## Plano Internal Medicine Associates, P.A.

**O Gary Tigges, MD** **O Son Giep, MD** **O Shelly Heidelbaugh, MD**

### PATIENT INFORMATION

**NAME:** _____ **DATE OF BIRTH:** _____

**ADDRESS** _____ **CITY/STATE**_____**ZIP** _____

**SSN:** _____ **SEX:** **Female** **Male** **MARITAL STATUS:** _____

**HOME #** _____ **WORK #** _____ **CELL #** _____

**EMAIL:**_____

**EMPLOYER:** _____

**ADDRESS**_____ **CITY/STATE**_____**ZIP** _____

**WHO REFERRED YOU?** _____

### IN CASE OF EMERGENCY - CONTACT INFORMATION

**NAME:** _____ **PHONE:** _____

### PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

**CONSENT TO TREATMENT:**

**I hereby consent to evaluation, testing, and treatment as directed by my provider or those under his/her supervision.**

**ASSIGNMENT OF INSURANCE BENEFITS:**

**I hereby authorize direct payment of my insurance benefits to the physician indicated above for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay, coinsurance or balance due that my provider is unable to collect from my insurance carrier.**

**MEDICARE/MEDICAID/INSURANCE BENEFITS:**

**I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to the physician on my behalf.**

**CANCELLATION/ NO SHOW POLICY/LATE:**

**Our office policy requires patients who request to cancel or reschedule their appointment to call our office at least 24 hours prior to their scheduled visit. A $25.00 No Show/Cancellation Fee may be assessed to you if the office is not contacted according to the policy. This fee also applies to any patients that do not show up for their scheduled appointment. The office and/or automated system will attempt to confirm your appointment in advance of the appointment. Please note insurance companies cannot be billed for missed appointments. Please arrive on time for your scheduled appointment. Your appointment time is scheduled for you to be seen. If you are late, there is a possibility the office may ask you to reschedule out of consideration for those patients scheduled after you.**

**PATIENT'S SIGNATURE/** _____ **DATE** _____
**AUTHORIZED REPRESENTATIVE**

## Plano Internal Medicine Associates, P.A.

**O Gary Tigges, MD** **O Son Giep, MD** **O Shelly Heidelbaugh, MD**

**TESTING**

**Patients should expect to receive notification for results of any testing including labs and radiology within one week. We will attempt to contact you but in the event we are unsuccessful in reaching you, it is patient responsibility to obtain your results. If you are scheduled for a visit to review your results, including physicals, we will plan to go over your results at the time of the visit and not attempt to contact you before the visit. If you miss the appointment to review, it is your responsibility to contact our office to reschedule.**

**TREATMENT**

**We make the best effort to diagnose and treat your condition(s) based upon the information we have. Sometimes, however, diseases and conditions may evolve. If you do not improve or your condition worsens and/or changes, it is your responsibility to inform us so we may re-evaluate your condition and diagnosis.**

**RESEARCH PROGRAMS**

**The physician(s) or staff may ask if you would like to participate in a clinical trial or research program. These may be sponsored programs. Please note the physician(s) and/or patients may be compensated for services rendered in connection with these programs. You are not obligated to participate in any of these programs. Your permission will be obtained prior to your participating in any of the programs that your provider may believe is appropriate for you. Please feel free to ask the staff and/or provider(s) if you have any questions regarding the research programs.**

**PAYMENT POLICY:**

**I understand and acknowledge the following:**

- **We will file insurance for our PPO, HMO, and other managed care patients.**
- **Verification of benefits given to us by your insurance company is not a guarantee of payment.**
- **All copays, deductibles, and/or coinsurance are due at the time of services rendered according to insurance contract provisions.**
- **We cannot guarantee payment of your claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.**
- **We accept assignment and will file for our Medicare patients. Any calendar year deductible amount, to the extent of the visit amount) are due at time of service if applicable. Patient will be responsible for 20% if there is no secondary insurance. If a secondary is available, we will file secondary insurance after payment from Medicare.**
- **There is a $25 fee assessed for any returned check. You will subsequently receive a bill for this amount. Payment will need to be made in cash, money order, or VISA/MC. If payment is not received by the due date, you information will be turned over to the Collin County District Attorney. Any returned check will immediately restrict any future acceptance of checks as payment on your account.**
- **Late fees may apply to accounts past due 90 days.**
- **If your policy is an HMO, you are responsible for contacting your insurance prior to your visit and assigning the provider you are scheduled with. Failure to do so may result in claim denial and you will be responsible for the balance due on account.**
- **If any patient is owed a refund, all claims on the account must be processed and paid in full before overpayment is refunded. If account is eligible, refunds will be processed 30 days from the date we are made aware of the refund due.**
- **Failure to provide the correct and accurate information regarding insurance in order to file claims accurately and timely could result in claim denial therefore may result in patient responsibility.**
- **I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.**

**PATIENT'S SIGNATURE/ AUTHORIZED REPRESENTATIVE** _____ **DATE** _____

## Plano Internal Medicine Associates, P.A.

**O Gary Tigges, MD** **O Son Giep, MD** **O Shelly Heidelbaugh, MD**

**AUTHORIZATION TO MAIL, CALL OR E-MAIL:**

**I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Plano Internal Medicine Associates, PA, designated provider(s), or those under his/her supervision and/or representatives to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Plano Internal Medicine Associates, PA to that effect in writing.**

**I certify I understand the following:**

- **Email should never be utilized for an urgent or emergency problem.**
- **Providers are not required to communicate via email; this is at the discretion of the provider.**
- **Email should never be used for time sensitive issues.**
- **Email is not confidential and should not be used for sensitive information.**
- **All emails will become part of the permanent medical record.**
- **Email responses may not receive an immediate response. Responses may take a full business day or more.**
- **The provider(s) will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond the office's control.**
- **I agree that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.**

**IN GENERAL, THE HIPAA PRIVACY RULES GIVES PATIENTS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). PATIENTS ARE ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICAITONS DISCLOSURES OF PHI TO BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDANCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THEIR HOME.**

**I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:** ***(check all that apply)*** **Initials_____**

| | |
|---|---|
| **_____ Home Telephone** | **O OK to leave message with detailed information**<br>**O Leave message with call back number only** |
| **_____ Work Telephone** | **O OK to leave message with detailed information**<br>**O Leave message with call back number only** |
| **_____ Mobile Telephone** | **O OK to leave message with detailed information**<br>**O Leave message with call back number only** |
| **_____ Written Communication** | **O OK to mail to my home address**<br>**O OK to mail to my work address** |
| **_____ Fax Machine** | **O OK to fax to this number: _____** |
| **_____ Other (please specify)** | **_____**<br>**_____** |

**PATIENT'S SIGNATURE/ _____ DATE _____**
**AUTHORIZED REPRESENTATIVE**

## Plano Internal Medicine Associates, P.A.

**O Gary Tigges, MD** **O Son Giep, MD** **O Shelly Heidelbaugh, MD**

**NOTICE OF PRIVACY PRACTICES AND HIPAA RELEASE OF INFORMATION:** **Initials_____**

**I certify and acknowledge that I have read and been made available a copy of the Notice of Privacy Practices. I understand the Notice of Privacy Practices provides information on how we may use and disclose protected health information (PHI). The Notice contains information regarding your rights under the law. The terms of our Notice may change. If we change our Notice, you will obtain a revised copy during your next office visit. You have the right to request that we restrict PHI about you for treatment, payment, or healthcare operations. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 199 (HIPAA).**

**I understand that PHI may be disclosed or used for treatment, payment, or healthcare operations. The practice has the Notice posted and available for the patient to review. The practice reserves the right to change the Notice of Privacy Practices. The practice reserves the right to restrict the uses of their information but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing at any time and all future disclosures will cease.**

**This authorization expires at the end of each calendar year or is revoked by the patient in writing. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.**

**Finally, you may revoke this authorization in writing at any time by sending written notification to Plano Internal Medicine Associates, PA Attn: Practice Manager. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.**

***PLEASE CHOOSE ONE:***

**_____** **I do not wish my information to be disclosed to any person.**

**_____** **I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):**

**Name: _____Relationship:_____Phone:_____**

**Name:_____Relationship:_____Phone:_____**

**Name:_____Relationship:_____Phone:_____**

**Name:_____Relationship:_____Phone:_____**

**Name:_____Relationship:_____Phone:_____**

**I certify that I have read, acknowledge and understand Plano Internal Medicine Associates, PA Patient Registration Form Disclosures & Consents.**

**This complete and full Disclosure and Consent Form assignment will remain in effect until revoked by me in writing. A photocopy and/or electronic copy of this instrument will have the same validity as the original.**

**PATIENT'S SIGNATURE/ _____ DATE _____**
**AUTHORIZED REPRESENTATIVE**

**Plano Internal Medicine Associates, PA**

**Gary A Tigges, MD** **Son N Giep, MD** **Shelly Heidelbaugh, MD**

# PATIENT MEDICAL HISTORY

**Name:** _____ **Age:** _____ **Occupation:** _____

**Chief Complaint:** _____

**VITALS** **Weight:** _____ **Height:** _____ **Blood Pressure:** _____/ _____ **Temp:** _____

**FAMILY HISTORY**

| | | | |
|---|---|---|---|
| Has any relative had: | Cancer of breasts, female organs, colon, melanoma | Yes | No |
| | Tuberculosis in the last 5 years | Yes | No |
| | Diabetes | Yes | No |
| | High blood pressure | Yes | No |
| | Kidney trouble (other than kidney stones) | Yes | No |
| | Heart Disease | Yes | No |
| | Anethesia complication | Yes | No |

**Exercise**: Do you exercise at least 20 minutes, 3 times a week? Yes No

**Alcoholic Beverages:** _____ Never _____ Occassionally _____Moderately _____ Daily

**Smoking:** Do you smoke? Yes No

If yes, how many packs per day? _____

If you quit, how long has it been? _____

**Drug Use:** Have you used, previously used, or had problems with any of the following:

_____ Marijuana _____ Heroin _____ Cocaine _____ Other Recreational Drug :_____

**MEDICAL HISTORY** Have you ever had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Asthma or breathing problems | Yes | No | Colon trouble or bowel disorder | Yes | No |
| Anemia (longer than 3 months) | Yes | No | Kidney trouble | Yes | No |
| Tuberculosis | Yes | No | Venereal disease | Yes | No |
| High Blood Pressure | Yes | No | Varicose veins or Phlebitis | Yes | No |
| Heart Disease or murmur | Yes | No | Bleeding disorders | Yes | No |
| Diabetes | Yes | No | Seizures, loss of consciousness | Yes | No |
| Depression | Yes | No | Visual disturbance | Yes | No |
| Thyroid disorder | Yes | No | Treatment for nervous disorder | Yes | No |
| Ulcer or stomach problems | Yes | No | Cancer | Yes | No |
| Hepatitis, jaundice | Yes | No | Blood transfusions | Yes | No |
| Hospitalization for psychiatric reasons | Yes | No | Alchol abuse | Yes | No |
| Other _____ | | | Drug Abuse | Yes | No |

Please explain "Yes" Answers: _____

_____

**IMMUNIZATIONS and OTHER**

Have you had a tetanus shot in the last 10 years? Yes, Date _____ No

(Only age 50 and over) Have you had a pneumonia shot in the last 10 years? Yes, Date _____ No

Have you had any other immunization in the past? _____

Last Dental Exam: _____ Dentist Name: _____

Last Eye Exam: _____ Eye Dr Name: _____

**SURGERIES** (*Please include Dates)*

_____

**DRUG ALLERGIES**: _____

**MEDICATIONS**: ***Please list all medications you are currently taking including dosage***

_____

_____

_____

**Patient Signature:**_____ **Date:** _____