Welcome to Doctors of Internal Medicine your new Medical home!

The Patient-Centered Medical Home is a team-based approach to providing comprehensive primary care. The PCMH is a health care setting that facilitates a partnership between the patient and their Primary Care Physician, educating and supporting the patient's active participation in the care they receive, helping you make healthy lifestyle choices. Your Care Team includes **YOU.**

We understand that having a Primary Care Physician that knows you, your history, and family history is important to maintaining your health. The PCP can provide screenings you need to identify and treat minor problems before they become major problems, treating the patient as a whole person. A PCP can provide options for conditions that may not truly require emergency care or recommend a specialist to meet your health care needs. Your PCP will become your central point of contact coordinating information between specialists and other health care providers.

Our New Patient Registration Forms are available at www.doctorsofplano.com under Patient Forms tab. You will want to complete the standard Medical Release form and send it to your previous health care providers as soon as possible. Please complete ALL of the forms and bring them with you to your first appointment. If you wish, you may mail or drop off your completed packet prior to your appointment. We do ask that you plan to arrive 15 minutes prior to your appointment time so that we may complete the registration process and prepare your electronic chart.

Care coordination and Referrals: As your Medical Home, we coordinate care with your other health care providers. The recommended specialist's office may contact you directly to schedule an appointment. If you have received a referral and have not been contacted or your referral requires a prior-authorization from your insurance carrier, please let us know.

It is important to let us know when you have received care outside of our practice. This allows us to obtain health information from other providers so that your Primary Care Physician has an accurate representation of your health status each time he/she sees you. This information is collected as part of the new patient registration process; however, you may have seen another physician since your first visit. A Medical Release Form can be completed at any time. You may choose to fax the request directly to your other physician or complete the form in the office and we can fax it for you. Please include the name of the Physician you have seen and a telephone or fax number. The office fax number is (972) 758-4433. If you have any questions about obtaining copies of medical records from outside our practice, please contact one of our friendly front office staff members at (972) 758-4455.

Messaging: Although we would like to answer each phone call personally, it is sometimes impossible to do so. In order to accommodate all of our patients, we use a voicemail system and by leaving a complete message your concern will be attended to as quickly as possible. When leaving a message, please speak clearly and leave your complete name, date of birth, and telephone number for a return call. Most calls are returned the same day. Messages left after 3:30 pm may be returned the following day. If you have an urgent need, please follow the instructions to speak with the physician on call. Please allow 48 hours for prescription refill requests.

Laboratory and Diagnostic Test Results: After your physician has reviewed your test results, a nurse or medical assistant will contact you to discuss with you the physician's comments and recommendations. Results are usually available within 48 hours and can be printed directly from our patient portal.

Patient Portal: Ask about our Patient Portal. The portal allows you access to your past appointment history, notifications of upcoming appointments, and the ability to confirm or cancel a scheduled appointment. You can also update your demographic/insurance information and receive laboratory/diagnostic test results. Results can be downloaded and/or printed directly from the portal. Register for portal use at https://www.health.healow.com/DIM.

Appointments: Call the appointment line at (972) 758-4455 to schedule an appointment. We are NOT a walk-in clinic, so please call ahead to schedule an appointment for your urgent needs. Same-Day appointments are available for both routine and urgent care. Established patients should check in 10 minutes prior to your appointment so that we may update your demographic and insurance information. Late arrivals may need to be rescheduled.

Please make every effort to keep your appointments and notify the office as early as possible to cancel or reschedule. Last minute cancellations or failing to show without advanced notice may result in a No-Show charge.

Patient Satisfaction Survey: We are committed to quality. You may receive a survey regarding your visit. We encourage you to complete the survey to help us improve our quality of service to you.

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PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____

Previous Name: _____
(Maiden name, former married name, etc.)

Home Address: _____
(No PO boxes)

City: _____

State: _____ Zip Code: _____

Primary (_____) _____ ❑Cell Phone ❑Home Phone

Secondary (_____) _____ ❑Cell Phone ❑Home Phone

Date of Birth: _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number: _____

Employer Name: _____

❑ Full Time ❑Part Time

Referring Provider's Name & Number: _____

_____

Race: ❑ African American ❑Asian ❑ Hispanic ❑ Native American ❑ White ❑ Pacific Islander ❑ Other ❑ Declined

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Declined

Please sign up for our **patient portal** today. Our portal gives you access to your health-care data (medication list, laboratory results and medical summary) and most importantly you can communicate with us through the secure portal system. You can ask questions or refill your medications through the portal. Please be advised that it may take up to 3 working days to answer your request.

Patient's Email: _____

Does someone care for you at home? If so, who? _____

Is this person your guardian/legal proxy? ❑ Yes ❑No

What is your primary language? ❑English ❑Spanish ❑ Other

Do you require the assistance of a translator? ❑Yes ❑No

Pharmacy Information:

Name: _____

Location (City & Intersection):

_____

Phone: _____ Fax: _____

Responsible Party (if different from patient information above)

Name: _____ Date of Birth: _____

Relationship: ❑Self ❑Spouse ❑Parent ❑Other Social Security Number: _____

Street Address: _____

City / State / Zip Code: _____ Home Phone: _____

Minor Consent (Required if the patient is under the age of 18):

I (_____) am the parent and/or legal guardian of _____ and I hereby give my consent to Doctors of Internal Medicine / Doctors of Primary Care at McKinney to give medical treatment as deemed necessary by the physician and/or his/her Physician's Assistant or Nurse Practitioner.

_____ _____

Signature of Parent/Legal Guardian Date

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Financial Policy

Payment is required for all services at the time they are rendered. As a courtesy we will file your claim with your insurance carrier. Applicable co-payments, estimated deductibles, coinsurance and non-covered services will be collected. Once our office has received an "Explanation of Benefits" from your insurance, and the provider adjustments have been applied, you will receive a statement for any outstanding balance, which is due upon receipt. In the event an overpayment has been made and to ensure the most accurate refund amount, please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.

If you are a member of a plan in which you must choose a "primary care physician", it is your responsibility to select the physician you are appointed with prior to your first visit with him/her. If you have not done so, your visit may not be covered and you will be responsible for payment in full at the time of service or you may choose to reschedule your appointment.

We accept payment in the form of cash, check, and all major credit cards. If a check is returned to our office, there will be a $35.00 return check fee added to your account. Please note that all future appointments will need to be paid with cash, credit card or money order only. For appointments which are missed or cancelled with less than 24-hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make, in-full, prompt payment to Doctors of Internal Medicine/Doctors of Primary Care at McKinney when billed for, any and all, charges not covered or paid by valid insurance benefits for services rendered. Further, I authorize payment directly to Doctors of Internal Medicine/Doctors of Primary Care at McKinney for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature Date

Consent for Treatment

I hereby consent to evaluation, diagnostic procedures, testing and treatment as directed by my physician or his/her designee. I understand that this consent to treat will be valid for each visit I make to Doctors of Internal Medicine/Doctors of Primary Care at McKinney until revoked by me in writing.

By signing below, I understand and agree to all stated and filled in above.

_____ _____

Signature Date

_____ _____

Patient Name (Please print clearly) Date of Birth

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Notice of Privacy Practices

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies. HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your protected health information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other than expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information, for which we would receive compensation, would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes".

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions on disclosures that are otherwise allowed. However, in certain instances, if you make a request for restrictions on disclosures, we will be obligated to abide by them. Specifically, if you pay for an item or service in full, out of pocket, and request that we not disclose the information relating to that service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

To the extent that this office maintains your Protected Health Information (PHI) in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three (3) years prior to such request, as required by HIPAA.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined in HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Hunan Services. You may speak with the Office Manager to obtain additional information regarding any questions you may have

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Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave **DETAILED** information related to the following, on your voicemail:

❑ Test results, labs, medical issues ❑ Billing questions ❑ Scheduling issues

Primary: (_____) _____ ❑ Cell phone ❑ Home Phone

Secondary: (_____) _____ ❑ Cell phone ❑ Home Phone

It is our practice's policy to confirm all scheduled visits with a phone call or email. This will be done for all patients. Please notify the receptionist if there is an urgent reason not to confirm appointments.

Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent. I authorize this facility to speak to the following family members or my personal representative regarding:

❑ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.

The above medical information shall only be released to the following person(s):

1._____Relationship: _____Phone number: _____

2._____Relationship: _____Phone number: _____

3._____Relationship: _____Phone number: _____

❑ Do not disclose any information on file other than to patient on record.

In case of an emergency please contact:

_____Relationship: _____ Phone number: _____

Privacy Practices (HIPAA)

I have been given the opportunity to review, understand and consent to this practice's Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

_____ _____

Signature Date

_____ _____

Patient Name (Please print clearly) Date of Birth

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Health History Questionnaire

All questions are confidential and will become part of your medical record.

Name _____ Date _____/_____/_____

Date of Birth _____/_____/_____ □ M □ F Marital Status _____

Whom may we thank for referring you to our practice? _____

What problem brought you to the doctor? _____

_____

MEDICAL CONDITION

Condition	Date Diagnosed (Mo/Yr)	Type of Treatment Received (i.e. medication, hospitalization, chemotherapy, radiation, etc.)	Date Resolved (Mo/Yr)

PRIOR SURGERIES

Type of Surgery	Date (Mo/Yr)

DEPRESSION SCREENING

In the last 2 weeks, have you found you have had less pleasure in doing activities that you normally do?	Yes / No
Any feelings of being down, depressed, or hopeless?	Yes / No

Name _____ Date of Birth _____/_____/_____

MEDICATIONS (Please include over-the-counter medications and herbal supplements)

Medication	**Dose (mg., units, etc.)**	**Frequency**	**Date Started**	**Last Taken**

ALLERGIES

Drugs / Foods	**Reactions**

SOCIAL HISTORY

What is your occupation?	Education Level: (circle one) HS / Tech / Some College / Bachelors / Masters / Doctorate
Do you currently smoke? Yes / No Are you a former smoker? Yes / No	Age started: ____ Average # of packs per day: ____ Total years you smoked: _____ Are you interested in quitting? Yes / No Age quit: _____
Do you drink alcohol? Yes / No How often do you drink? daily / weekly / monthly / yearly	Whenever you do drink, how many drinks do you consume? _____ Do you ever consume 6 or more drinks in 1 day? Yes / No
Do you drink caffeinated beverages? Yes / No	Average number per day: _____ coffee / tea / soda
Do you exercise regularly? Yes / No Type of exercise _____	Average # of times per week: 1-2 3-5 5-7 Average # minutes per session: < 30 30-60 60-90
Have you ever used drugs? Yes / No	Type: _____ current use / past use
Are you engaged in activities that put you at risk for HIV? Yes / No	
Do you wear seat belts? Yes / No	Do you see the ophthalmologist regularly? Yes / No Date of your last eye exam: _____ (Mo/Yr)

Name _____ Date of Birth _____/_____/_____

HEALTH MAINTENANCE

Date of last **physical exam** (Mo/Yr):		
Date of last **cholesterol testing** (Mo/Yr): Total Cholesterol: LDL: HDL: Triglycerides:		
Date of last **colonoscopy** (Mo/Yr): Results: Any polyps?		
Date of last **upper GI** or **endoscopy** (Mo/Yr): Results:		
Date of last **PSA** (Mo/Yr): Normal / Abnormal If abnormal, any other testing or treatment?		
Date of last **EKG** (Mo/Yr): Results:		
Date of last **stress test** of heart (Mo/Yr): Results: Type of stress tests (treadmill / chemical / nuclear / echo) please circle one		
Immunizations and Dates (Mo/Yr)	□ Tetanus (Td / Tdap) please circle one	□ Hepatitis A
	□ Influenza	□ Hepatitis B
□ HPV	□ Pneumonia	□ Shingles

WOMENS HEALTH

Age at onset of menstruation:	Age at onset of menopause (if applicable):
Periods every _____ days.	Date of last menstrual period:
Heavy periods, irregularity, spotting, pain, or discharge?	
Number of pregnancies: Number of live births:	Number of miscarriages / abortions:
Current method of contraception:	
Date of last **Mammogram**:	Normal / Abnormal - Any further testing or treatment?
Date of last **Pap smear**:	Normal / Abnormal - Any further testing or treatment?
Date of last **Bone Density** test:	Normal / Abnormal - Any further testing or treatment?

FAMILY HISTORY

Relative	**Significant Medical Problem**	**Age and Cause of Death**
Father		
Mother		
Brother # _____		
Sister # _____		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Paternal Uncles		
Paternal Aunts		
Maternal Uncles		
Maternal Aunts		

Name _____ Date of Birth _____/_____/_____

Past Week	Past 3 Months	Condition
General Health		
□	□	Fatigue
□	□	Fever
□	□	Unexpected weight loss or gain
Eyes		
□	□	Blurred vision
□	□	Double vision
□	□	Cataracts
□	□	Glaucoma
Head / Neck		
□	□	Hay fever (pollen allergy)
□	□	Hearing loss
□	□	Neck pain
□	□	Sinusitis / sinus problems
Cardiovascular		
□	□	Circulatory problems
□	□	Coronary heart disease
□	□	Congestive heart failure
□	□	Arrhythmias (irregular heartbeat)
□	□	Heart murmur / valve condition
□	□	High blood pressure
□	□	High cholesterol
Respiratory		
□	□	Asthma
□	□	Emphysema/COPD
□	□	Cough
□	□	Pneumonia
□	□	Shortness of breath
□	□	TB (tuberculosis)
Breast		
□	□	Abnormal mammogram
□	□	Breast lumps
□	□	Breast biopsies
Gastrointestinal		
□	□	Colon polyps
□	□	Constipation
□	□	Diarrhea
□	□	Diverticulosis/diverticulitis
□	□	Hemorrhoids
□	□	Hernia
□	□	Hepatitis
□	□	Jaundice
□	□	Irritable bowel syndrome
□	□	Liver disease
□	□	Ulcers

Past Week	Past 3 Months	Condition
Genital and Reproductive		
□	□	Abnormal pap smear
□	□	Genital warts / HPV
□	□	Infertility
□	□	STD (herpes, gonorrhea, chlamydia, etc.)
Urinary		
□	□	Incontinence (loss of urine)
□	□	Kidney disease
□	□	Prostate enlargement (BPH)
□	□	Slow urine stream
□	□	Frequent urination
Musculoskeletal		
□	□	Arthritis
□	□	Gout
□	□	Joint pains
□	□	Muscle aches
Skin and Lymph Nodes		
□	□	Eczema
□	□	Lymph node swelling
□	□	Other skin disorder
Neurologic		
□	□	Headaches
□	□	Seizures / epilepsy
□	□	Stroke
Psychiatric		
□	□	ADD / ADHD
□	□	Alcohol / Drug problems
□	□	Anxiety / Panic attacks
□	□	Depression
□	□	Eating disorder
□	□	Insomnia
Endocrine		
□	□	Diabetes
□	□	Thyroid problems
Heme-Onc and Immunology		
□	□	AIDS / HIV
□	□	Anemia
□	□	Blood clots
□	□	Cancer
□	□	Easy bleeding
□	□	Easy bruising
□	□	Sickle cell anemia
□	□	Transfusion

OTHER HEALTHCARE PROVIDERS THAT YOU SEE

Name / Specialty	Name / Specialty

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Authorization for Use and Disclosure of Protected Health Record Information

Physician Name _____ Fax _____

The information that is to be released from my medical records is for the following purpose:

Is authorized to release the following:

☐ Discharge Summary ☐ History and Physical ☐ Operative Reports ☐ Pathology Reports ☐
☐ Laboratory Reports ☐ Consultation Reports ☐ EKG/ECHO ☐ Emergency Room Records
☐ Shot Records ☐ Progress Notes ☐ X-Ray Reports/Films ☐ Occupational Health
☐ Senior Health Records ☐ Basics/Abstracts ☐ Psychiatric Records
☐ Complete Records ☐ Itemized Bill ☐ Other: _____
Continued Medical Care ☐ Billing/Claims ☐ Patient Request ☐ Other _____

To _____Phone _____Fax_____

Releasing information about drug abuse, alcohol abuse, psychiatric care, and STDs

I understand if my medical or billing records contain information that reference my drug abuse, alcohol abuse, psychiatric care, sexually transmitted disease history, Hepatitis B or C testing, and/or other sensitive information, I still agree to its release.

Please check one: ____ Yes ____ No ____ Initials

I understand if my medial or billing record contains information that refers to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I still agree to its release.

Please check one: ____ Yes ____ No ____Initials Time limit and right to revoke authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Doctors of Internal Medicine & Doctors of Primary Care at McKinney.

Re-disclosure

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act (HIPAA-Act of 1996). DIM & DPCM and its employees are hereby released from any form of legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Management of medical records

I understand that once DIM & DPCM have received and reviewed these medical records, the necessary records will be scanned into the patient's chart and the remaining medical records will be properly disposed of per HIPAA standards.

Signature of patient or personal representative

I authorize DIM & DPCM to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for copies.

_____ _____
Signature of patient or legal representative Date

_____ _____
Printed Name (or representative) DOB