Vital Step Medical Center PLLC

2425 County Rd 90 Pearland TX 77584
Ph. 281-997-7333 Fax. 281-485-1146

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurse practitioner, physician assistant, medical assistants, and office staff work closely in a "team approach" to support your patient care.

Our Pearland office is open Monday through Friday from 8:30am-5:00pm.

Our offices will be closed for major holidays and any inclement weather days. Every effort is made to see our patients for medical problems during the daytime hours. Please note that our schedulers are available every day and will do their best to accommodate you. Booking an appointment in advance is essential to ensuring all patients receive the time they require for quality medical care. After hours we provide on-call answering services to be able to leave messages. As your primary care physician, we work collaboratively with your physician specialist to coordinate all aspects of our patient care including inpatient hospitalization and specialty consultation care, as needed.

Before you visit, please notify your health insurance company of your new primary care provider if required. We also request that a copy of your medical records be sent to us. Please fill out the enclosed forms during your initial visit, we will be reviewing your health status, and these forms contain information necessary to complete this process. Please bring your health insurance identification card as well as a photo I.D. Please bring a completed list of all your medications, as well as the strength and dose of each one.

Once again, we would like to thank you for choosing us as your primary health care.

Sincerely,

The Providers and Staff of Vital Step Medical Center PLLC /Simcare, PLLC Medical Group

Vital Step Medical Center PLLC

Thank you choosing our office with your healthcare needs! In order to serve you properly, we need the following information. All information will be confidential.

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Race: _____ Ethnicity: _____ Language: _____

Emergency Contact Name: _____ Phone #: _____

Relationship to ER contact: _____

Pharmacy Name: _____ Phone # _____

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Signature of Patient **Date**

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General Review Of Symptoms

Patient Name: _____ DOB: _____ Date: _____

Are you experiencing any of these symptoms?

O Fever	O Runny Nose	O Itchy Nose
O Frequent Sneezing	O Itchy Nose / Lips / Throat	O Postnasal Drip
O Ringing in the ears	O Cough	O Stuffy Nose

Are you experiencing or have experienced any of these symptoms / conditions now or during the last 1 year?

O Sinus Related	O Fatigue	O Numbness
O Re-occurring seasonal cold	O Drowsy Driving	O Tingling
0 Cough	O Concussion	O Abnormal Involuntary
O Chronic Cold	O Choking / gasping	O Migraines Headaches
O on CPAP Treatment	O Changes in coordination	O COPD
O Prior OSA Diagnosis	O Vertigo / Dizziness	O Snoring During the night
O Trauma/ Head Injury	O Consistent or re-occurring	O Morning Headaches
O Changes in Vision	O Reactive	O Difficulty Sleeping
O Psychiatric Disorder	O Sinusitis	O Head Injury
O Epilepsy Surgery	O Asthma	O Loss of Consciousness
O Anticonvulsant Therapy	O Dry and / or itchy skin	O Tics / Tourette
O ADHD	O Sinusitis	O Epilepsy
O Memory Problems	O Bronchitis	O Brain / Spinal Tumor
O Abnormal Movements	O Recurring Bronchitis	O Seizures with Fever
O Changes in language	O Excessive Sleepiness	O Aneurysm
O Changes in memory,	O Observed apneas	O Fainting Spells
O Change in Speech	O Weakness	O Leg Restlessness / Jerks

Other: _____

Have you had your annual physical?	**O Yes O No**
Do you need medication refills?	**O Yes O No**
Have you been to ER or Hospitalized since your last visit?	**O Yes O No**

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Adult Health History

Are you currently or have you ever been treated for:

ASTHMA	YES – NO	
PSYCHOLOGY/PSYCHIATRIC	YES – NO	
BLOOD PRESSURE	YES – NO	
BLEEDING DISORDER	YES – NO	
CANCER	YES – NO	
CHOLESTEROL	YES – NO	
DIABETES	YES – NO	
EMPHYSEMA	YES – NO	
EPILEPSY – SEIZURES	YES – NO	
GALL BLADDER DISEASE	YES – NO	
GOUT	YES – NO	
HEART DISEASE	YES – NO	
HEMORRHOIDS	YES – NO	
EAR / SINUS	YES – NO	
KIDNEY DISEASE	YES – NO	
MENSTRUAL PROBLEMS	YES – NO	
MUSCULO-SKELITAL DISEASE	YES – NO	
SLEEP DISORDER	YES – NO	
THYROID DISEASE	YES – NO	
SERIOUS INJURY	YES – NO	
OTHER	YES – NO	

List all prescribed medications you are currently taking and please bring all your medication bottles with you at your appointment.

Medication	Dose	Reason

Any allergies to medications: _____

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Surgeries and/or Hospitalization:

Reason n Type	Month/Year

Family History:

Relative	Age	Age at death	Illness

Social History:

Do you drink coffee? O Yes O No
Do you use alcohol? O Yes O No
Do you use cocaine, heroin, marijuana, etc.? O Yes O No
Do you currently smoke or chew tobacco? O Yes O No
Have you ever smoke or chew tobacco? O Yes O No

Females Only:

Number of pregnancies ___ Number of live births ___ Number of abortions ____
When was you last papsmear? _____
When was your last mammogram? _____
When was the first day of your last period? _____

Males Only:

Do you have any sensation of not emptying bladder? O Yes O No
Do you have to push or strain to begin urination? O Yes O No
Do you have a weak urinary stream? O Yes O No
How many times do you get up at night to urinate? ____

Vaccines:

TDAP O Yes O No Date:
Shingles O Yes O No Date:.
Influenza O Yes O No Date:
Pneumonia O Yes O No Date:

OFFICE POLICIES FOR OUR PATIENTS

Thank you for choosing Vital Step Medical Center PLLC / SIMCARE PLLC as your Primary Care. We are committed to provide highest quality of care. Policies are designed to make the care we provide more streamlined, efficient, and patient-centered for you.

OFFICE HOURS: Monday - Friday 8:30am - 4:30pm (We are closed for Lunch from 12:45 to 1:45pm)

Telephones are answered during regular office hours Monday to Friday and our staff will always assist you to the best of their abilities. However non - urgent questions and messages will be answered at the end of the day or following day unless urgent.

APPOINTMENTS/CANCELLATIONS/NOSHOWS:

We prefer to diagnose your illness in the office instead of over the phone. We hope that our hours and same day scheduling will accommodate your busy schedule and enable you to come in and see us for the best possible medical care.

Appointments can be scheduled by phone or in person at the office. Please contact the office ahead of time if you cannot make your appointment on time, so we may offer that time to another patient. If you fail to cancel, you will be billed the cancellation fee. Please review cancellation policy.

MEDICATION REFILLS.

Under no circumstances will refill request be processed during non-office hours. All refill requests should be made during normal Business Hours or Prior to Holidays. Prescription refills, appointment scheduling, and Lab/Test results will be handled only, during routine office hours. Please allow at least 3 business days to process refills. Please take the “no refills” message on the prescription bottle as a reminder to schedule your next office visit. Please understand that this policy is for your safety and in your best interest.

MEDICAL FORMS: There will be a fee charged for filling out a variety of health – related forms. The fee will be $25.00. Forms cannot be filled out while you wait. We need at least 3-4 days to fill out most forms.

CONTROLLED MEDICATION POLICY: Controlled medication presents unique challenges in primary care. At SIMCARE we prefer that our patients use Pain Medicine Specialist for chronic pain medication and Psychiatrists for chronic anti-anxiety medications. We are extremely selective in prescribing addictive medications of any type. We have very strict policies and make no exceptions. Unwillingness to follow our medical recommendations concerning the use of addictive medications will result in dismissal from practice. No phone refills for controlled substances. They need regular office visits. If patient fails to follow with regular visits, no refills will be given.

INSURANCE: PLEASE MAKE SURE PRIOR TO YOUR APPOINTMENT THAT WE ARE THE PARTICIPATING PROVIDER TO YOUR INSURANCE PLAN. Some of the services you receive may not be covered by your insurance and you will be responsible for the payment. Please check with your insurance for your benefits prior to service. It is important to be aware of your insurance plan polices regarding: co-payments, deductibles, co-insurances, in and out of network status and responsibilities, and referral requirements.

PAYMENTS/BALANCES: ALL CO-PAYS AND BALANCES ARE DUE AT THE TIME OF YOUR OFFICE VISIT. As a courtesy to our patients, we will submit charges to your health insurance companies. However, you as the patient are ultimately responsible for payment on any services provided by our office. ALL OUTSTANDING BALANCES NOT PAID BY INSURANCE COMPANY ARE PATIENT RESPONSIBILITY, STATEMENTS WILL BE SENT TO THE ADDRESS PROVIDED. IN THE EVENT OF NONPAYMENT ALL ACCOUNTS WILL BE OUTSOURCED TO THIRD PARTY COLLECTIONS.

WELLNESS/SICK VISIT: Preventative Medical Visit includes age and gender appropriate history, examination, counseling, screening lab and imaging. INSURANCE PROVIDERS MAY OR MAY NOT PROVIDE COVERAGE FOR SCREENING LABS OR IMAGING; rules are carrier specific. Preventative Visits are exempt from Copayments, however, if an abnormality is encountered or a preexisting problem is addressed in the process of performing preventative evaluation and requires additional work up or medication, then A SEPARATE OFFICE VISIT CODE MAY BE CHARGED. The use of additional code will require a copayment if one is charged by your insurance plan have read and understand all of this information, I agree to all of the above policies and procedures.

Signature: _____. Date: _____

If you have any questions, please do not hesitate to ask one of our staff members.

Vital Step Medical Center PLLC

MEDICATION AGREEMENT

• **You agree to take the medications at the dosage and frequency prescribed**.
You MUST follow the prescription directions exactly. Although it may be tempting, do not take less medication on low-pain days so you will have extra left for high-pain days.

• **You agree not to increase, decrease or change in any way how you take the medications without the prior approval of your management doctor.**
If you feel the dosage prescribed is too low because you're still in a lot of pain or too high because you feel lightheaded all the time, call your doctor and tell her what you're experiencing. Do NOT under any circumstances change the dosage on your own. If you are drug tested and found to have too much in your system, it will be assumed you are abusing the drugs. On the other hand, if you have too little of the drug in your system, it will be assumed you are selling or giving your medication to someone else.

• **You agree to random drug testing to assure you are only taking the prescribed medications in the prescribed amounts**.
While you know you are trustworthy and would not abuse drugs, there is no way for your doctor to know that. Because prescription drug abuse is so prevalent today, physicians have to be extra vigilant. If a doctor is found to be prescribing controlled substances to people who are either abusing them personally or selling them to others, he can lose his medical license and face criminal prosecution.
You agree to obtain all of your medications at one pharmacy, which you must name, and give your consent for the physician and pharmacist to exchange information about you.
The reason this is included is because abusers sometimes try to obtain prescriptions from multiple doctors and fill them at different pharmacies. Since prescriptions are now entered into computers with interconnected databases, this practice is currently much more difficult to get away with.

• **You understand that lost, stolen or destroyed prescriptions and medications will not be replaced under any circumstances**.
Some agreements may allow the doctor to use his discretion in the event your medication is stolen and you file a police report, but he is not required to replace the stolen medication. Therefore, it is essential that you safeguard your medications and make sure no one else has access to them. Ideally, all opioid meds should be kept under lock and key.

• **You agree to inform your management physician of all other medications you are taking.**
Although it is important to inform every doctor you see of any medications and supplements you take, it is essential that you do so with the physician who manages your pain and writes your opioid prescriptions.

• **You agree to inform your other health care providers of the medications you are taking and of the agreement you have signed**. **This includes dentists and emergency care providers.**
It is not unusual for other doctors and dentists to prescribe a short-term opioid for special circumstances, such as oral surgery or an injury requiring emergency room care. However, if you have signed a medication agreement, ONLY your management physician can prescribe these drugs for you. Other health care providers must contact your pain management doctor if you have a need for additional pain medication.

• **You agree not to request any pain medications or controlled substances from other health care providers**.
As stated before, only the physician who is managing your pain treatment can prescribe opioids or other controlled substances for you.

• **You agree not to use illegal drugs, street drugs, or another person's prescription**.

• **You agree to keep all of your scheduled appointments.**
We require a 24-hour's notice to cancel an appointment and/or have a maximum number of appointments you can reschedule and still continue to be treated. The main reason for including this stipulation is to prevent you from canceling an appointment because you have been using your medications improperly and are afraid you would not pass a drug test.

• **You will likely be told that your physician may stop prescribing controlled medications**: If you show little or no improvement, quickly develop a tolerance for the treatment, experience significant side effects from the medication, and/or fail to abide by the terms of the agreement.

Print Name: _____ Patient Signature: _____ Date: _____

Vital Step Medical Center PLLC

HIPPA NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosures of protected health information
Treatment: We will use and disclose your protected health information to provide coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.
Healthcare operations: We may use or disclose as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training or medical students, licensing, and conducting or arranging for other business activities.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable diseases: Health Oversight: Abuse or Neglect: Food and drug administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the secretary of the department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. other permitted and Required Uses and Disclosure will be made only with your consent. You may revoke this authorization at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Your Rights: following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information.
You have the right to request a restriction of your protected health information.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location; you have the right to obtain a paper copy of this notice form us.
You may have the right to have your physician amend your protected health information.
You may have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.
You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us.
You may file a complaint with us by notifying our privacy contact of your complaint we will not retaliate against you for filling a complaint.
We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 281-395-8688.

_____	_____	_____
Print Name	Patient Signature	Date

Vital Step Medical Center PLLC

Conditions for Disclosure

It is often difficult to talk to patients in person. Therefore, we must have your permission as to how we may communicate with you. Please check if you agree to the following conditions.

_____ The practice may disclose my medical information to me and to the following individual(s) in my presence and when I am not physically present, including disclosures by telephone, voice mail, email or regular mail.
If you do not agree please give other instructions: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give permission for Simcare PLLC and its staff to disclose my personal medical information to the following individuals.

NAME	Relationship to Patient

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Name (print): _____ Date: _____

Patient Signature: _____

Witnessed by: _____ Title/Position: _____

Vital Step Medical Center PLLC

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to SIMCARE PLLC. When you schedule an appointment with SIMCARE we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. You may contact us during normal office hours at 281-997-7333 or through the Patient Portal 24/7. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

• Effective September 1, 2019, any established patient who fails to show or cancel/reschedule an appointment and has not contacted our office with at least 24 hours' notice, will be considered a No Show and charged a $25.00 fee.

• Any established patient who fails to show or cancel/reschedule an appointment without 24 hours' notice a second time will be charged a $50.00 fee.

• If a third No Show or cancellation/ reschedule without 24-hour notice should occur, the patient may be dismissed from SIMCARE or changed to Walk-in Status. Once on Walk-in status you may schedule an appointment at 8:00 AM or 1:00 PM only if space is available.

• Any new patient who fails to show for their initial visit will be switched to Walk-in Status.

• The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

• As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder, call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager who may be able to waive the No Show fee.
I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____	_____	_____
Print Name	Patient Signature	Date