Dallas Medical Physician Group

How Did You Hear About Us? _____

New Patient? ☐ Update Only? ☐

PLEASE PRINT VERY CLEARLY

Thank you for your assistance.

■ Patient Information

Name (Last, First, Middle) _____ Today's Date _____

Birthdate _____ **Soc. Sec. #** _____ **Home Phone** _____

Email Address _____ Cell Phone _____

Address _____ Work Phone _____

City _____ **State** _____ **Zip** _____ **Sex:** ☐ M ☐ F ☐ Transgender

☐ Check if Minor (less than18) **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referring Physician _____ Phone _____

Race _____ Ethnicity _____ Preferred Language _____

■ Primary Insurance

Insurance Company _____

Insurance ID # _____ **Group #** _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Secondary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company _____

Insurance ID # _____ **Group #** _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Assignment, Release, & Consent to Treatment

I hereby authorize payment directly to Dallas Medical Physician Group of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. I certify that I am the patient or the parent/legal guardian of the patient, and I consent to the treatment necessary for the care of the patient indicated on this form.

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Dallas Medical Physician Group

Patient Name: _____

■ Medical Information

Please state the reason(s) for your visit today: _____

_____

Primary Care Physician's Name _____ Phone _____

Emergency Contact Name _____ Realtionship to Patient _____

Emergency Phone Number _____

Are you ALLERGIC to or have you ever had any reaction ? (Please list all allergies)_____

_____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
Please describe: _____		
2. Have you ever had any hospitalizations or operations?	☐	☐
Please describe: _____		
3. Are you taking any medications?	☐	☐
Please list: _____		
4. Do you use tobacco in any form?	☐	☐
5. Do you drink alcohol?	☐	☐
6. Do you use any illicit drugs?	☐	☐

7. Have you had any allergic reactions to the following?	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Other Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐
Please describe: _____		

8. Women Only:	Yes	No
Do you have regular periods?	☐	☐
Are you using birth control pills / patch / injection?	☐	☐
Are you pregnant now?	☐	☐
Have you ever been pregnant?	☐	☐
Number of Pregnancies: _____		

Please indicate which of the following conditions/illnesses you have or have not had:

	Yes	No
Acid Reflux	☐	☐
ADHD	☐	☐
Anemia (low blood count)	☐	☐
Anorexia (no appetite)	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding Tendency	☐	☐
Blood Disease	☐	☐
Cancer	☐	☐
Chemical Dependency (drug addiction)	☐	☐
Chemotherapy	☐	☐
Chicken Pox	☐	☐
Chronic Fatigue Syndrome	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Lesions	☐	☐
Cough – persistent or bloody	☐	☐
Diabetes	☐	☐

	Yes	No
Emphysema	☐	☐
Epilepsy	☐	☐
Frequent Ear Infections	☐	☐
Heart Murmur	☐	☐
Heart Disease	☐	☐
Hepatitis – Type ____	☐	☐
Hernia	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
HIV / AIDS	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Latex Sensitivity	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Measles	☐	☐
Migraines	☐	☐
Mitral Valve Prolapse	☐	☐

	Yes	No
Pacemaker	☐	☐
Pneumonia	☐	☐
Prostate Problem	☐	☐
Psychiatric Care	☐	☐
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐
Any Other Condition	☐	☐
Please Describe: _____		

Dallas Medical Physician Group

BILLING and COLLECTION POLICIES

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office at your first appointment after it changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged $25 for each no-show occurrence. Should this occur more than three within a 12 month period, you may be dismissed from the practice. By signing below, you accept this policy.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans every week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Copayments/Deductibles/Coinsurance: It is our responsibility, as detailed by the terms of our contracts with health insurance to collect any copayment, deductibles, or coinsurance at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any amounts that are your responsibility at the time of your appointment. Please have your payment ready upon check-in. You may be responsible for additional amount at check-out depending on your level of service.
By signing below, you accept these policies.

Previous balances and/or deductibles: It time is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account will be sent to collections and/or legal action pursued. You may be dismissed as a patient by our practice for failure to meet your financial obligations. Payment arrangements are available.
By signing below, you accept these policies.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed within 30 days. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. Some cosmetic services require a deposit upon scheduling, which may be taken over the telephone and charged to a credit card, and are not refundable. Should your credit card subsequently be declined or charged back, you will still be responsible for the deposit amounts. By signing below, you accept these policies. A prompt pay discount is available if payment is made in full at time of service.

Return Check Fee: $25.00

FMLA/Disability/Misc Forms: There is a $25 fee charged for any paperwork filled out by your provider.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Dallas Medical Physician Group for any services furnished to me or my dependents.

Signature of Patient: _____ Date: _____
If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

Dallas Medical
Physician Group

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my Protected Health Information*(PHI), may be shared with the following other people:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name _____ Relationship_____

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Dallas Medical Physicians Group.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print):_____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Dallas Medical
Physician Group

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over the counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Pharmacy:_____

Address:_____ **Phone:**_____

Patient/Parent/Guardian Signature_____

Date:_____

Dallas Medical
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NO SHOW POLICY

- Patients who fail to present for a scheduled appointment without contacting the practice to cancel or reschedule the appointment will be considered a "no-show".
- After your first no-show the staff will remind you of this policy.
- If the patient no-shows for three appointments they will be dismissed from the practice.
- You will receive a dismissal letter by certified and regular mail stating that the physician will only see you for 30 days from the date of the dismissal letter.
- You can request that your medical records at that time be sent to your new physician.

_____ _____

Patients Signature **Date**

Prime Healthcare

Authorization and Consent to Photograph, Record, Interview and Publish

I, _____ *(name of patient/participant)* authorize Prime Healthcare to photograph or permit other persons to photograph, record, conduct media interviews and/or publish information, including images regarding _____ obtained while under the care of the hospital and/or health system. The purpose of the photo/video/interview is for_____.

I agree that the photographs, audio recordings, media tapes that may include images may be used in publications or in broadcast format with radio or television or on Prime Healthcare-sponsored *social media sites such as Facebook and YouTube. I agree that Prime Healthcare may use, and permit others to use the negatives or prints prepared from such photographs for such purposes and in such manner as identified above. I understand and agree that the photographs, recordings and/or publications may reveal my identity. I understand that Prime Healthcare adheres to the privacy regulations promulgated by the Health Insurance and Portability and Accountability Act (HIPAA) and that re-disclosure by the recipient will no longer be protected under HIPAA. I agree that the photographs and recordings may be used for identified, specific purposes including but not limited to dissemination to hospital staff, physicians, health professionals, and members of the public for education, treatment, research, scientific, public relations, promotional and charitable purposes and that such dissemination may be accomplished in the manners specified and that such use is subject only to the following limitations:

_____

I have entered into this agreement in order to assist scientific research, education and/or treatment, public relations, marketing, promotion and/or charitable goals and hereby waive any right to compensation for these uses by reason of the foregoing authorizations, and I, or my successors or assigns hereby hold Prime Healthcare, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

I understand that I have the right to request cessation of the "photograph" and have the right to rescind consent up to a reasonable time before the "photograph" is used. The term "photograph," as used in this agreement, shall mean motion picture or still photography in any format, as well as videotape, video disc, and any other means of recording and reproducing images.

Date: _____ Time: _____ AM/PM

Signature:_____ *(patient/participant/parent/guardian)*
If signed by other than patient/participant, indicate relationship: _____.

Witness: _____
□ Original: Medical Record □ Copy: Patient □ Copy: Public Relations Department

** Social Media are Internet-based communication vehicles for sharing information. Social Media sites include but are not limited to Facebook, YouTube, blogs, discussion forums, Wiki sites, podcasting and videocasting.*

Dallas Medical
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Notice of Patient Information Privacy Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

1. What is the purpose of this notice?

The purpose of this notice is to advise you of the information and patient privacy policies that are part of the **Dallas Medical Physician Group** medical practice. In order to provide your healthcare and at the same time effectively manage our medical practice we must collect non-public personal information about you. We want you to know that we consider this information private and confidential, and that we have policies and procedures in place to protect this information against unlawful use and/or disclosure. This notice describes, to the best of our abilities, the types of information we collect and when, how and for what purposes it may be disclosed to others. If you have questions about this information or our policies and procedures please don't hesitate to call our Director of Patient Privacy and Information Protection 972-488-9656.

2. What is "Non-public Personal Information"?

Non-public personal information ("NPI") is information specific to and may serve to identify an individual who is currently receiving or who has received medical care from our medical practice. Among other things, this information may include details about the person's physical or mental health, the medical care evaluation, testing and treatment they may have received, and other information relating to payment for these various services. NPI does not include information that is publicly available or information that is available or reported in a summarized or aggregated fashion that does not identify individual patients.

3. How is Non-public Personal Information protected?

Dallas Medical Physician Group is required by law to restrict access to NPI to those healthcare providers, employees and vendors of business services to the medical practices who must have access to the information in order to provide you with the best possible medical care. **Dallas Medical Physician Group** maintains physical, electronic and procedural safeguards to protect NPI against unauthorized access and disclosure. The Director of Patient Privacy and Information Protection, along with other employees who are engaged as needed, has overall responsibility for developing, educating employees about, and overseeing the enforcement of policies and procedures to safeguard NPI against inappropriate access, use or disclosure, consistent with applicable laws.

4. What personal information might be disclosed to outside third parties, and for what purposes?

Dallas Medical Physician Group does not disclose NPI to anyone, except with patient authorization or as otherwise permitted by law. Disclosures permitted by law include the following:

- Whenever necessary for the patient's care and treatment or related activities, NPI is shared internally within the practice of **Dallas Medical Physician Group.**
- Whenever necessary for the patient's care and treatment or related activities, NPI is shared externally with other healthcare providers (doctors, physician's assistants, dentists, pharmacists, hospitals or other caregivers), insurers, third party administrators, payers (employers who sponsor self-funded health plans, health care provider organizations, and others who may be financially responsible for payment for the services or benefits that a patient may receive under the terms of a healthcare plan), venders, consultants, government authorities, and their respective agents. For example, NPI may be provided to your insurer as they attempt to determine the medical necessity of testing and treatment recommended to you by a referring physician. All of these external parties are required in turn to keep your NPI confidential as provided by applicable law.

In addition to the uses described above, **Dallas Medical Physician Group** routinely utilizes NPI to provide patient appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

On your first visit to **Dallas Medical Physician Group** you will be asked to sign an authorization for the permitted uses of NPI. **Dallas Medical Physician Group** will not use NPI for any purpose other than those falling within the scope of the above policy statement without the patient's written permission to do so. You have the right at any time to revoke this authorization in writing to your **Dallas Medical Physician Group** healthcare provider.

5. How may a patient request other disclosures of personal information?

Should you wish to have a copy of your own NPI you may request it by calling the Director of Patient Privacy and Information Protection at the telephone number listed in Section 1. Above, You must complete a written NPI Copy Request Form and **Dallas Medical Physician Group** will arrange a time for you to review your NPI and decided which pages, if any, you desire to have copied. **Dallas Medical Physician Group** will charge you $1 per page to help to defray the costs of locating and duplicating this information. Applicable law provides that you have the right to notify us of any errors or inconsistencies in your NPI and that we maintain a record of your comments and amendments in this regard.

Should you wish us to disclose your NPI to other third parties or for reasons other than those addressed in Section 4. above, you must also complete a written NPI Copy Request Form and **Dallas Medical Physician Group** will decide, on an individual case basis, whether or not a charge for this service is applicable depending upon the proposed use of the NPI. In general, the provision of NPI for the purposes of on-going medical care or payment for services will be done at no charge, while that for all other purposes will involve a charge.

You also have the right under current law to request restrictions on certain uses and disclosures of your NPI permitted under applicable law, though current law does not require **Dallas Medical Physician Group** to necessarily agree to honor the requested restrictions.

6. What does Dallas Medical Physician Group do with personal information if and when you no longer obtain your medical care through our practices?

NPI is not destroyed when patients leave our care. The information continues to be available for use for all of the purposes described in Section 4. Above, and in most cases is subject to legal retention requirements (typically, 7 years).

7. How is this notice being distributed?

This notice w ill be provided to all new **Dallas Medical Physician Group** patients at the time of their first visit. Current patients will receive a copy as they visit our offices in the course of their usual healthcare activities over the coming months. **Dallas Medical Physician Group** ***reserves the right to change the terms of this notice and to substitute the provisions of the new notice in regards to all NPI we maintain.*** **Dallas Medical Physician Group** ***is required by law to make all reasonable effort possible to see that you receive a copy of the new notice if and when any policy changes are made.***

8. What to do if you have reason to believe we may have violated our own patient information and privacy policies?

If you believe our Patient Information and Privacy Policies have been violated with respect to the NPI of yourself or your dependents, please contact our Director of Patient Privacy and Information Protection at 972-488-9656. We will be happy to provide a copy of our internal grievance procedures regarding these issues upon your request to do so.