Sweetwater Medical Associates, PLLC
16651 Southwest Freeway, #100
Sugar Land, Texas 77479
281/494-4900

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the care of the patient named on this form, including, but not restricted to drugs, medications, lab tests or other studies, which may be used, by the physician and/or his/her qualified designate.

I understand and acknowledge that I am solely responsible for providing the valid and correct insurance information for any services provided by Sweetwater Medical Associates before services are rendered. I also understand by failing to supply said information that I will be entirely responsible for payment in full.

Sweetwater Medical Associates, PLLC verifies insurance coverage & files claims as a courtesy to our patients'. Upon verification of patient benefits, every insurance company has a disclosure statement stating there is no guarantee of coverage. Therefore, we too cannot guarantee your coverage. It is your responsibility, as the insured, to confirm with your insurance company as to what is covered and what is not covered, under your policy. By signing below, I acknowledge that any charges, not covered under my insurance, are my sole responsibility.

At the time services are rendered I acknowledge and understand: 1) I am fully responsible for cash payment (if self pay or auto accident), co-payment, deductible and/or co-insurance of such services and agree to pay my bill ***at the time services are rendered unless other arrangements are made with the financial department in advance***. 2) That it is my sole responsibility to provide the correct insurance information for the services rendered on any given day in order for Sweetwater Medical Associates to bill my insurance company. 3) Sweetwater Medical Associates will not bill to any insurance provided after services are rendered. 4) Should I fail to provide the correct information at the time services are rendered, I am ultimately responsible for payment in full, before being issued an itemized receipt, and that no contractual adjustments will be honored.

I authorize Sweetwater Medical Associates to release information as required to my insurance or third party payer (including my employer or my employer's worker's compensation carrier) for the purposes of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/or mental issues. I also authorize Sweetwater Medical Associates to bill my insurance or third party payer and receive payment directly from them for services rendered.

This authorization shall remain valid for a period of one year or until such as I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Patient Name: _____ Signed: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____ Date: _____/_____/_____

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:

_____
Name of person or organization

_____
Name of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____
Name of person or organization

_____
Name of person or organization

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Sweetwater Medical Associates, PLLC. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
The person or organization to which it is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____
Name of patient (Print or type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

PATIENT SYMPTOMS UPDATE

SWEETWATER MEDICAL ASSOCIATES

Providers: Jeffory Alford, M.D. Dina White, M.D. Jonathon Shaffer, M.D.

Patient Name: _____ Today's Date: _____ DOB: _____ AGE: _____

Best Daytime #: _____ Best Evening #: _____ e-mail: _____

Height: _____ Weight: _____ ( ) OK to leave message? Y / N

General Health Questions: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
High Blood Pressure, Low Blood Pressure, Rapid Heart Rate, Irregular Heart Rate, etc	Y / N
High Cholesterol	Y / N
Difficult Breathing (COPD, Asthma, etc)	Y / N
Digestive Disturbances (Indigestion, Constipation, Irritable Bowel Syndrome, etc)	Y / N
Endrocrine (Diabetes, Thyroid, etc)	Y / N
Chronic Pain Syndromes (Chronic Fatigue Syndrome, Fibromyalgia, etc)	Y / N
Migraines or Other Headaches	Y / N

Neurological & Brain Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you have a history of Epilepsy or Seizure activity?	Y / N
Have you ever had abnormal involuntary muscle contractions, jerking or convulsions?	Y / N
Have you ever had a mini stroke? If yes, did you lose consciousness?	Y / N
Have you ever had a concussion? If yes, did you lose consciousness?	Y / N
Have you ever Fainted or had any unexplained loss of consciousness? Explain	Y / N
Have you ever had unexplained episodes of Confusion or Loss of Awareness?	Y / N
Do you ever feel Disoriented, Feel Brain Fog, Zone Out, lose track of time or where you are?	Y / N

Quality of Sleep: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months			
Do you stop breathing, choke, or gasp for air during sleep?			Y / N
Do your legs kick at night and interfere with your sleep?			Y / N
Have you been told that you snore loudly?			Y / N
Do you have difficulty falling and staying asleep?			Y / N
How many hours of restful sleep do you get most nights?			_____
How likely are you to Doze off or Fall Asleep in the following situations? (0=Never,1=Slight,2=Moderate,3=High)			
Sitting and Reading	0 1 2 3	Lying Down to Rest in the Afternoon	0 1 2 3
Watching Television	0 1 2 3	While Having a Relaxed Conversation	0 1 2 3
Sitting Quietly After Lunch	0 1 2 3	In a Car While Stopped at a Traffic Signal	0 1 2 3
As a Passenger in a Car for One Hour	0 1 2 3	Sitting Inactive in a Seminar, Theater or Meeting	0 1 2 3

Bladder Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you lose urine while coughing, sneezing, laughing, lifting, jumping or running?	Y / N
Do you use protective undergarments because you cannot hold your urine?	Y / N
Do you wet your clothing because you cannot make it to the bathroom in time?	Y / N
Do you have to hurry to empty your bladder when full?	Y / N
How often do you; urinate during the day? _____ times; wake to urinate during the night? _____ times	

Balance & Fall Prevention: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have you ever Fainted, Lost Your Balance, Feel Dizzy or Unsteady?	Y / N
Does dizziness or imbalance problems interfere with your job or your household responsibilities?	Y / N
Do you feel dizzy when rising from a seated or lying position?	Y / N
Have you fallen more than once in the past year?	Y / N

Nerve and Muscle Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you experience ANY of the following (*please check those that apply*):	
( )Radiating Pain, ( )Numbness, ( )Tingling, ( )Burning, ( )Coldness, ( )Sharp Pain, ( )Dull Pain	
In The: ( ) Neck, ( ) Shoulders, ( ) Arms or ( ) Hands (ie Upper extremities)	Y / N
In The: ( ) Low Back, ( ) Hips or ( ) Legs (ie Lower Extremities)	Y / N
Have you experienced loss of motion or weakness in your neck, shoulders, arms or hands?	Y / N
Have you experienced loss of motion or weakness in your low back, hips or legs?	Y / N
Have you been told that you have Neuritis or Neuropathy?	Y / N
Do you experience tremors, spasms, cramps, involuntary muscle movements?	Y / N

Cognitive Brain Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have daily problems with making judgments or decisions?	Y / N
Have daily problems with memory / Repeat the same things over and over again (questions, stories, statements) ?	Y / N
Have you been told that you may have dementia or pre-dementia?	Y / N
Have feelings of Anxiety and/or Depression?	Y / N
Have trouble handling financial affairs (paying bills) or learning how to use a tool, appliance or gadgets?	Y / N

Cognitive Behavioral Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have difficulty getting organized or Avoid getting started on a challenging task?	Y / N
Have trouble completing assignments or tasks?	Y / N
Fidget or squirm with your hands or feet when you have to sit for a long time?	Y / N
Feel overly active or feel like you have to constantly do something, like you were driven by a motor?	Y / N

Allergy & Immunology: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you have Allergy and Hay Fever symptoms, such as sneezing, watery nasal drainage and nasal itching?	Y / N
Do you have persistent nasal congestion and/or post nasal drip?	Y / N
Do you have sinus problems, frequent colds, sinus headaches?	Y / N
Do your eyes itch, water, get red and/or swell?	Y / N
Do you have asthma, tight chest, and or persistent cough?	Y / N
Do you have skin problems such as eczema, hives or itching?	Y / N
Are you aware of any Food Allergies that you may have?	Y / N
My Symptoms are Worse when:	
( ) Seasons Change ( ) going from indoors to outdoors ( ) in parks and grassy areas ( ) around animals	
( ) while vacuuming or around dust ( ) in the morning and/or after waking	
Do you take medications to control your allergies? If so, describe: _____	
Do they help?	Y / N

Major Accidents/Traumas: _____

Major Surgeries: _____

Medications: _____

This Patient Symptoms Update, which will be part of your medical record, lists symptoms and other factors that may allow your physician to recommend appropriate diagnostic studies to better manage your care. *Upon review and approval*, you may be contacted by our Medical Services Scheduling Company to schedule these tests.

Patient Signature: _____ Date: _____

(rev 2-9-2017, Fax 281-310-6330)