Butterfly Wellness Clinic
P.O. Box 841294
Pearland, TX 77584

Check One: ___ I AM A NEW PATIENT ____ I AM AN EXISTING PATIENT

PATIENT MEDICAL HISTORY FORM

Full Name:_____ **Date of Birth**:_____

Social Security #:_____ **Ethnicity:**_____

Gender: __M ___F ___Other **Marital Status:** :___Single ___Partner ___Married ____Divorced ____ Widowed

Address: _____ **Phone #**: _____
Email: _____ **Cell #:** _____**Insurance**:_____

Emergency Contact: _____ **Phone#** _____

ALLERGIES _____Yes _____No *If yes list below*

MEDICATIONS

MEDICATION	DOSE	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N

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COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP: _____	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENT
Asthma			
Cancer *(type:_____)*			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Stroke			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

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WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation:_____Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

FAMILYMEDICALHISTORY _____ **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

Check All That Applies	Diabetes	Asthma	Cancer	Blood Pressure	Kidney Problems	Other
Mother						
Father						
Brother						
Sister						

SOCIAL HISTORY

Occupation *(or prior occupation)*:	___ Retired ____Unemployed ___ Disabled
Marital Status *(check one)*: _____ Single _____ Partner ____ Married ____ Divorced ____ Widowed ____ Other	
Do you have children? _____Y _____N	If yes, how many? _____

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? _____Y _____N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day_____# of Years: _____	***Past:*** Quit Date:_____Packs/day_____# of Years: _____		
Other Tobacco *(check one)*: ____Pipe ___ Cigar _____Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? ___Y ___N	___Beer ___ Wine ___Liquor	# of Drinks/week: _____
Do you use marijuana or recreational drugs? ____Y ____N		Have you ever used needles to inject drugs? ___Y ____N	
Have you ever taken someone else's drugs? _____Y ____N			

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? ___Y ____N	If yes, where?

OTHER SPECIALIST YOU HAVE SEEN

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SPECIALIST	NAME	LAST SEEN
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		

REVIEW OF SYSTEMS: *CHECK ALL THAT APPLY*

	CONSTITUTION		CARDIOVASCULAR		SKIN
☐	Activity change	☐	Chest pain	☐	Color change
☐	Appetite change	☐	Leg swelling	☐	Pallor
☐	Chills	☐	Palpitations	☐	Rash
☐	Diaphoresis		**GASTROINTESTINAL**	☐	Wound
☐	Fatigue	☐	Abdominal distention		**ALLERGY/IMMUNO**
☐	Fever	☐	Abdominal pain	☐	Environmental allergies
☐	Unexpected weight change	☐	Anal bleeding	☐	Food allergies
	HEAD, EAR, NOSE & THROAT	☐	Blood in stool	☐	Immunocompromised
☐	Congestion	☐	Constipation		**NEUROLOGICAL**
☐	Dental problem	☐	Diarrhea	☐	Dizziness
☐	Drooling	☐	Nausea	☐	Facial asymmetry
☐	Ear discharge	☐	Rectal pain	☐	Headaches
☐	Ear pain	☐	Vomiting	☐	Light-headedness
☐	Facial swelling		**ENDOCRINE**	☐	Numbness
☐	Hearing loss	☐	Cold intolerance	☐	Seizures
☐	Mouth sores	☐	Heat intolerance	☐	Speech difficulty
☐	Nosebleeds	☐	Polydipsia	☐	Syncope
☐	Postnasal drip	☐	Polyphagia	☐	Tremors
☐	Rhinorrhea	☐	Polyuria	☐	Weakness
☐	Sinus pressure		**GENITAL**		**HEMATOLOGIC**
☐	Sneezing	☐	Difficulty urinating	☐	Adenopathy
☐	Sore throat	☐	Dysuria	☐	Bruises/bleeds easily
☐	Tinnitus	☐	Enuresis		**PSYCHIATRIC**
☐	Trouble swallowing	☐	Flank pain	☐	Agitation
☐	Voice change	☐	Frequency	☐	Behavior problem
	EYES	☐	Genital sore	☐	Confusion
☐	Eye discharge	☐	Hematuria	☐	Decreased concentration
☐	Eye itching	☐	Penile discharge	☐	Dysphoric mood
☐	Eye pain	☐	Penile pain	☐	Hallucinations

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	Eye redness		Penile swelling		Hyperactive
	Photophobia		Scrotal swelling		Nervous/anxious
	Visual disturbance		Testicular pain		Self-injury
RESPIRATOR			Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness	**MUSCULAR**			
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

Patient Name _____ Date: _____

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Patient's Rights and Responsibilities

Butterfly Wellness is committed to providing excellent customer service to our patients and visitors. The following list explains what patients can expect to receive during their care and what is expected of patients in return

As a Butterfly Wellness patient, you have the right to:

- Be treated with respect and dignity
- Consent to or refuse a treatment, as permitted by law, throughout your treatment. If you refuse the recommended treatment, you will be informed of the medical consequences other needed and available care.
- Be given facts about your care.
- To participate in decisions about your care, treatment, and services.
- Be informed of the name of the provider who has the primary responsibility for your care, treatment, and services.
- Get information you need to make choices about your care. This includes the name of your treatment and the risks
- Receive your care in private.
- Have privacy and confidentiality of your medical information
- Have your bill explained to you
- Have a significant other participate in your care.
- Make a complaint and receive a response.
- Be asked about your pain and receive the appropriate pain relief treatment.
- Access, request amendment to and obtain information on disclosure of my health information, in accordance with law and regulations.
- Have your cultural and personal values, beliefs and preferences respected.
- To receive information in a manner that you understand.
- To complain and have the complaints investigated
- The right to be free from neglect, exploitation, verbal, mental, physical, and sexual abuse.

As a Butterfly Wellness patient, you have the responsibility to:

- Give us full and honest facts about your health history. Your history is illnesses, hospital stays, medicine you take or have taken, instructions to your doctor about your care and other health matters.
- Ask questions when you do not understand.
- Tell us about changes in your address, phone number and insurance. Give us the correct address, phone number for you and your next kin.
- Treat the people who take care of you, or other patients, and our property with respect and courtesy.

I have received, read and understood a copy of Butterfly Wellness Patients' Rights and Responsibilities and understand that a copy of this signed form will be retained in my medical chart.

Patient Signature:_____ Date: _____
Printed Name: _____ Date: _____

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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.

Butterfly Wellness is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this Notice or if you want more information about the privacy practices at Continuum Integrated Treatment Centers call (281) 969 5601.

Understanding Your Medical Record/Health Information

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, assessment, diagnosis, treatment plan, and treatment recommendations. These records may also disclose or reveal that you are a recipient of public welfare benefits. This Protected Health Information (PHI), often referred to as your medical record, serves as a basis for planning your treatment, a means to communicate between service providers involved in your care, as a legal document describing your care and services, and verification for you and/or a third party payer that the services billed were provided to you. It can also be used as a source of data to assure that we are continuously monitoring the quality of services and measuring outcomes. Understanding what is in your medical record and how, when and why we use the information helps you make informed decisions when authorizing disclosure to others. Your health information will not be disclosed without your authorization unless required or allowed by State and Federal laws, rules or regulations.

Our Responsibilities

Butterfly Wellness must protect and secure health information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care. We are only allowed to use and disclose protected health information in the manner described in this Notice. This Notice is posted on our website and we will provide you a paper copy of this Notice upon your request.

How Butterfly Wellness May Use or Disclose Your Health Information
The following categories describe ways that Continuum Integrated Treatment Centers may use or disclose your health information. Any use or disclosure of your health information will be limited to the minimum information necessary to carry out the purpose of the use or disclosure. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Payment Functions – We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. Health information may be shared with other government programs such as Medicare or Medicaid, or private insurance to manage your medical necessity of health care services, determine whether a particular treatment is experimental or investigational, or determine whether a treatment is covered under your plan.

Healthcare Operations – We may use and disclose health information about you to carry out necessary managed care/ insurance-related activities. For example, such activities may include premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities such as handling and investigating complaints; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration.

Treatment – Butterfly Wellness - some of our treatments require that we make a referral for an assessment or perform other activities which include helping formulate a treatment plan, coordinating appropriate and effective care, treatment and services or setting up an appointment with other health care providers. We may also share your health information with emergency treatment providers when you need emergency services. We may also communicate and share information with governmental entities with whom we have

Business Associate Agreements. These include hospitals, licensed facilities, licensed practitioners and governmental entities. When these services are contracted, we may disclose your health information to our contractors so that they can provide you services and bill you or your third-party payer for services rendered. We require the contractor to appropriately safeguard your information. **We are required to give you an opportunity to object before we are allowed to share your PHI with another HIPAA Covered Entity such as your Primary Care Physician or another type of physical health type provider. If you wish to object to us sharing your PHI with these types of providers, then there is a form you must sign that will be kept on file and we are required by law to honor your request.**

Required by Law – Butterfly Wellness may use and disclose your health information as required by law. Some examples where we are required by law to share limited information include but are not limited to: PHI related to your care/treatment with your next of kin, family member, or another person that is involved in your care; with organizations such as the Red Cross during an emergency; to report certain type of wounds or other physical injuries; and to the extent necessary to fulfill responsibilities when a consumer is examined or committed for inpatient treatment.

Public Health – Your health information may be reported to a public health authority or other appropriate government authority authorized by law to collect or receive information for purposes related to: preventing or controlling disease, injury or disability; reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Health Oversight Activities – We may disclose your health information to health, regulatory and/or oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings related to oversight of the health care system. For example, health information may be reviewed by investigators, auditors, accountants or lawyers who make certain that we comply with various laws; or to audit your file to make sure that no information about you was given to someone in a way that violated this Notice.

Judicial and Administrative Proceedings – We may disclose your health information in response to a subpoena or court order in the course of any administrative or judicial proceeding, in the course of any administrative or judicial proceeding required by law (such as a licensure action), for payment purposes (such as a collection action), or for purposes of litigation that relates to health care operations where Continuum Integrated Treatment Centers is a party to the proceeding.

Public Safety/ Law Enforcement – We may disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent danger or threat to the health or safety of a particular person or the general public or when there is likelihood of the commission of a felony or violent misdemeanor.

National Security – We may disclose your health information for military, prisoner, and national security.

Worker's Compensation – We may disclose your health information as necessary to comply with worker's compensation or similar laws.

Disclosures to Plan Sponsors – We may disclose your health information to the sponsor of your group health plan, for purposes of administering benefits under the plan. If you have a group health plan, your employer is the plan sponsor.

Applicability of More Stringent State Laws – Some of the uses and disclosures described in this notice may be limited in certain cases by applicable State laws or rules that are more stringent than Federal laws or regulations, including disclosures related to mental health and substance abuse, intellectual/developmental disabilities, alcohol and other drug abuse (AODA), and HIV testing.

Use and Disclosure of Health Information without your Authorization

Federal laws **require or allow** that we share your health information, including alcohol and drug abuse records, with others in specific situations in which you do not have to give consent, authorize or have the opportunity to agree or object to the use and disclosure. Prior to disclosing your health information under one of these exceptions, we will evaluate each request to ensure that only necessary information will be disclosed. These situations include, but are not limited to the following:

- To a county Department of Social Services or law enforcement to report abuse, neglect or domestic violence; or
- To respond to a court order or subpoena; or
- To a health care provider who is providing emergency medical services; or
- To qualified service organization agencies when appropriate. (These agencies must agree to abide by the Federal law.)

When We May Not Use or Disclose Your Protected Health Information

Except as described in this Notice, Butterfly Wellness will not use or disclose your health information without written authorization

from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

- Your authorization is necessary for most uses and disclosures of psychotherapy notes.
- Your authorization is necessary for any disclosures of health information in which the health plan receives compensation.
- Your authorization is necessary for most uses and disclosures of alcohol and drug abuse records (exceptions are listed above).

Statement of Your Health Information Rights

Although your health information is the physical property of Butterfly Wellness, the information belongs to you. You have the right to request, in writing, certain uses and disclosures of your health information.

Right to Request Restrictions – You have the right to request a restriction on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to the Privacy Officer at the address listed below. We will let you know if we can comply with the restriction or not.

Right to Inspect and Copy – You have the right to inspect and receive an electronic or paper copy of your health information that may be used to make decisions about your plan benefits. To inspect and copy information, you must submit your request in writing to the Privacy Officer at the address listed below. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. There are certain situations where we will be unable to grant your request to review records.

Right to Request Amendment – You have a right to request that we amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can appeal the denial. To request an amendment, you must make your request in writing to the Privacy Officer at the address listed below. You must also provide a reason for your request.

Right to be Notified of a Breach – You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Changes to this Notice and Distribution

Butterfly Wellness reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. As your health plan, we will provide a copy of our notice upon your enrollment in the plan and will remind you at least every three years where to find our notice and how to obtain a copy of the notice if you would like to receive one. If we have more than one Notice of Privacy Practices, we will provide you with the Notice that pertains to you. The notice is provided and pertains to the named Medicaid beneficiary or other individual enrolled in the plan.

As a health plan that maintains a website describing our customer service and benefits, we also post to our website the most recent Notice of Privacy Practices which will describe how your health information may be used and disclosed as well as the rights you have to your health information. If our Notice has a material change, we will post information regarding this change to the website for you to review. In addition, following the date of the material change, we will include a description of the change that occurred and information on how to obtain a copy of the revised Notice in any annual mailing required by 42 CFR Part 438.

I have read, understood, and received a copy of the Center's Notice of Privacy
Practices and understand that a copy of this form will be retained in my medical chart.

Signed: _____ Date: _____

Printed Name: _____ Date: _____

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Consent for Treatment

I have chosen to receive healthcare services for myself and/or my child from Butterfly Wellness. My decision is voluntary, and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Health Services

I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff
- The right to confidentiality of clinical records and personal information according to federal and state laws

Emergencies

I understand I may reach the Butterfly Wellness provider at (281) 969- 5601. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency situation, I may call 911.

I have read, discussed and understood all of the above.
Printed Name _____ Date _____

Signature _____ Witness Date _____