



PATIENT DEMOGRAPHICS

243 FM 1903, Suite 800 | Greenville, TX 75402 | Phone: (903) 310-3231 | Fax: (866) 538-5188

Patient Information

Last Name: _____ First Name: _____ M.I.: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Information

Phone: _____

Is this a mobile number? Yes No

Do you consent to receive text messages from Nuvia Health regarding appointments, results, and health communications?

Yes No

Message and data rates may apply. You may opt out at any time by notifying the office.

Email Address: _____

Do you consent to receive non-urgent communications from Nuvia Health at this email?

Yes No

Gender & Identity

Sex Assigned at Birth:

Female Male Prefer not to answer

Pronouns (optional): _____ Preferred Language: _____



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Insurance -- Primary

Carrier Name	Group Number
ID Number	Relationship to Subscriber
Subscriber Name (if not self)	Subscriber DOB

Subscriber Address (if not self): _____

Insurance -- Secondary (if applicable)

Carrier Name	Group Number
ID Number	Relationship to Subscriber

Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

Do you authorize Nuvia Health to electronically send prescriptions?

Yes No

Emergency Contact

Name: _____

Phone _____ Relationship to Patient _____

This individual will only be contacted in the event of an emergency and is not authorized to receive medical information unless otherwise permitted by law.

Acknowledgment & Signature

By signing, I acknowledge the accuracy of the information provided above.

Patient Signature

Date



HEALTH HISTORY FORM

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Patient Name: _____ Date of Birth: _____ Date: _____

ALLERGIES

List all allergies (medications, food, environmental):

FAMILY & PERSONAL HEALTH HISTORY

Condition	Self	Mom	Dad	Sis	Bro	GM	GF
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Type:____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes — Type 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes — Type 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IBS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATIONS & SURGERIES

Hospitalization / Surgery	Reason	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



HEALTH HISTORY FORM

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CURRENT MEDICATIONS

Include Rx, OTC, vitamins, and supplements.

Medication	Dose	How Often	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTHCARE SCREENINGS

Screening	Date	Screening	Date
Routine Physical Exam	_____	Routine Eye Exam	_____
Stool Occult Blood	_____	EKG	_____
Cardiac Stress Test	_____	Sigmoidoscopy	_____
Colonoscopy	_____	Bone Density Scan	_____
Tetanus Shot	_____	Pneumonia Shot	_____
TB Skin Test	_____	Mammogram	_____
PAP Smear	_____		

HABITS & LIFESTYLE

Do you use any form of tobacco? Yes No
Type/amount: _____

Do you drink alcoholic beverages? Yes No
Type/amount: _____

Do you use recreational drugs? Yes No
Details: _____

Are you sexually active? Yes No

Do you exercise regularly? Yes No
Type/freq: _____

Do you follow any special diet? Yes No
Describe: _____

FEMALE PATIENTS ONLY

Age Menses Began: _____ Regular Menses: Yes No

Last Menstrual Period: _____ Last Mammogram: _____

Last PAP: _____ OB/GYN: _____

Pregnancies: _____ Live Births: _____

Birth Control: _____ Currently pregnant? Yes No

CERTIFICATION & SIGNATURE

I certify that the above information is correct and true to the best of my knowledge.

Patient Signature

Date



ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

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Assignment of Benefits

In providing my insurance information, I authorize Nuvia Health to submit claims to my insurance company on my behalf and assign my right to insurance claim payments to Nuvia Health. This includes all services billed for by Nuvia Health.

I further acknowledge and understand I am responsible for all copayments, coinsurance, deductibles, and charges not covered by my insurance company. Should my insurance information change at any time, it is my responsibility to provide Nuvia Health with my updated insurance information as soon as possible. If I do not provide the information timely, I understand denial of claims may result in the financial liability being transferred solely to me.

I agree to be financially responsible for all charges not covered by my insurance plan, including services deemed non-covered, out-of-network, or patient responsibility amounts. I understand that fees may apply for certain services regardless of insurance coverage.

I have read the above assignment of benefits and financial responsibility. I understand all of the information and a copy may be made available to me upon request.

Patient Signature

Date

If signed by someone other than the patient:

Printed Name

Relationship to Patient



CONSENT TO TREAT

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Patient Consent

I hereby consent and authorize Nuvia Health to provide medical treatment to me based on their professional clinical judgment. I have the right to revoke this consent at any time, in writing to Nuvia Health's office, except to the extent the practice has already taken action in reliance on this consent.

I understand that medical care at Nuvia Health may be provided by nurse practitioners and other licensed healthcare professionals. These providers work collaboratively and under physician supervision as required by Texas law. I understand that I may not be treated directly by a physician at every visit.

I understand that Nuvia Health provides outpatient primary care services and is not an emergency facility. In the event of a medical emergency, I understand I should call 911 or go to the nearest emergency room.

I have read the above consent to treat. I understand all of the information and a copy may be made available to me upon request.

Patient Signature

Date

If signed by someone other than the patient:

Printed Name

Relationship to Patient



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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HIPAA Privacy Practices

I consent to the use or disclosure of my protected health information by Nuvia Health and its providers for the purposes of diagnosing and providing treatment, obtaining payment from insurance companies, or conducting health care operations of Nuvia Health.

I acknowledge that I have been offered or received Nuvia Health's Notice of Privacy Practices, which describes how my protected health information may be used and disclosed.

I understand that I have the right to request restrictions on certain uses and disclosures of my protected health information. I understand that Nuvia Health is not required to agree to any restrictions I may request, but if Nuvia Health agrees to a restriction, it is bound by that agreement.

I have read the above acknowledgment. I understand all of the information and a copy may be made available to me upon request.

Patient Signature

Date

If signed by someone other than the patient:

Printed Name

Relationship to Patient



PAPERLESS BILLING ACKNOWLEDGMENT

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Patient Name: _____ Date of Birth: _____ Date: _____

Electronic Billing Notice

Nuvia Health utilizes paperless (electronic) billing statements delivered through the patient portal. This allows us to streamline billing, reduce costs, and provide timely notification of patient responsibility for services rendered.

Billing statements and other billing-related notifications may be delivered through the patient portal. This includes, but is not limited to, balance statements, payment reminders, and pre-collection notices. Paper billing statements are generally not sent.

Patient Portal Access

Patients are responsible for accessing their patient portal to review billing statements, notifications, and other communications from our office. The patient portal is also used to communicate laboratory results, appointment information, and clinical messages.

Some patients choose to disable portal notifications. If notifications are disabled, it remains the patient's responsibility to log in regularly to review billing and other important information.

Acknowledgment

By signing below, I acknowledge that I have been informed of Nuvia Health's paperless billing process and understand that billing statements and notifications will be delivered through the patient portal.

If you have questions or need assistance accessing your portal, please contact our front office.

Patient Signature

Date

If signed by someone other than the patient:

Printed Name

Relationship to Patient



OFFICE & FINANCIAL POLICIES

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Patient Name _____ Date of Birth _____ Date _____

OFFICE POLICIES

Appointment Arrival

New patients must arrive at least 15 minutes prior to their scheduled appointment time with a valid photo identification and insurance card. Paperwork should be completed on the patient portal or printed, fully completed by hand, and brought to the appointment.

Established patients must arrive at least 10 minutes prior to their scheduled appointment time. This allows our staff to update the chart, complete check-in, and obtain any new information needed before the visit.

Patients arriving late may be required to reschedule if adequate time is not available to address their medical needs.

Cancellations & No-Shows

This office requires a minimum of 24 hours' notice to cancel an appointment.

Late Cancellation (less than 24 hours' notice):	\$30.00
No-Show (missed appointment without notice):	\$50.00

Repeated missed or late-canceled appointments may result in discharge from the practice.

Service Animals

Patients using a service animal are welcome. Advance notice is appreciated when possible so we may best accommodate all patients.

I understand and agree to the office policies as described above.

Patient Signature

Date



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FINANCIAL POLICIES

Payment

Payment for services not covered by insurance and estimated patient responsibility amounts are due at the time of service. Payment will be collected at check-in for scheduled appointments. Patients may also pay via the patient portal or by phone prior to the appointment.

Insurance Verification

Patients must ensure that our office has current and accurate insurance information prior to check-in. We must be able to verify insurance at the time of the visit. If insurance cannot be verified, the patient may be asked to pay as self-pay or reschedule.

Insurance & Billing

Our office policies govern payment arrangements between the patient and Nuvia Health. For insurance carriers and networks in which we participate, we will accept assignment, collect the estimated patient responsibility, and bill for covered services.

Arrangements between a patient and their insurance carrier are separate from arrangements between the patient and Nuvia Health. Although we may appeal claims determinations from time to time, our office does not become involved in disputes between patients and their insurance carriers regarding plan benefit coverage.

It is the patient's responsibility to know and understand their insurance coverage. If services are denied due to non-coverage or maximum benefits being met, the patient will be responsible for the full charge for services rendered.

Payment Methods

We accept American Express, Apple Pay, cash, checks, debit cards, Discover, Mastercard, and Visa.

Returned checks are subject to a \$35.00 fee. The amount of the check plus the fee are due and payable immediately. No further appointments will be honored until the balance is satisfied.

Laboratory Services

Laboratory and pathology services are billed separately by the processing entity. Please refer to the Laboratory Services Acknowledgment for full details.

I understand and agree to the financial policies as described above.

Patient Signature

Date



LABORATORY SERVICES ACKNOWLEDGMENT

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Patient Name: _____

Date of Birth: _____

Date: _____

Reference Laboratory Services

Nuvia Health sends most laboratory testing to an independent reference laboratory. These laboratories are not employed by or financially affiliated with Nuvia Health.

Reference laboratory services are billed directly by the laboratory to your insurance. Nuvia Health does not bill for these services and does not determine laboratory pricing or patient responsibility amounts.

If the laboratory determines that your insurance does not cover certain tests, or applies charges toward your deductible, the laboratory will bill you directly. Any billing questions related to reference lab services should be directed to the laboratory, not to Nuvia Health.

Insurance Coverage

Coverage for laboratory services depends on your specific benefit plan. Not all labs ordered may be covered by your insurance, particularly at problem or sick visits. Preventive visits may include basic bloodwork such as a complete blood count, metabolic panel, or lipid panel, but this varies by plan.

Some insurance plans have preferred laboratory networks that may differ from the reference laboratory used by our office. You are encouraged to verify your lab benefits with your insurance carrier to avoid unexpected charges.

In-Office Point-of-Care Testing

Nuvia Health performs a limited number of CLIA-waived point-of-care tests in the office (such as rapid tests). These tests are performed at the time of your visit, and results are typically available the same day. Charges for point-of-care testing performed in the office are billed by Nuvia Health and may be subject to insurance coverage, deductible, or patient responsibility depending on your benefit plan.

Patient Options

You are not required to have labs drawn at our office. You may request a lab order to take to a laboratory of your choosing. Please note that results from outside laboratories may not be automatically received by our office, which could affect timely follow-up on your care.

Lab Results

Lab results are available through the patient portal. If your results are normal, your provider may not send a separate message; however, you may always contact our office with questions or concerns.

Acknowledgment

By signing below, I acknowledge that I have read and understand this notice. I understand that reference laboratory services are billed separately by the laboratory and that Nuvia Health is not responsible for laboratory pricing or billing. I understand that my insurance may not cover all laboratory services and that I am encouraged to verify my benefits with my insurance carrier.

Patient Signature

Date

If signed by someone other than the patient:

Printed Name

Relationship to Patient