SWEETWATER MEDICAL ASSOCIATES
16651 Southwest Freeway, Suite 100
Sugar Land, Texas 77479
Telephone: (281) 494-4900 Fax: (281) 494-4905
www.sweetwatermed.com

General Physical Exam

Most insurance companies will pay for only <u>one type</u> of visit in a day: either an annual/general physical exam or an illness/problem exam.
If the physician does address a condition outside of the"Annual/General Physical Exam", be aware that you will be responsible for TWO SEPARATE CO-PAYMENTS on the same day.

Thank you for scheduling your annual physical exam with our office. This exam consists of the following elements:

1) A review/update of your family history of diseases and medical conditions.
2) A review/update of your social history including tobacco use, alcohol use, drug use.
3) A review of your medical risk factors-this is not to change treatment or refill medications. This is to help make decisions in risk assessment for heart attacks, cancer, lung disease, etc....
4) Physical examination.
5) The need for lab work, diagnostic testing, imaging and/or vaccination is determined from the above information.

****Again, due to restrictions by your insurance company, if we address any medical problems outside of the above-mentioned list, which constitutes an "Annual/General Physical Exam", they may not cover more than one type of visit in a day.****

**********BY SIGNING BELOW, I AGREE THAT ANY SYMPTOMS, MEDICAL PROBLEMS, AND/OR LABS NOT ASSOCIATED WITH THE ABOVE-MENTIONED LISTING, THAT ARE REQUESTED BY ME TODAY ARE MY RESPONSIBILITYTO PAY AT TIME THE SERVICES ARE RENDERED. IN THE EVENT THAT MY INSURANCE WILL NOT PAY FOR BOTH A SYMPTOM VISIT AND A PHYSICAL IN THE SAME DAY, I WILL BE FULLY RESPONSIBLE TO PAY FOR NON-COVERED SERVICES. **********

If you have a new or acute medical condition that you feel needs to be addressed today, please notify the medical assistant and we will help you reschedule your general physical exam to another time, or if you choose to have your acute problem evaluated today you will be expected to pay two separate co-payments.

Thank you for your understanding and cooperation in this matter.

Jeffery T. Alford, M.D.
Jonathon B. Shaffer, M.D.
Dina B White, M.D.

_____
Date

_____
Patient Name

_____
Medical Assistant Signature

_____
Patient Signature

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Services Waiver

Date: _____/_____/_____ Patient: _____

Dear Patient,

Before receiving the following treatment we need to make you aware and have you sign that you have been made aware of the possibility you may be financially responsible for charges incurred.

Your insurance company will only pay for services that it determines to be "Reasonable and Necessary" or a covered benefit. Medicare will only pay for services that it determines to be "Reasonable and Necessary" under section 1862 (a) (1) of the Medicare Law. If your insurance carrier or Medicare determines that a particular service is not "reasonable and necessary" under their standards, they will deny payment for that service. Most insurance companies do not pay for routine examination/lab work, lab testing utilized as a screen to rule out a condition, pre-existing conditions or experimental treatment that has yet to be proved effective. Medicare does not cover routine examination/lab work.

Although this wording implies your insurance company may not consider this/these services medically necessary, I emphasize that in my professional judgement, the service(s) listed below is/are needed in order to render high quality care to you.

Your insurance carrier and/or Medicare may deny payment for the following service(s):

☐ Ambulatory Blood Pressure Monitor	☐ Hepatitis A or B Vaccine	☐ Pulse Oximetry
☐ Audiogram/Tympanogram	☐ Holter Monitor	☐ Sleep Study
☐ B-12 Injection	☐ Influenza vaccine	☐ Spirometry/Nebulizer
☐ Bone Mass Density	☐ Normal Saline w/ KOH Mount	☐ Stool Guaiac Test
☐ Depo-estradiol Injection	☐ Pap Smear	☐ TB Test (PPD)
☐ Dipstick Urinalysis/Microalbumin	☐ Pneumococcal Vaccine	☐ Tetanus Vaccine
☐ EKG	☐ PT/INR	☐ Weight Loss Program
☐ HPV Test		

☐ Other: _____

Beneficiary Agreement:

By signing below, I acknowledge that I have been notified by my physician that (s)he believes that, in my case, my insurance company and/or Medicare may deny payment for the services identified above. If insurance denies payment, I understand and agree to be personally and fully responsible for payment.

Patient Signature: _____ Date: _____/_____/_____

Witness Signature: _____

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)

Name:
Date:

Hearing Health Questionnaire

The onset of hearing loss is usually very gradual. It may take place over 25-30 years or it may happen more rapidly if you are exposed to loud noises at work or through hobbies. Because it usually occurs slowly, you may not even be aware you have a problem until someone else brings it to your attention. Here is a simple test you can take to determine if you have a hearing problem.

1. Do you ever experience feelings of dizziness? Yes or No

2. Do you have ringing or other noises (tinnitus) in your ears? Yes or No

3. Do others complain that you watch television with the volume too high? Yes or No

4. Do you frequently have to ask others to repeat themselves? Yes or No

5. Do you have difficulty understanding when in groups or in noisy situations? Yes or No

6. Do you have to sit up front in meetings or in church in order to understand? Yes or No

7. Do you have difficulty understanding women or young children? Yes or No

8. Do you have trouble knowing where sounds are coming from? Yes or No

9. Are you unable to understand when someone talks to you from another room? Yes or No

10. Have others told you that you don't seem to hear them? Yes or No

11. Do you avoid family meetings or social situations because you "can't understand"? Yes or No

English

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Well Woman Exams

Thank you for scheduling your well woman exam with our clinic. This exam is conducted in our office much as it would be in a gynecologist's office and includes the same elements to the exam. These are:

Breast Exam	Urinalysis
Pelvic Exam	Birth control or hormone replacement therapy
Pap Smear	

Due to restrictions by your insurance company we cannot address medical problems outside of the above-mentioned list, which constitutes a "Well Woman Exam". Most insurance companies will pay for only one type of visit in a day: either a well/physical exam or an illness/problem exam. Also note, that most insurance companies will not pay for more than one well-woman exam per calendar year, while others will only pay for one every 365 days. Should your insurance company not allow coverage for today's exam or testing that is part of the exam, such as the HPV test, which is recommended for women ages 30 and above, due to these or any other factors you will be responsible for payment. **If you decide not to receive one of the exams or tests recommended during your Well Woman Exam please note that determining medical conditions may not be targeted and will not allow early symptoms and concerns to be evaluated.**

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If you have a new or acute medical condition that you feel needs to be addressed today, please notify the medical assistant and we will help you reschedule your well woman exam to another time. This will allow for us to evaluate your acute problem today.

Thank you for your understanding and cooperation in this matter.

Jeffery T. Alford, M.D.
Jonathon B. Shaffer, M.D.
Dina B White, M.D.

_____
Date

_____
Patient Name

_____
Medical Assistant Signature

_____
Patient Signature

BREAST CANCER RISK SURVEY

Patient Name: _____ Date:_____

Patient Instructions:
While you are waiting to see the physician, we ask that you complete the survey below. It will help us to assess your risk for developing breast cancer. Thank you.

Have you ever had breast cancer? **Yes** ☐ **No** ☐
If you checked "yes," you have completed this survey. Please give the survey to your health care provider

1. Have you ever had a breast biopsy that showed lobular carcinoma in situ (LCIS) or ductal carcinoma in situ (DCIS)? **Yes** ☐ **No or Don't Know** ☐

2. How old are you? _____

3. How old were you when you had your first menstrual period? _____

4. How old were you when your first child was born?
(If you never had a child, enter "0.") _____

5. How many of your sisters, daughters, or mother have had breast cancer? _____

6. Have you ever had a breast biopsy? (A breast biopsy is when the doctor removes tissue from your breast to test for cancer.) **Yes** ☐ **No** ☐ **Don't know** ☐

   6a. If yes, how many breast biopsies have you had? _____

   6b. Did the doctor ever tell you that one of your biopsies showed atypical hyperplasia (a precancerous condition)? **Yes** ☐ **No** ☐ **Don't know** ☐

7. What is your race? **White** ☐ **Black** ☐ **Asian** ☐

Thank you for completing this survey. Please give the survey to your health care provider. The doctor will discuss the results with you.

Health Care Provider Instructions:
Please use this survey in conjunction with the Gail Model Risk Assessment Tool.

ZENECA
Pharmaceuticals

Roche Pharmaceuticals

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☐ Bone Mass Density	☐ Normal Saline w/ KOH Mount	☐ Stool Guaiac Test
☐ Depo-estradiol Injection	☐ Pap Smear	☐ TB Test (PPD)
☐ Dipstick Urinalysis/Microalbumin	☐ Pneumococcal Vaccine	☐ Tetanus Vaccine
☐ EKG	☐ PT/INR	☐ Weight Loss Program
☐ HPV Test		

☐ Other: _____

Beneficiary Agreement:

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Patient Signature: _____ Date: _____/_____/_____

Witness Signature: _____