Dallas Medical Physician Group

How did you hear about us?
____

New Patient? □ Update Only? □

Thank you for entrusting us with your care.

Please Print Clearly

- **Patient Information**

Name (Last, First, Middle) ______________________________ Today's Date: ______________

Birthdate: ____________ Social Security # ________________ Home Phone: ______________

Email Address: ______________________________________ Cell Phone: ______________

Address: ____ Work Phone: ______________

City: ____________ State: _____ Zip Code: ________ Sex: □ Male □ Female □ Transgender □ Male to Female □ Female to Male

Employer: ____________________________

*If Child, Provide Parent/Guardian name(s) below: __________________________________	** If Student, Please Complete: □ Full-Time □ Part-Time School: ____________________

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Race: _____________ Ethnicity: ____________________ Preferred Language: ____________

Primary Emergency Contact's Name: __________________ Relationship to Patient: ___________

Primary Emergency Contact's Phone Number: ____________________

Secondary Emergency Contact Name: __________________ Relationship to Patient: ___________

Secondary Emergency Contact's Phone Number: ____________________

- **Primary Insurance**

Insurance Company ____

Insurance ID # __________________________ Insurance 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: ___________ Social Security # ____________ Birthdate: _____________

- **Secondary Insurance**

Insurance Company ____

Insurance ID # __________________________ Insurance 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: ___________ Social Security # ____________ Birthdate: _____________

Dallas Medical Physician Group

Patient Name:	DOB:

- **Medical Information**

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

____

Previous Primary Care Physician's Name: __________________________ Phone Number: _________________

If applicable Current Primary Care Physician's Name: _________________ Phone Number: _________________

Other Treating Physicians: __________________________ Phone Number: _____________________

Other Treating Physicians: __________________________ Phone Number: _____________________

❖ Have you had any allergic reactions to the following?

Local Anesthetics (ex. Novocaine)……. Yes □ No □

Penicillin or other Antibiotics………….. Yes □ No □

Sulfa Drugs…… ………………………………. Yes □ No □

Barbiturates (sleeping pills) ……………. Yes □ No □

Other Sedatives……………………………… Yes □ No □

Iodine……………………………………………. Yes □ No □

Aspirin…………………………………………… Yes □ No □

Latex……………………………………………… Yes □ No □

● Have you had a colonoscopy……………. Yes □ No □

Date of last colonoscopy ________________

● Date of last eye exam ________________

● Date of last dental exam ________________

● Previous Hospitalizations/Surgeries/Serious Illness

____

____

____

____

Please list any other allergies: ____

____

❖ Women Only:

Do you have regular periods? …………. Yes □ No □

History of abnormal PAP? ………Yes □ No □

Date of last menstrual cycle? _________________

Date of last PAP? _________________

Are you using birth control pills / patch / injection? ……….. Yes □ No □

Have you ever been pregnant? …………. Yes □ No □

Number of pregnancies? _____________

Any complications in pregnancies? Describe: ____

____

Are you pregnant now? ………………. Yes □ No □

Date of last mammogram? _______________

Date of last bone density? _________________

Dallas Medical Physician Group

Patient Name:	DOB:

Tobacco	Alcohol	Illicit Drugs	Caffeine
Never / past / active Cigarette / cigar / pipe Snuff / dip / chewing Start__________ Stop__________ Packs per day _______	Never / Past / Active Liquor / wine / beer ____drinks per Day / week / month AA / Alcohol Rehab	Never / past / active Cocaine / marijuana Heroin / amphetamine Barbiturate / LSD / PCP IV Drug abuse / Drug Rehab	Never / past / active Coffee / tea / soda ___ cans / cups per day

Exercise: none walking running aerobics weightlifting other ___________days/week

Have you ever had the following? (Please check or leave blank if uncertain)

	Yes No
Acid Reflux……………………..	☐ ☐
ADD/ADHD…………………….	☐ ☐
Asthma ………………………..	☐ ☐
Anorexia ………………………	☐ ☐
Anxiety ………………………..	☐ ☐
Back Problems……………….	☐ ☐
Bleeding Tendency ………..	☐ ☐
Blood Disease ………………	☐ ☐
Specify: ________________	
Cancer…………………………	☐ ☐
Specify: ________________	
Chemotherapy……………….	☐ ☐
Chicken Pox……………………	☐ ☐
Cholesterol ……………………	☐ ☐
Chronic Fatigue Syndrome….	☐ ☐
Congenital Heart Lesions…..	☐ ☐
Diabetes………………………..	☐ ☐
What type? __________________	
Depression…………………….	☐ ☐
Emphysema/COPD…………….	☐ ☐
Epilepsy/Seizures…………….	☐ ☐

	Yes No
Heart attack……………………	☐ ☐
Date of heart attack_________	
Heart Murmur…………………	☐ ☐
Heart Disease………………….	☐ ☐
Hepatitis………………………..	☐ ☐
Type? ______________________	
Hernia…………………………..	☐ ☐
Type? ______________________	
Herpes………………………….	☐ ☐
High Blood Pressure……….	☐ ☐
HIV/AIDS……………………….	☐ ☐
Undergoing Treatment for	
HIV/AID………………………..	☐ ☐
Kidney Disease………………	☐ ☐
Low blood pressure………..	☐ ☐
Measles……………………….	☐ ☐
Migraines…………………….	☐ ☐
Pacemaker…………………..	☐ ☐
Prostate problem……………	☐ ☐
Psychiatric……………………	☐ ☐
Type? ____________________	

	Yes No
Rheumatic Fever…………..	☐ ☐
Stroke …………………………..	☐ ☐
When/type? _______________	
Hypothyroidism…………….	☐ ☐
Hyperthyroidism…………….	☐ ☐
Tuberculosis………………….	☐ ☐
Tuberculosis treated……..	☐ ☐
Ulcers…………………………..	☐ ☐
Date of last EGD? ___________	
Venereal Disease (STD)…..	☐ ☐
Type? ____________________	
Any other condition ……….	☐ ☐
Please describe: ____________	

____
____
____
____
____
____
____

Dallas Medical Physician Group

Patient Name:	DOB:

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father:	______	________________________	______________________________
Mother:	______	________________________	______________________________
Siblings:	______	________________________	______________________________
	______	________________________	______________________________
Children:	______	________________________	______________________________
	______	________________________	______________________________
Maternal Grandmother	______	________________________	______________________________
Maternal Grandfather	______	________________________	______________________________
Paternal Grandmother	______	________________________	______________________________
Paternal Grandfather	______	________________________	______________________________

Immunization Record

(Please provide date of vaccination)

________ Hepatitis A ________Hepatitis B ________Influenza ________DPT ________Polio

________Mumps ________Rubella ________Prevnar ________MMR ________Pneumovax

________Td. ________Dt. ________Tetanus ________Toxoid ________Rubeola

Please list the medications currently taken, their dosages, and how many times per day you take them. (Please include vitamins and over the counter supplements)

Dallas Medical Physician Group

Patient Name:	DOB:

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: ____________________

Consent to Obtain Patient Medication History

Patient medication 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 give 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 you 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 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: ____________________

Email: ____

{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 _________________ Contact Number _________________

Name ______________________ Relationship _________________ Contact Number _________________

Name ______________________ Relationship _________________ Contact Number _________________

Name ______________________ Relationship _________________ Contact Number _________________

- I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Dallas Medical Physician 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: __________________

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 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.

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. Our billing process works better if you provide social security numbers.

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 times within a 12 month period, you may be dismissed from the practice.__________
(Initial Here)

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. 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 companies to collect a copayment, deductible, 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 an additional amount at check-out depending on your level of service. By signing below, you accept these policies.

Previous balances and/or deductibles: It 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 may be legal action pursued. You may be dismissed as a patient from 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 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 you 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. __________
(Initial Here)

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

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.

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 HIPAA Officer at 972-888-7037.

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 HIPAA Officer, 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), vendors 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 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 HIPAA Officer 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 will 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 HIPAA Officer at 972-888-7037. We will be happy to provide a copy of our internal grievance procedures regarding these issues upon your request to do so.

9. What to do if you wish to file a complaint with the Texas Board of Medicine?

   The Board investigates complaints against physicians, physician assistants, acupuncturists, surgical assistants, respiratory care practitioners, medical radiologic technologists, medical physicists, and perfusionists. If you wish to complain to the Board, please do so in writing. Provide full name and practice address of practitioner. Also, provide dates and details of any incident, being as specific as possible. If your complaint is within the Board's jurisdiction, it will be assigned for proper study. Complainants are advised of an investigation status approximately every 90 days until final action is taken. **Complaint Hotline 1-800-201-9353** and follow the automated prompts to request a complaint form. Mail to: Investigations Department MC-263, P.O. BOX 2018, Austin, Texas 78768-2018

Dallas Medical Physician Group

Prescription Guidelines

- In general, your provider will give you enough medicines to last you until your next appointment.
- If you do not have Rx refills left, please contact your pharmacy at least 3 days before your medicines run out. If you use a mail order refill service, please contact them at least 14 days before your medicines run out. They will send your provider an Rx request. DO NOT CALL AND LEAVE A MESSAGE FOR THE NURSE TO REFILL MEDICATIONS.
- Certain medications require laboratory testing before they can be refilled.
- Refills on medication can only be authorized on medications prescribed by physicians in our office. We will not refill medications prescribed by other physicians.
- Calls for Rx refills will not be accepted outside of regular business hours.
- If you call to request a refill but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit. It is your responsibility to schedule an appointment before you run out of medication. You should schedule your next appointment before you leave our office.
- If a prescription needs prior authorization from an insurance company it will be handled in a timely manner. All insurances vary in the length of time it takes to process authorizations.
- Our office will not refill a prescription for a patient what has not been seen in the last year. It is not appropriate to refill prescriptions for patients who have not had adequate follow up visits. It is important for our providers to be able to monitor patient's progress and use of medication.
- If your medication is stolen we will not refill your medications early without a police report.
- You cannot be prescribed the same medications by different physicians. We will terminate your care if this happens.
- Triplicate prescriptions must be picked up in the office, they cannot be called in. Do not wait until you are out of medicine to come in to the office. Please contact the office 5-7 days prior to your medication running out.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name of Patient: ____ Date of Birth: ________________________

Last Four Digits of Social Security Number (SSN): ______________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

Patient information is requested for:

□ Continuing Medical Care　□ Military　□ Social Security/Disability

□ Insurance　□ Personal Use　□ Other: _____________________

□ Legal Purposes　□ School　____________________________

Information to be released or accessed:

Description:	Date(s):	Description:	Date(s):
□ All PHI in medical record □ Consultation Report □ Death Summary □ Discharge Summary □ Emergency Room Record		□ Face Sheet □ Lab Reports □ Operative Reports □ Pathology Reports □ X-ray Reports/Images	

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

____　_____________________　____________________

Address (Street, City, State and ZIP)　(Phone number)　(Fax number)

FROM:

____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

____　_____________________　____________________

Address (Street, City, State and ZIP)　(Phone number)　(Fax number)

I understand that my records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: ____________________　Signature: ____

Patient or Legally Authorized Representative

____

Printed Name of Patient or Legally Authorized Representative

____

Relationship to Patient