Primary Health & Wellness Center, L.L.C.

Donald Hund, DC, NP-C / Yvonne Rudolph, DC

Welcome to our practice. Our number one goal is help patients recover and sustain optimal healthy function after an incident, illness, accident or injury. We focus on customizing a treatment plan based on your individual lifestyle, occupation, and personal goals. We also provide a broad range of comprehensive rehabilitation services.

Donald Hund, DC, NP-C practices as both a family nurse practitioner and chiropractor. His training includes various types of rehabilitative techniques, physical medicine, manual therapy, and family practice medicine.

Family Nurse Practitioners (NPs) are advanced practice nurses who are able to provide comprehensive and focused physical examinations and can diagnose and treat common acute illnesses and injuries as well as chronic health problems. In addition they can order and interpret diagnostic tests such as X-rays, MRls, EKGs, and laboratory tests. They are also able to. prescribe medications and therapies; perform procedures; and educate and counsel patients .regarding healthy lifestyles and health care options.

Yvonne Rudolph, DC has extensive experience treating, neck, back and joint pain, headaches and conditions requiring post-surgical rehabilitation. She emphasizes non-surgical care for disc herniations, disc degeneration, and nerve compression. Her training throughout the years has encompassed progressive rehabilitation, myofascial release techniques, joint manipulation, and nutrition.

I consent to treatment from Donald Hund, NP-C and/or Dr Rudolph and their associated practitioners, as necessary or desirable for the care of my condition. My treatment may include therapy such as ultrasound, cryotherapy, heat therapy, electrical muscle stimulation, spinal traction, joint manipulation, exercise, and massage therapy performed by one of the qualified, designated associates practicing at his office.

I hereby acknowledge that I have read and that I understand the above information about Primary Health & Wellness, L.L.C.

Patient Signature _____ Date _____

13445 East Freeway Houston, TX 77015 Phone: 713-451-9911 Fax: 713-451-4573
1806 Humble Place Drive Humble, TX 77338 Phone: 281-359-4220 Fax: 281-359-4208

PRIMARY HEALTH & WELLNESS CENTER, L.L.C.

Name _____ Date _____

Address _____

City: _____ State: _____ Zip: _____

Occupation _____ Date of Birth _____ Age _____

Social Security #: _____ Check One: Married ☐ Single ☐

Phone (Primary) _____ E-mail _____

Medication Allergies

_____

_____

_____

_____

_____

Current Medications

_____

_____

_____

_____

_____

_____

_____

Medical History

	YOU	Mother	Father	Mother's Parents	Father's Parents	Siblings
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date	Reason	Date

Women only: Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No

Medical History

☐ Headache _____
☐ Shortness of breath _____
☐ Heart palpitations _____
☐ Heart murmur _____
☐ Chest pain _____
☐ Dizziness/Fainting _____
☐ Peripheral vascular disease _____
☐ Allergies/Hay fever _____
☐ Asthma _____
☐ Bronchitis _____
☐ Pneumonia _____
☐ Ulcer _____
☐ GI disorder _____

☐ Lactose intolerance _____
☐ Gallbladder disease _____
☐ Prostate disease _____
☐ Bowel irregularity _____
☐ Incontinence _____
☐ Sexual/menstrual dysfunction _____
☐ Recent Fever _____
☐ Frequent infections _____
☐ Hepatitis _____
☐ Anemia _____
☐ Arthritis _____
☐ Osteoporosis _____
☐ Nervousness _____

☐ Difficultly Seein_____
☐ Blurred Vision _____
☐ Difficulty Hearin_____
☐ Ringing in Ears _____
☐ Skin Rash _____
☐ Bruisin_____
☐ Enlarged Lymph node _____
☐ Blood Clot _____
☐ Seizures _____
☐ Black or Red stool _____
☐ Recent Weight Loss _____
☐ Other _____
☐ Other _____

Habits

☐ Smoke: Packs daily _____
How long? _____
Interested in stopping? _____
☐ Exercise routine: _____
_____
_____

☐ Coffee: Cups daily _____
Other caffeine _____
☐ Alcohol: Type _____
Drinks per week _____
☐ Diet: Salt intake _____
Fat intake _____

☐ Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____

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Patient Registration

Date _____

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Name: _____

Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance Company _____
Insured/Card Holder's Name _____ Relationship _____
Policy # _____ Group # _____ Phone (___) _____

Your Pharmacy Information

Name of Pharmacy: _____
Pharmacy's Phone Number: _____ Zip Code: _____ Street/Address: _____

Emergency Contact

First Name _____ Middle _____ Sex _____
Last Name _____ Primary Phone (___) _____
Relationship _____ Secondary Phone (___) _____

Spouse/Guarantor/Responsible Party

First Name _____ Middle _____ Sex _____ DOB (MM/DD/YY) _____
Last Name _____ Primary Phone (___) _____
Address _____ Employer _____
City _____ State _____ ZIP _____ Relationship _____

Assignment of Benefits and Release of Patient Healthcare Information I hereby authorize Primary Health and Wellness Center,L.L.C. to release patient healthcare information compiled from the medical records pertaining to my services, in accordance with the policy of this office and Texas law, to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency. I hereby authorize the release any information acquired in the course of my treatment necessary to process insurance claims. I also hereby authorize payment of insurance benefits under the terms of my policy directly to Primary Health and Wellness Center,L.L.C. for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.	_____ Signature (Patient or Parent if Minor) Date
Financial Agreement and Statement of Responsibility For and in consideration of services rendered or to be rendered by Primary Health and Wellness Center,L.L.C., I agree to pay said office for all services and charges. Payment in full is due at time services are rendered or payment arrangements are to be made before your appointment.	_____ Signature (Patient or Parent if Minor) Date
AUTHORIZATION OF ELECRONIC COMMUNICATION: I hereby authorize Primary Health and Wellness Center to send and receive appointment reminders to me via electronic communication (i.e. Email, Text message, etc.).	_____ Signature (Patient or Parent if Minor) Date
Consent to Medical Treatment by a Family Nurse Practitioner I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services from a nurse practitioner. I fully understand that a family nurse practitioner IS NOT A PHYSICIAN. I further acknowledge that the general medical services provided to me by a family nurse practitioner are in conjunction with a collaborating physician and their collaborative agreement to provide services at Primary Health and Wellness Center,L.L.C. both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients.	_____ Signature (Patient or Parent if Minor) Date

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CURRENT HEALTH CONDITION

Please describe what kind of problems you are having and when it began:

Problem *When and How did condition start?*

Example: Lower back pain. I felt it first in early 2015 but had not felt it again until last night after exercising. session.

1)
2)
3)
4)
5)

Is this condition(s) getting..... ☐ Better ☐ **Worse** ☐ Unchanged

Is your condition(s) interfering with..... ☐ **Work** ☐ Housework ☐ Sleep ☐ Other _____

Have you missed work because of this condition? Yes ☐ **No** ☐

Have you been treated by other doctors/providers for this condition? Yes ☐ **No** ☐

If yes, please write their names and specialty:

Doctor/Provider *Speciality (family doctor, orthopedic, therapy.....)*

Please indicate what treatment you have had for this condition: *Medication* ☐ *Therapy* ☐ *Injection* ☐ *Surgery* ☐

Other: ***I am taking Ibuprofen for the pain.***

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HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____

1) Place a circle by a number to indicate your present pain level

0	1	2	3	4	5	6	7	8	9	10

(No Pain) (Extreme Pain)

2) Place a circle around a number to indicate your typical or average pain level in the past week:

0	1	2	3	4	5	6	7	8	9	10

(No Pain) (Extreme Pain)

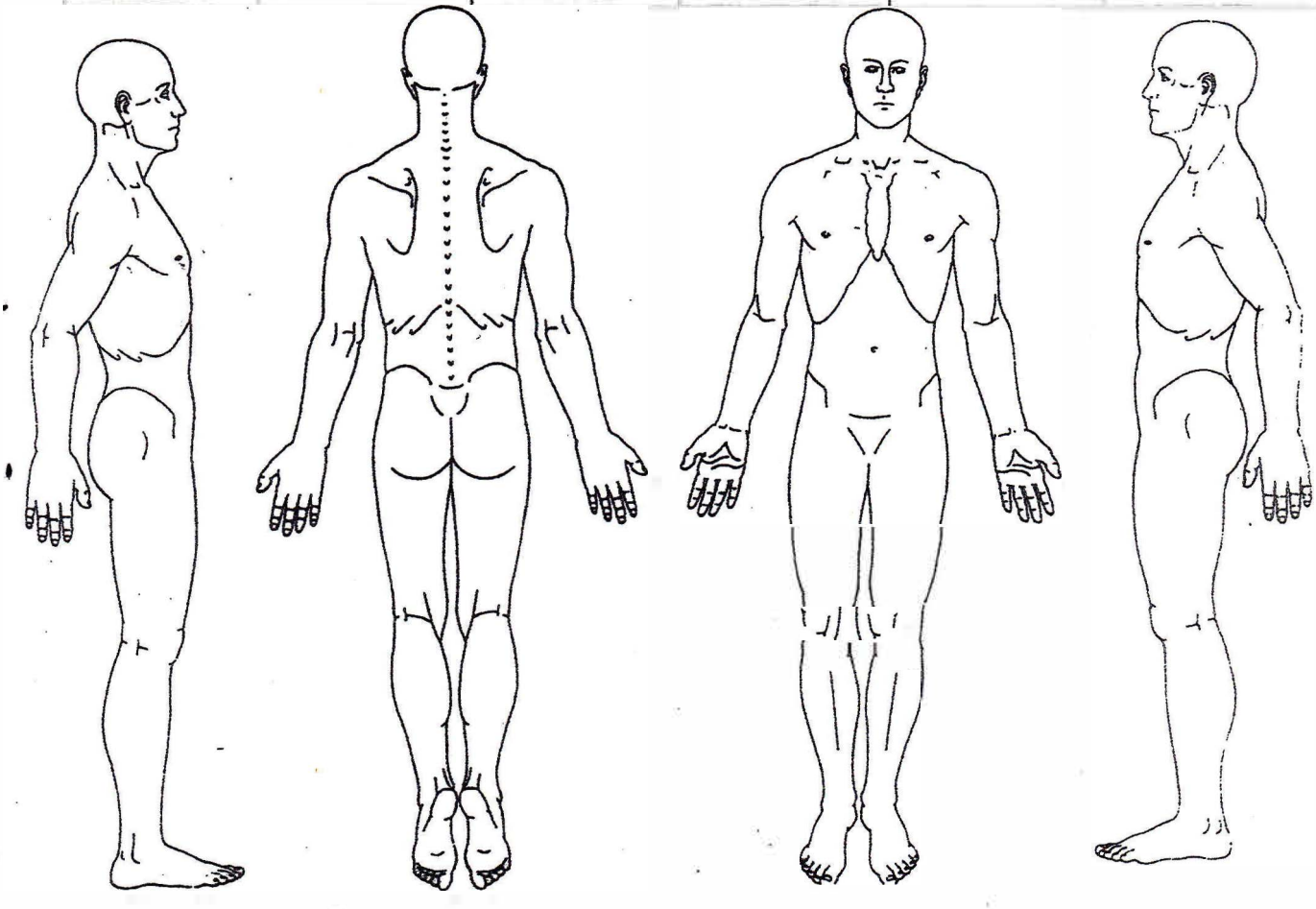
3) Place a circle around a number to indicate your worse pain level in the past week:

0	1	2	3	4	5	6	7	8	9	10

(No Pain) (Extreme Pain)

4) In the diagram below, mark the areas of the body, *using the symbols*, where you have experienced any of the following symptoms today:

ACHING	BURNING	STABBING	TINGLING	NUMBNESS	STIFFNESS
XXXXX	^^^^^^^	///////////	0000000	=======	++++++
XXXX	^^^^^	////////	000000	=====	+++++



Patient Signature: _____

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Health Insurance Portability and Accountability Act (HIPPA)
Privacy Compliance Patient Questionnaire

All patients have the right to have confidential care provided. All information, medical, or social (whether written, spoken, electronic or computer generated) is to be held in strict confidence. Please fill out this information in order for Primary Health & Wellness Center, L.L.C. to provide better service.

For any tests that may return with abnormal results, our office will notify you by telephone. Letters may be sent out regarding other tests. If you are not notified, please DO NOT assume everything is normal. Call our office if it has been over four weeks since your test and you have not been notified.

1. Please list the family members or other persons, if any, whom we may inform about general medical condition and your diagnosis. Please list complete name and phone number:

   _____

   _____

2. Please list the family members or significant others (if any) whom we may inform about your medical condition ONLY IN EMERGENCY. Please list complete name and phone number

   _____

3. Please print the address of where you would like your billing statements and/or Correspondence from our office to be sent:

   _____

   _____

4. Please print the telephone number and Email address (if any) where you want to receive calls about your appointments, lab and x-ray results, or other healthcare information:
   Phone Number: _____
   Email Address: _____
5. Can confidential messages (including appointment reminders) be left on your home answering machine or voicemail? Yes ☐ No ☐
6. If you DO NOT have voice mail, can a message asking you to call us about results or to confirm your appointment be left at your place of employment? Yes ☐ No ☐
7. Are you moving in 30 days, or changing your home or work phone number? If so, please notify our office as soon as you have your new information in order for us to contact you with any test results or provide information below:
   New address and effective date:

   _____

   _____

   New phone number(s) and effective date: _____

_____ (Guardian if under 18 years old)
Patient Name (Printed)

_____ _____
Patient/Guardian Signature Date

Primary Health & Wellness Center, L.L.C.

Written Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, you acknowledge receiving the Primary Health & Wellness Center, L.L.C. Notice of Privacy Practice ("Notice"). The Notice explains how Primary Health & Wellness Center, L.L.C. may use or disclose your protected health information for treatment, payment, and healthcare operation purposes. "Protected Health Information" refers to your personal health information found in your medical and billing records.

Primary Health & Wellness Center, L.L.C. reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice will be posted at patient service locations throughout Primary Health & Wellness Center, L.L.C.. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, Primary Health and Wellness Center, L.L.C. will have available for you, at your request, a copy of the current Notice in effect.

YOUR SIGNATURE BELOW ONLY ACKNOWLEDGES THAT YOU HAVE RECEIVED THIS NOTICE

Contact information is located in the Notice

Name of Patient (Printed): _____

Name of Guardian (if under 18 years of age; Printed): _____

Signature of Patient or Guardian: X_____

Date: _____

( ) Signature declined. On the initial patient visit, the practice made a good faith effort to obtain the patient's written acknowledgement of our notice of privacy policies. _____ **Staff Initials**