EVANGELION
MEDICAL

Welcome to Our Practice

Dear Prospective Patient,

Thank you for choosing us to be part of your healthcare journey. Whether you are here for preventive care, chronic condition management, or simply looking to feel your best, we are honored to be your partners in health.

At our clinic, we believe that building a healthier patient starts with a strong and respectful relationship between you and your care team. Your goals, concerns, and experiences matter deeply, and we are committed to listening, educating, and guiding you every step of the way. Every appointment, conversation, and plan is shaped around the belief that good health is achieved through collaboration, not just treatment.

Our approach is rooted in compassion, evidence-based medicine, and personalized care. We work together to identify what matters most to you, whether it is keeping up with your family, reducing stress, improving lab results, or simply feeling heard. We see healthcare as a partnership, where your voice guides your care and our expertise helps you make confident, informed decisions.

Please review the materials in this packet carefully and do not hesitate to ask questions. We are here for you, not just today, but throughout every chapter of your health journey.

Here is to working together toward a healthier you.

P. Douglas Cochran, MD | **Kristin Groves, FNP-C** | **Elizabeth Vitulli, FNP-C**

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15 Smith Rd. ● Suite 3004 ● Midland, Texas 79705
432-699-6000 ● www.evangelionmedical.com

GENERAL PATIENT INFORMATION

Full Legal Name: _____ ❑ Male ❑ Female

Date of Birth: _____/_____/_____ Social Security Number: _____

Primary Language: ❑ English ❑ Spanish ❑ Other: _____ Do you need a translator? ❑ Yes ❑ No

Please Note: *If English is not your primary language, you must have a translator with you at your appointments.*

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Email: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Other Family Members Treated in this Office: _____

Did anyone refer you to our office? _____

IF PATIENT IS A MINOR:

Parent's Full Legal Name: _____

Parent's Contact Number: _____ Parent's Employer: _____

INSURANCE INFORMATION

A valid driver's license or ID card must be presented with your insurance card for scanning and verification.
The patient or responsible party must inform us immediately of any changes in insurance plans or coverage.

PRIMARY

Insurance Company: _____ ID#: _____ Group#: _____

Name of Insured: _____ SS#: _____ DOB: _____/_____/_____

Relationship to Patient: _____

SECONDARY

Insurance Company: _____ ID#: _____ Group#: _____

Name of Insured: _____ SS#: _____ DOB: _____/_____/_____

Relationship to Patient: _____

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PATIENT MEDICAL HISTORY

Please check if you have ever been diagnosed with or treated for any of the following conditions.

- ADHD
- Anemia
- Anxiety
- Arthritis
- Asthma
- Autoimmune Diseases
- Bipolar Disorder
- Bladder Problems
- Blood Clots
- Cancer
- Congestive Heart Failure
- Colitis
- COPD
- Coronary Artery Disease
- Crohn's Disease
- Depression
- Diabetes
- Ear/Nose/Throat Problems
- Eating Disorder
- Emphysema
- Eye Problems
- Fertility Issues
- Fibromyalgia
- GERD/Heart Burn
- Glaucoma
- Headaches/Migraines
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Insomnia
- Irritable Bowel Syndrome
- Kidney Disease
- Liver Problems
- Low Blood Pressure
- Lupus
- Migraines
- Neurological Problems
- Peptic Ulcer Disease
- Schizophrenia
- Seasonal Allergies
- Seizures or Epilepsy
- Sleep Apnea
- STDs
- Stroke
- Thyroid Disease
- Vascular Issues
- Other (indicate below)
- None

Please use this space to provide more information on any boxes checked if needed: _____

_____

Past Hospitalizations: _____

_____

Past Surgeries *(include year)*: _____

_____

Have you ever been treated for mental/behavioral health at an in-patient facility? ❑ Yes ❑ No

Have you ever received counseling services for Mental Health? ❑ Yes ❑ No

Who is on your Care Team? *(please list any providers that you have seen or currently receive services from)*

- NONE
- Previous PCP:
- Allergy:
- Cardiology:
- Dermatology:
- Endocrinology:
- ENT:
- GI:
- Hematology:
- OBGYN:
- Orthopedic:
- Nephrology:
- Neurology:
- Pain Management:
- Psychiatry:
- Pulmonology:
- Rheumatology:
- Urology:

To help our office serve you best, please provide us with records of any recent (<5 years) hospitalizations or imaging.

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PATIENT MEDICAL HISTORY

Allergies *(include reaction)*: _____

Current Medications, Vitamins & Supplements

Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____
Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____
Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____
Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____
Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____
Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____
Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____
Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____
Name: _____ Dose: _____ Frequency: _____ Prescribed by: _____

Do you take your current medications as prescribed? ❑ Yes ❑ No

If not taking your medications as prescribed, why? ❑ Side Effects ❑ Cost ❑ Insurance Coverage ❑ Other

Have you ever been on therapy for ❑ Hormone Replacement ❑ Weight Loss ❑ None

Preventive Screenings

Test	Date of Last Test		Results/Notes
Colonoscopy	❑ Never		
Mammogram	❑ Never		
Pap Smear / HPV Test	❑ Never		
Prostate Exam / PSA	❑ Never		
EKG (Electrocardiogram)	❑ Never		
Echocardiogram	❑ Never		
Cardiac Stress Test	❑ Never		
Bone Density (DEXA Scan)	❑ Never		
Sleep Study	❑ Never		

Immunizations

Are your childhood immunizations complete or up to date for age? ❑ Yes ❑ No, explain: _____

Please provide the date of your last vaccinations below, if applicable, or provide a copy of your immunization record:

- Flu: _____
- COVID: _____
- Pneumonia: _____
- Meningitis: _____
- Shingles: _____
- HPV: _____
- TDAP (Tetanus): _____
- Hepatitis A: _____
- Hepatitis B: _____

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OBGYN HISTORY (Females)

Do you still get your periods? ❑ Yes ❑ No **Date of last period**: _____

Are your periods regular? ❑ Yes ❑ No

Are you currently on any kind of birth control? ❑ No ❑ Yes, Type: _____

Have you had a hysterectomy (partial or complete)? ❑ No ❑ Yes, Date: _____

Have you ever been pregnant before? ❑ No ❑ Yes, Number of pregnancies: _____

Have you ever had an abnormal:

- **PapSmear** ❑ Yes ❑ No If yes, results/followup: _____
- **Mammogram** ❑ Yes ❑ No If yes, results/followup: _____
- **Breast Ultrasound** ❑ Yes ❑ No If yes, results/followup: _____
- **Breast Biopsy** ❑ Yes ❑ No If yes, results/followup: _____

SOCIAL HISTORY

Marital Status: ❑ Single ❑ Dating ❑ Married ❑ Divorced ❑ Widowed ❑ Partner

Sexual Orientation: ❑ Heterosexual ❑ Homosexual ❑ Bisexual ❑ Other

Alcohol Use: ❑ Never ❑ Rarely ❑ Moderate or Daily (7-10 drinks/wk) ❑ Heavy (>10 drinks/wk)

Tobacco/Nicotine Use: ❑ Never ❑ Dip ❑ Cigarettes ❑ Vape ❑ Zyn or other smokeless ❑ Other

Tobacco/Nicotine Frequency: ❑ Current (describe use): _____ ❑ Quit (include date): _____

Illicit Drug Use: ❑ Never ❑ Previously, date quit: _____ ❑ Current: _____

FAMILY HISTORY

Include pertinent conditions like Mental Health Issues, Diabetes, High BP, High Cholesterol, Heart Attack, Stroke, Autoimmune, Cancer, etc.

Mother ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Father ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Maternal Grandmother ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Maternal Grandfather ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Paternal Grandmother ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Paternal Grandfather ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Sibling (❑ brother ❑ sister) ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Sibling (❑ brother ❑ sister) ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Sibling (❑ brother ❑ sister) ❑ Living ❑ Deceased, age at death: _____ Problems: _____

Sibling (❑ brother ❑ sister) ❑ Living ❑ Deceased, age at death: _____ Problems: _____

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PRIMARY GOALS & CONCERNS

Please tell us your top 3 goals/concerns. Is there anything we need to know to help you move forward with your health and wellness journey?

1. _____
   _____
2. _____
   _____
3. _____
   _____

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ANNUAL ADMINISTRATIVE FEE

Thank you for choosing Evangelion Medical as your partner in healthcare. We look forward to a long-term relationship with you and your family.

Evangelion Medical is committed to providing you with exceptional care. Many changes have taken place in the healthcare industry, and amongst these changes is the rise in administrative costs of operating a medical practice. Services once covered by insurance are now either partially covered, covered under certain medical necessity, or not covered at all. We want to continue to provide you with the highest quality medical care, but unfortunately, this requires providing services your insurance company will not cover.

After much consideration, Evangelion Medical finds it necessary to charge an Annual Administrative Fee (AAF) of $225.00 per patient, with a discount of $50 for additional patients per immediate family. The AAF is intended to cover services such as maintaining medical records, prior authorization, completion of immunization records, third-party forms, insurance filings and applications, email correspondences, etc.

Please note that your insurance company will not cover the annual administrative fee or any of these services and this fee is non-refundable. We will collect this fee prior to your first appointment, and then annually thereafter. You may speak with a receptionist to pay your AAF. Evangelion Medical values the opportunity to provide care for you, and we desire to maintain the most exceptional care. Thank you for your understanding.

By signing this form, you acknowledge that your insurance will not cover your AAF because the fee is for uncovered services. You also agree to assume financial responsibility for payment and not to submit a bill to your insurance provider for the AAF.

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Signature: _____

Today's Date: _____

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PATIENT OFFICE POLICIES

Payment Terms
Co-payments and deductibles are due at the time of service. Payment plans are only available by prior agreement. A $50 fee applies to payments with insufficient funds, which must be paid immediately along with the original charge, or the case will be sent to the District Attorney. Outstanding balances must be paid before future services.

Cancellations, No-shows, and Missed Appointments
If you must cancel, we prefer 48 hours but REQUIRE you to notify us (by speaking with a staff member and receiving a confirmation number) BEFORE WE CLOSE the PREVIOUS business day. Messages to cancel left after hours do not suffice for appointments the next day. If you wake up sick, we are more than happy to move your appointment to a telemedicine visit without incurring a cancellation fee. To keep your and others wait times to a minimum, please note that if you arrive late, your scheduled appointment time with the provider will be reduced**. If you are more than 10 MINUTES LATE, you will be considered a "No-show" and will not be seen. A $75 rescheduling fee applies per 15-minute increment and must be paid before rescheduling.**

AI Usage
With AthenaHealth, our electronic medical record software, parts of the visit encounter notes might be generated by AI based on audio conversation. Content review by the provider is required prior to finalizing the note to ensure accuracy. By being a patient, you are giving your consent for our office to utilize this technology.

Record Reproduction Terms
Request for reproduction of paper medical records for legal, insurance, or private use will incur a fee of $25.00 for the first 20 pages and $0.50 per page thereafter. A request for records in electronic format will incur a fee of $25.00 for 500 pages or fewer and $50.00 for more than 500 pages.

Additional Provider Paperwork Terms
Form completion, disability paperwork, or similar requests are $200 per activity unless completed during a dedicated appointment. Forms requiring only a signature may be completed for $50 if deemed appropriate by the provider.

Patient Behavior and Interaction Terms
Abusive, dishonest, or non-compliant behavior will not be tolerated and may result in dismissal from the practice and reporting to authorities. Dr. Cochran reserves the right to terminate the physician-patient relationship at any time, with reasonable notice provided for care transfer.

Phone Calls and Requests
Patients must allow 24 hours for refill requests or non-urgent phone call returns.

Minor Patients Terms
Minors must be accompanied by a legal guardian or legal representative. Non-parental adults must present signed consent or legal documentation.

Service Restriction Terms
Appointments are required. Dr. Cochran does not provide hospital, nursing home, or chronic inpatient care. Non-English speakers must bring a translator or be rescheduled. One visitor per patient is allowed (excluding parents of minors). The practice does not participate in legal, insurance, Workers' Compensation, or disability cases. Legal actions involving providers will incur fees payable by the issuing party; a fee schedule is available on request. Testimony will be impartial and fact-based.

Controlled Substance Policy
This policy reflects evolving standards and regulatory requirements, not distrust in our patients. Controlled substances include, but are not limited to:

- **Narcotics** (Hydrocodone, Norco, Vicodin, Tramadol, etc.)
- **Stimulants** (Adderall, Vyvanse, etc.)
- **Benzodiazepines** (Xanax, Klonopin, Valium, etc.)
- **Hypnotics** (Ambien, Lunesta, etc.)
- **Hormones** (Testosterone or Hormone Replacement, etc.)

Long-Term Pain Management: Due to patient safety concerns, rising national misuse, and stricter Texas Medical Board regulations, Evangelion Medical generally does not provide ongoing narcotics.

Office Visits: No refills of controlled substances will be given without an office visit. **Visits do not guarantee a prescription**. An initial visit is required to begin any controlled substance. **Follow-up is required at least every 3 months** (or monthly, per some insurance rules). A $20 fee applies to prescriptions issued without an in-person appointment.

Prescription Duration: Most narcotics will be prescribed for no more than 30 days; some other controlled substances may be given up to 90 days at the provider's discretion, with compliance and insurance approval.

Drug Testing: Patients on or requesting controlled substances may be randomly tested for compliance. Any illegal substance use (e.g., marijuana, cocaine, heroin) will result in the discontinuation of prescriptions and may lead to dismissal from the practice.

Specialist Involvement: Patients under the care of a specialist (e.g., pain management, psychiatry, orthopedics) for controlled substances will not receive those prescriptions from this office. If a patient stops seeing the specialist, it is their responsibility to secure another provider.

Non-Compliance: Dishonesty or failure to follow this policy will result in discontinuation of controlled medications and possible dismissal from the practice.

By signing below, I hereby certify that the information I have furnished on these forms is complete, true, and accurate. I have carefully read and understand all of the terms above.

Patient/Guardian Signature: _____ **Date:** _____

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STATEMENT OF FINANCIAL RESPONSIBILITY

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct payment of my medical benefits to the offices of Evangelion Medical for any services furnished to me by the physician(s) or offices. I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical services to third-party payers and/or health practitioners. I agree to inform the offices of Evangelion Medical immediately of any changes in my insurance plans or coverage benefits. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.

_____ _____

Signature of Patient or Responsible Party Date

PAYMENT

I hereby assume responsibility to pay the costs of all services provided by the offices of Evangelion Medical to the patient.

_____ _____

Signature of Patient or Responsible Party Date

AUTHORIZATION OF PAYMENTS

I understand that Evangelion Medical will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Evangelion Medical and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance, and non-covered services.

_____ _____

Signature of Patient or Responsible Party Date

LABORATORY BILLS

I understand that the outside reference laboratory will bill me directly for all laboratory tests performed by the company. I understand that fee schedule (cost) for laboratory tests performed by Evangelion Medical, shall be available to the patient upon request.

_____ _____

Signature of Patient or Responsible Party Date

PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

I have been informed and understand that Evangelion Medical employs physician assistants (PA) and nurse practitioners (NP). I hereby authorize that a PA or NP, under the supervision of the attending physician, may render my medical care jointly. I authorize the PA and/or NP to communicate my diagnosis and treatment with his or her supervising physician, as well as with other health care practitioners involved in my care. I authorize the admittance of qualified observers, including medical students, during my consultation and/or examination.

_____ _____

Signature of Patient or Responsible Party Date

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Evangelion Medical for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to Evangelion Medical for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of Patient or Responsible Party Date

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and understand Evangelion Medical's "Notice of Privacy Practices" in accordance with HIPAA rules and regulations, which explain how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

_____	_____	_____
Printed Name of Patient	Signature of Patient or Representative	Date

CONSENT TO COMMUNICATE

At Evangelion Medical, we are committed to protecting your privacy while ensuring you receive timely and appropriate communication regarding your care.

Voicemail and Communication Consent
If we are unable to reach you directly, may we leave detailed messages on your voicemail or answering machine, which may include test results, appointment information, and treatment recommendations?

- ❑ **Yes** – I give consent for Evangelion Medical to leave detailed messages.
- ❑ **No** – Please leave only a request for me to return the call.

Preferred Method of Contact
Please indicate your preferred method of contact for routine communication (appointments, reminders, results, etc.):

❑ Phone Call ❑ Patient Portal Message

Permission to Share Health Information
I give Evangelion Medical permission to discuss and/or release information about my care, including test results, medications, diagnoses, and treatment plans to the following individuals:

Name of Individual & Relationship	Contact	Comments/Instructions *(may pick up meds, disclose test results, etc.)*

By signing below, I hereby certify that to the best of my knowledge, all of the information I have furnished on these forms is complete, true and accurate.

Patient/Guardian/Legally Recognized Representative Signature: _____ **Date:** _____

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RELEASE OF RECORDS

SECTION I: AUTHORIZATION *(please select one)*

❑ I hereby authorize Evangelion Medical **to release my medical record** information to the person/facility listed below.

Name/Facility: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose of Request: ❑ Personal ❑ Insurance ❑ Legal ❑ Referral or 2nd Opinion ❑ Other: _____

❑ Transfer from Practice (please specify): _____

❑ I hereby authorize Evangelion Medical **to obtain my medical record** information to the person/facility listed below.

Name/Facility: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

SECTION II: SPECIFIC RECORD/REPORT(S) TO BE RELEASED *(please select one)*

❑ Please provide a two year abstract of my records.

❑ Please provide specific records *(include pertinent dates and information)*: _____

_____

_____

COPY FEE: for patient record requests, pursuant to HIPAA 45 CFR 154.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record or more than the 2 year abstract, the rate will increase proportionately based on the cost. For all other release of information requests, the applicable US state statute governing fees for medical records will be applied.

_____ _____

Signature of Patient or Responsible Party Date

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RELEASE OF RECORDS

SECTION III: RESTRICTED AUTHORIZATION TO BE RELEASE PROTECTED INFORMATION

It is extremely important that you select "I DO" or "I DO NOT" for each item in the following section. Do not skip any items as it could impact our ability to fulfill your request and cause delays.

❑ I DO ❑ I DO NOT want mental/behavioral health or Disability Services Provider Documentation released *

❑ I DO ❑ I DO NOT want HIV/AIDS Screen Test Results released.

❑ I DO ❑ I DO NOT want information about Alcohol and/or Substance Abuse Treatment released.**

❑ I DO ❑ I DO NOT want Genetic Testing results released. ***

❑ I DO ❑ I DO NOT Confidential Communications with a Social Worker released.

❑ I DO ❑ I DO NOT want information about Rape/Sexual Assualt Victim Services released.

❑ I DO ❑ I DO NOT want Child/Adult/Elder Abuse or Neglect or Abuse or Neglect of an Individual with a Disability released.

❑ I DO ❑ I DO NOT want Information about Sexually Transmitted Illness released.

❑ I DO ❑ I DO NOT want information about Domestic Violence Victim Counseling released.

"This Authorization is not valid for use or disclosure of psychotherapy notes
••only applicable to records that are created by an "individual or entity who holds itself out as a providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility. •••The term "genetic tests" means only those tests which determine future chances of developing a disease but not tests done to diagnose a current condition or problem. This includes information related to the testing of embryos created I VF.

Term: This Authorization will remain in eITcct until Evangelion l'vledical fulfills this request Revocation: I understand that I may revoke this Authorization at any time by requesting it of Evangelion Medical in writing at the address listed above. The revocation will be eITective immediately upon Evangclion Medical's receip1 of my writ1en notice. I understand that the revocation will not have any effect on any action taken by Evangelion Medical in reliance on the Authorization before it received my written notice of revocation.
Effect on Treatment: : I understand that I may refuse to sign this Authorization before any reason and 1ha1 such refusal will not affect the commencement, continuation, or quality of my treatment at Evangelion Medical.
Potential for Rcdisclosurc: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be pro1ected by 1he applicable state and federal law once it *Is* disclosed by Evngelion Medical.
Access: I understand that in certain circumstances P Douglas Cochran, MD LTD has the right 10 deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.

_____ _____
Signature of Patient or Responsible Party Date

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COURT ACTION & SUBPOENA POLICY

This policy is purposefully designed to discourage patients from having their physician/provider subpoenaed to civil court matters. This is not only in the best interest of Evangelion Medical physicians and providers, but it is also in the best interest of the patient. Court appearances, depositions, preparation times, and other legal matters take time away from the patients. Physicians and providers are forced to focus on issues of law instead of matters of healthcare and medicine, which is not in the best interest of the patients, staff, or the community at large.

All actions and court appearances undertaken by the physicians and providers at Evangelion Medical because of a subpoena or other legal action will result in respective fees incurred by the issuing party. A complete fee schedule is available upon request. The party that issues the subpoena will be responsible for all costs incurred, but this does not mean that testimony or records produced will be solely in your favor. Testimony must be based strictly on the facts of the case and the physician or provider's professional opinion, including when answering questions from opposing counsel.

I acknowledge that I, the patient or guardian of the patient, have received this notice declaring that all fees associated with issuing a subpoena or other legal mechanism requiring action on the part of Evangelion Medical or any of its physicians or providers. I acknowledge that I can request a complete fee schedule if desired.

_____ _____
Signature of Patient or Responsible Party Date

By signing below, I hereby certify that to the best of my knowledge, all of the information I have furnished on these forms is complete, true and accurate.

Patient/Guardian/Legally Recognized Representative Signature: _____ **Date:** _____