authorize the release of medical records to:
(Including, but not limited to, radiology and lab reports, pathology reports, office notes and treatment plans.)

Achieve health Physician Services

Dr. Patrick Ryan Nolen

350 Westpark Way, Suite 103

Euless, TX 76040

Patient Signature: _____. Date: _____

CONSENT FOR TREATMENT

I voluntarily present to Achieve health Physician Services, PLLC and consent to treatment by Dr Patrick Ryan Nolen and whomever he may designate as his assistant, associate, and patient care staff to provide my care.

Such care may include, but not limited to, diagnostic and laboratory testing, radiological evaluations and procedures, and the administration of medications considered advisable for my diagnosis, treatment and course of my care.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of the treatment or examination by Dr Nolen.

Signature of patient. _____. Date: _____

PERMISSION FOR ACHIEVE HEALTH TO COMMUNICATE WITH YOUR INSURANCECOMPANY

I understand and agree that (regardless of whatever health insurance or medical benefits I have) I am ultimately responsible to pay Achieve Health Physician's Services and Patrick Ryan Nolen, D.O., as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/ healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/ insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights, that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

DATE _____

PATIENT SIGNATURE. _____

PRINT PATIENT NAME. _____