



Revive Primary Care & Med Spa
2570 FM 407, Ste. 160, Highland Village, TX 75077
Phone: 972-236-7060 Fax: 866-493-3020

NEW PATIENT REGISTRATION

Name (First, Middle, Last):

Date of Birth MM/DD/YYYY: Age: Social Security Number:

Street Address:

City: State: Zip Code: Sex: Male Female

Main Phone: Alternative Phone:

Email:

Reason for Visit:

Primary Care Physician's Name: Primary Care Physician's Phone:

How did you hear about us? Friend/Family Internet Other Drive by Mailer Other

Emergency Contact Full Name:

Relationship: Phone Number:

Marital Status (Optional) Married Single Divorced Separated Widowed

Ethnicity (Optional) American Indian or Alaskan Native Asian Black or African American White
Hispanic or Latino Native Hawaiian or Other Pacific Islander

PHARMACY INFORMATION

Pharmacy Name: Pharmacy Phone Number:

Pharmacy Address/Location:

INSURANCE INFORMATION

Company Name: Member ID: Group No:

RELEASE OF INFORMATION

Please list the individuals with whom we may discuss your medical information with OR check the box below:

Name: Relationship:

Name: Relationship:

PLEASE ONLY CHECK THE BOX BELOW IF YOU DO NOT AUTHORIZE!

I do NOT authorize discussion of medical information to any individual other than medical professionals involved in my care. This includes lab results, radiology reports, physician notes, prescription information, treatment plans, etc.

I certify that by my signature below, I give Revive Primary Care & Med Spa permission to discuss my medical information with the individuals listed above. If you checked the box above, please also sign below.

Printed Name

Signature

Date



Revive Primary Care & Med Spa

2570 FM 407, Ste. 160, Highland Village, TX 75077

Phone: 972-236-7060 Fax: 866-493-3020

As a patient of Revive Primary Care & Med Spa, I acknowledge and understand the following office policies

Initials _____ Consent for Medical Treatment: I give permission to Revive Primary Care & Med Spa to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (e.g.: including, but not limited to, x- rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements; and (c) completion of medically appropriate tests for communicable and other diseases.

Initials _____ Consent for Wellness and Preventative Health Screening: I give permission to Revive Primary Care & Med Spa to perform a wellness and/or preventative health screening. I understand that I am solely responsible for following up with my personal physician or other healthcare provider about the results of my screening. In performing the wellness screening, Revive Primary Care & Med Spa does not assume any responsibility for ongoing treatment or management of care.

Initials _____ Financial Policy: I give permission for my insurance benefits to be paid directly to Revive Primary Care & Med Spa and its related companies. I understand that I am financially responsible for any balance my insurance fails to cover. I also authorize Revive Primary Care & Med Spa, its related companies, or insurance company to release medical information required for claims. I understand I will be responsible for any co- payment and/or deductible, and the cost of any services not covered by insurance. I understand I am responsible for knowing what my insurance plan does and does not cover and that Revive Primary Care & Med Spa verifies my insurance as a courtesy. We also accept visa, master card, American Express, cash and checks. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents. If you have any questions regarding this, please call your insurance company. If you are unable to pay for your visit, you will need to reschedule until you are able to cover the visit cost.

Initials _____ Un-insured: If you do not have insurance coverage or Revive Primary Care & Med Spa does not have a direct contract with your insurance company, you will be required to pay in full for your any and all visits. You can expect to pay an initial payment for medical care/ treatment based on pricing at the clinic. This will be collected at check-in. If your treatment requires more complex evaluations, lab tests, vaccines, medications, X-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected either before or after service and treatment have been provided.

Initials _____ Non-payment: It is our office policy that all past due accounts be sent statements regularly. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to our collection agency and may result in discharge from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Initials _____ Card on File: Card on File is **REQUIRED** for all patients to ensure an efficient and smooth check-in process, along with reducing collection efforts. The amount of time and effort to collect payments that will be saved will allow our office to focus more on care.

Initials _____ Consent for Communication: I understand Revive Primary Care & Med Spa will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.

Initials _____ Prolonged Care: In accordance with AMA CPT guidelines, we reserve the right to bill for telephone calls with our medical professionals that include evaluation and management of your medical condition, as well as time spent for extensive medical review or coordination of care.

Initials _____ Annual/Physical Exams: This type of visit is **PREVENTATIVE ONLY**. If you are here for an Annual/Physical exam and want to be seen for other health issues in addition to this visit, then we will **bill your insurance for both sick AND well visit**. Your insurance might not pay for the combination visit: if this is the case, then you are responsible in paying the complete balance due. To avoid this, you will need to reschedule the Annual/Physical for another day.

Initials _____ Labs/Imaging: Laboratory billing is **separate** to the physician bill you receive. We are not responsible for any laboratory billing issues that arise after the service provided. We can suggest labs as part of your annual checkup or medical conditions, but we do not provide any guarantee for its insurance coverage. All labs and imaging are reported to patients within 7 business days. Your provider **MUST SEE YOU** within 1-2 weeks or sooner for all abnormal labs and imaging so that our providers can assist with management and/or treatment plan.

Initials _____ Prescriptions: Your provider **MUST SEE YOU** prior to prescribing a new RX, refills on Antibiotics or Narcotics (Controlled medications) and changing your existing medication. **NO** controlled medication will be prescribed over the phone, out of State, after hours, or weekends. If you have not been seen your provider within the past **3 months** and need a refill, you must schedule an appointment to see provider for your prescription refill. All medications have an appointment refill schedule that must be followed to ensure the safety of our patients. Please check with the staff if you have any questions about the refill schedule.

Initials _____ No shows: If you do not show up and/or do not call us **24 hours in advance** to cancel or re-schedule your appointment, we reserve the right to charge a \$25 fee for the scheduled time that we were unable to give to other patients. After **three consecutive** no shows or rescheduling, we reserve the right to discharge you as our patient.

Initials _____ Notice of Privacy Practices: Your name and signature below indicate that you have been made aware of Revive Primary Care & Med Spa Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the clinic and a copy will be provided to you if you request it. If this is your first date of service with Revive Primary Care & Med Spa, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Revive Primary Care & Med Spa Notice of Privacy Practices, contact Revive Primary Care & Med Spa's Privacy office at mgmt@revivepcms.com

By signing below, I certify that I have read and understand Revive Primary Care & Med Spa policies listed above.

Printed Name

Signature

Date



Revive Primary Care & Med Spa
 2570 FM 407, Ste. 160, Highland Village, TX 75077
 Phone: 972-236-7060 Fax: 866-493-3020

MEDICAL HISTORY

Patient Name: _____ **Age:** _____

Please check off the following that apply to you.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatological Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> ADHD/ADD |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Cancer | <input type="checkbox"/> STD | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Pneumonia | If so, what kind? _____ | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine | <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Congenital Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Clot in Vein | <input type="checkbox"/> Seizures | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ |

Surgical Procedures / Hospitalizations **Month/Year**

NO Surgical Procedures NO hospitalizations

Family History

Do any of the following conditions run in your family? If so, please list your relationship to them.

Mother's Age: _____ **Father's Age:** _____

Condition	Relationship	Alive?
<input type="checkbox"/> Stroke		
<input type="checkbox"/> Heart Attack/Disease		
<input type="checkbox"/> High Cholesterol		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Thyroid Disorder		
<input type="checkbox"/> Cancer		
What kind of Cancer?		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Genetic Condition		
<input type="checkbox"/> Breast Disease		
<input type="checkbox"/> My family has NO health conditions.		

Social History

Do you smoke? Yes No Former Smoker
 If yes, how many times per day? _____

Do you use any other Tobacco products? Yes No

Do you drink alcohol? Yes No
 If yes, how many drinks per week? _____

How often did you have 6 or more drinks? _____

Have you taken illegal drugs? Yes No
 If yes, which ones? _____

What year, if ever, did you last have the following?

_____ Routine Bloodwork	_____ Mammogram (Women 40+)	_____ Pneumonia Vaccine (65+)
_____ Flu Vaccine	_____ Colonoscopy/Cologuard (45+)	_____ Last Fall (65+)
_____ Covid Vaccine	_____ Prostate Screening (Men 50+)	_____ Vasectomy (Men)
_____ Last Menstrual Cycle	_____ Shingles Vaccine (50 +)	_____ Hysterectomy (Women)
_____ Pap Smear (Women 18+)	_____ Bone Density Screening (65+)	_____ Diabetic Eye Exam

MEDICATION LIST			ALLERGIES	
Name of Medication	Dose	Frequency	Food/Drug Name	Reaction

I am NOT on any medications

I do NOT have any known allergies