Addison Internal Medicine

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Date of Birth (Age):	Gender: ☐ Female ☐ Male	Marital Status: ☐ Married ☐ Single ☐ Divo ☐ Widowed ☐ Separated
Ethnicity: : ☐ Caucasian ☐ African-American ☐ Asian/Pacific Islander ☐ Hispanic ☐ Native-American ☐ Other	Social Security No.:	Email Address:
Address:	City, State, Zip Code:	Language/Translator needed: ☐ Yes ☐ No
Home No: Cell No: Work No:	☐ OK to leave detailed message at home/cell number. ☐ OK to mail/fax to my home address/number. ☐ OK to send text/email (portal)	Employment Status: ☐ Employed ☐ Retired ☐ Self-Employed ☐ Unemployed
Student Status: ☐ Full-Time ☐ Part-Time	Employer/ School:	Occupation:
Employer/ School Phone No.:	Referring Provider Name:	Advanced Directives (EX: DNR, Living Wil ☐ Yes ☐ No

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home Phone No.:

INSURANCE INFORMATION

Primary Health Insurance

Insurance Company:	Plan:	
Subscriber ID No.:	Group No.:	Copay:
Insured's Name (as it appears on insurance card):	Relation to Patient:	Date of Birth (Insured):
Insured's Address:	City and State:	Zip Code:

Secondary Health Insurance (if applicable)

Name of secondary insurance (if applicable):	Subscriber's Name:	Policy No.:	Group No.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Addison Internal Medicine or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

16980 Dallas Parkway, Suite 110, Dallas, TX 75248
Phone: 972-733-3090 | Fax: 972-733-4565 |www.AddisonInternalMedicine.com

Addison Internal Medicine

Patient General Consent to Treat

I, _____ the undersigned, hereby consent to the following:

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Addison Internal Medicine may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

Pharmacy Info/RX History Consent

We, at Addison Internal Medicine are very pleased that you have chosen us as your primary healthcare provider. In order to better serve you, your prescriptions will now be electronically processed directly to your pharmacy. Please provide us with your pharmacy information in the space provided below.

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

By signing this consent, you are authorizing Addison Internal Medicine to view your prescription history from external sources.

_____ _____

Patient (or responsible party) Signature Date

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Addison Internal Medicine
Patient HIPAA Form

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

Notice of Privacy Practices Acknowledgement

_____ (Patient initials) I acknowledge that I have received Addison Internal Medicine Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Addison Internal Medicine Notice of Privacy Practices.

Release of Information

_____ (Patient initials) I permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

1. Name: _____Relationship: _____ Phone No.: _____
2. Name: _____Relationship: _____ Phone No.: _____
3. Name: _____Relationship: _____ Phone No.: _____

_____ _____

Patient (or responsible party) Signature Date

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Patient Responsibility Form

Thank you for choosing Addison Internal Medicine for all your medical needs. We look forward to providing you a complete package of medical treatment. We file your charges to your insurance carrier as a benefit to you. It is, however, the patient's responsibility to know and understand what service is covered under the policy. To help keep healthcare costs down, we ask the following payments to be made on your account prior to being seen by your doctor. Any outstanding balance owed is due after your visit with your physician, payable at the front desk check in. For your convenience we accept cash, check and most major credit cards. There is a $25 fee for return checks.

INSURED: Your co-pay, in accordance with your insurance plan, is due at check-in. If you have a deductible plan, please note that $100 pre-payment will be collected at check in. Once we receive payment from your insurance, you will be billed for any balance owed. Because we are obligated under contract with your insurance company, this balance cannot be adjusted off your account.

UNINSURED: If you are a new patient $195.00 will be due at the time of check in. If you are an established patient $132.00 will be due at the time of check-in. Payment collected at check-in does not include any additional services such as labs, EKG, X-ray's or injections. Payment for these services will be due at check-out. Overpayments resulting in a credit balance will be applied to any outstanding balances on your account.

Motor Vehicle Accidents: If you are seeing one of our physician's due to a motor vehicle accident, payment must be made at the time of your appointment. We do not file claims to automobile insurance companies therefore; it will be your responsibility to provide your bills and receipts from Addison Internal Medicine to your Insurance Company. We will not file claims to Worker's Compensation.

Common Insurance denials include but are not limited to: Pre-Existing condition, insurance not in effect at the time of services, coverage by more than one plan in which coordination of benefits has not been arranged, policy maximum has been reached, or medical services rendered are not covered by the insurance policy. All unpaid balances remain the patient/guarantor responsibility.

How you can assist in several ways to expedite your claim and reduce denials: You will be asked when you check in at every visit to provide a picture ID, verify your personal information and make any changes so that your account can be updated. It is your responsibility to inform us of any demographic and insurance changes. If you have two or more insurance carriers, please advise us and provide a copy of both cards.

No show, cancellation and late patient policy: If you are unable to keep a scheduled appointment, please give 24-hour notice to ensure that you will not be charged the $25 no show fee. If there are three or more scheduled appointments which you do not keep without prior cancellation or if there are repeated scheduled appointments in which you arrive fifteen minutes late, you could be subject to dismissal from our practice.

FMLA/Disability paperwork: Blank forms will not be accepted. Personal information must be completed. Paperwork will be completed on or before 7 business days. Forms are completed for those accounts in good standing. Outstanding balances must be paid prior to forms being filled out. There is $25 fee due when forms are completed.

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf based on the information I provide. Both Addison Internal Medicine and I will receive an EOB (explanation of benefits) from my insurance carrier(s) that will detail any payments, deductions and adjustment per my plan's guidelines.

I understand that I will be fully responsible for payment of all medical services denied by my insurance company as applicable by state and/or federal law.

_____ _____

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