Plano Internal Medicine Associates, P.A.

Gary Tigges, MD **Herbert Bautista, APRN**

PATIENT INFORMATION

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

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

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

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

RACE: _____ _____ **ETHNICITY** _____ **PREFERRED LANGUAGE**_____

EMPLOYER: _____

ADDRESS_____ **CITY/STATE**_____**ZIP** _____

WHO REFERRED YOU? _____

WOULD YOU LIKE INFORMATION ON OUR PATIENT PORTAL: YES NO

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.

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. 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. All copays, deductibles, and/or coinsurance for all commercial insurance, Medicare and Medicare Replacement plans are due at the time of services rendered according to insurance contract provisions.

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 $50.00 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. Please note insurance companies cannot be billed for missed appointments late fees assessed. 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

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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:

- **Verification of benefits given to us by your insurance company is not a guarantee of payment.**
- **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.**
- **There is a $35 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. The HMO Policy will also be provided to you.**
- **If any patient is owed a refund, all claims on the account must be processed and paid in full before overpayment is refunded.**

POLICY FOR 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.**

PATIENT'S SIGNATURE/ _____ DATE _____
AUTHORIZED REPRESENTATIVE

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

_____Home Telephone O OK to leave message with detailed information O Leave message with call back number only

_____Work Telephone O OK to leave message with detailed information O Leave message with call back number only

_____Mobile Telephone O OK to leave message with detailed information O Leave message with call back number only

_____Written Mail O OK to mail to my home address

_____ Email address O _____

NOTICE OF PRIVACY PRACTICES AND HIPAA RELEASE OF INFORMATION:

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). This authorization expires at the end of each calendar year or is revoked by the patient in writing.

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 restrict the uses of their information but the practice does not have to agree to those restrictions. 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) scheduling and billing to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name: _____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

IN CASE OF EMERGENCY - CONTACT INFORMATION

NAME: _____ PHONE: _____

I certify with the signature below that I have read all the information, 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