

PERMIAN INTERNAL MEDICINE ASSOCIATES (PIMA)

403 PITTSBURG AVENUE, ODESSA, TEXAS 79761

Phone (432) 332-3400 Fax (432) 332-6500 www.pima1.com Patient Portal: <http://9460.portal.athenahealth.com>

UPDATED ESTABLISHED PATIENT REGISTRATION FORM 2022

Date _____ Primary Care Dr. _____

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

DOB _____ Legal Sex: Male Female Status: Single Married Widowed Divorced

SS# _____ Driver's License # _____

Address: _____ City/State/Zip _____

Home # (_____) _____ Cell # (_____) _____ Work\Other (_____) _____

E-Mail: _____ (of patient or family who is authorized to get your medical info. This is strictly for your medical information only. No solicitation).

Employer/School _____ Address: _____

Is the patient a minor? Yes No (If yes, the person accompanying the minor today is the guarantor)

GUARANTOR INFO:

Name _____ DOB _____ SS# _____

Address _____ Phone _____ Relationship _____

**** WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S) & DRIVER'S LICENSE ****

Primary Insurance Name _____ Insurance Phone _____

Policy Holder's Name _____ DOB _____ SS# _____

ID# _____ Group # _____ Relationship to the insured _____

Employer _____ Employer Phone _____

Secondary Insurance Name _____ Insurance Phone _____

Policy Holder's Name _____ DOB _____ SS# _____

ID# _____ Group # _____ Relationship to the insured _____

Employer _____ Employer Phone _____

Disclosure of Interest:

Drs. Suresh and Kalpana Prasad have ownership interest in ORMC, and as a result, may financially benefit from the referral of services to ORMC in the form of increased dividends or distributions. Please let us know if you have any concerns regarding the financial relationship between Drs. Prasad and ORMC facility. You do have the option of using an alternative health care facility.

Telehealth Acknowledgement:

Telemedicine services involve the use of secure interactive videoconferencing equipment and audio devices that enable health care providers to deliver health care services to patients when located at different sites. A copy of the acknowledgement has been made available to me. All my questions have been answered to my satisfaction.

Assignment and Release:

I, the Undersigned, certify that I (or my dependent) have insurance coverage. I assign directly to SURESH PRASAD MD, PA; dba Permian Internal Medicine Associates (PIMA); all insurance benefits, if an otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor's office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Acknowledgement:

I acknowledge that a copy of the Office Procedure and Financial Policy, Release of Information, Litigation Policy, HIPPA policy, ACO participation set forth by PIMA has been made available to me. My signature below indicates that I agree to the terms provided.

X _____
Signature of Patient or Guarantor

Date

PIMA Office Procedures and Financial Policy

NAME: _____ **DOB:** ____/____/____ **DATE:** ____/____/____

Permian Internal Medicine Associates (PIMA) is dedicated to providing quality care and service to each of our patients. We understand that the issues regarding medical insurance have become increasingly complex, and with that in mind, we feel that a complete understanding of both our office procedures and financial policy is an essential element of your care and service. Therefore, the following Office Procedure and Financial Policy, executed by your signature, is adopted.

APPOINTMENT / CANCELLATION:

- Automated phone call or Office staff will call and remind you of your appointment 24 to 48 hours prior to the appointment, in addition to giving you a card with a date and time when you checkout.
- Should you be unable to make your appointment, we ask that you call at least 24 hours in advance so that the time slot may be given to another patient. **You may be charged an office service fee for missing your appointment.** If we receive no intimation for you, office staff will contact you with an opportunity to reschedule the appointment. If we do not receive any word from you, this will be listed in your chart at a "NO SHOW". **Three consecutive "NO SHOW" appointments will then result in a termination of the patient-physician relationship.**
- As with any medical office, delays may occur due to unforeseen emergency situations. Please be patient with us as we work through these times. The same care and dedication will be given to you during your appointment. We will keep you informed of the anticipated delay-time, however, please feel free to reschedule your appointment if necessary.
- We try to accommodate our established patients if they are sick, even though they do not have a scheduled appointment. With that in mind, you may have to wait longer than the patient who already has a scheduled appointment.
- Most of the time we try to see our patients as they sign in, but we may have to see a sick patient out of order.

MEDICATION REFILLS:

Please bring all medications in their original bottles to each visit. If you need a prescription on one of your regular medications, **we prefer that you request a refill at the time of your office visit or request through patient portal.** You may also contact your pharmacy two week in advance and have them send a request over to our office. Medication refill requests can be processed online from the Athena Patient Portal. You are able to access the patient portal from our website www.pimal.com or by going to <http://9460.portal.athenahealth.com>. Please keep in mind, we are NOT open on Saturday and Sunday and no refills are done during these days, as well as on holidays. **We may deny your prescription refill if you have not been in our office for more than 6 months unless a scheduled follow-up appointment has been made accordingly.**

CONTROL SUBSTANCES:

- Our office usually does NOT prescribe any medications that may require a "triplicate" prescription.
- **Prescription or refill of a narcotic medication, weight loss medication, anti-anxiety medicine and sleeping pill shall be made only at the time of an office visit or during regular hours. It will not be filled beyond a 30-day period at a time for most circumstances. **Controlled substances will not be refilled if you have not been in our office for over 90 days to see one of our providers.****
- Patients also agree, not to share, sell or trade any of these medication with anyone. Patients must not attempt to obtain any of these controlled substance from any other physician unless previously discussed, documented and agreed upon with PIMA provider. If we receive any notification/alert from a pharmacy that multiple refills of the drug with potential abuse have been made involving multiple providers, physician-patient relationship will be terminated. Should you need additional medication, you are requested to seek a pain management specialist or a psychiatrist.

LABORATORY/RADIOLOGY RESULTS:

Please allow 7 business days for ALL results on lab and radiology including x-rays, CT, MRI, etc. Our staff tries to be diligent in corresponding lab and imaging results. However, if you have lab work done and/or any imaging and **have not received the results within two weeks, it is your responsibility to contact our office to obtain the results.** Also, **you may not receive a call from our office or may get an automated phone call, if your labs are normal / none concerning and it would be placed on patient portal.** You can access your labs and any imaging studies done via the patient portal.

FINANCIAL POLICY:

- Co-Pays are recommended to be paid upon sign-in. Past balances will be collected PRIOR to seeing the physician in the office. The patient may be rescheduled if the balance is not paid or prior arrangements have not been fulfilled. We gladly accept cash, check, money order, care credit and all major credit cards, as well as post-dated checks. We can also have your credit card information in file for recurring payment authorized by you. **If your balance is more than \$200, you may be asked to sign a payment plan. Nonpayment of the dues can results in termination of the physician-patient relationship.**
- As a courtesy to our valued patients, we participate with many of the major health plans. However, you are ultimately responsible for payment of the services. Please be aware of your specific plan benefit. If your insurance company fails to pay in a timely manner, you will then be responsible to pay the balance. It is therefore your responsibility to know and understand the benefit package associated with your plan, including co-payments, co-insurance, deductible, requirements, non-covered services, and restrictions.
- There will be a charge on all returned checks. Returned checks will be referred to the outside collection agency, which will send to district/county clerk for collection.
- We do NOT participate in Medicaid, Personal Letters of Protection, or Workman's Compensation Insurance.
- While every effort is made to verify insurance and payer source ahead of your appointment, sometimes this may not be possible. Should we be unable to verify payer source, we will provide you an opportunity to pay for the service rendered as "OUT OF POCKET EXPENSE". The details of the charges are available with the office staff. An opportunity to reschedule the appointment will be available if needed.

PIMA Office Procedures and Financial Policy continued

NAME: _____ **DOB:** ____/____/____ **DATE:** ____/____/____

- We do NOT do in-house billing, but one of our front office staff will be glad to explain any questions regarding your balance. We have changed our billing software from October 2014, so there may be some confusion between old and new balances and we will try our best to resolve any billing related problem satisfactorily.

TELEMEDICINE

- Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.
- The same standard of care applies to a telemedicine visit as applies to an in-person visit.
- I will not be physically in the same room as my health care provider. I will be notified of, and my consent obtained for anyone other than my healthcare provider present in the room.
- There are potential risks to using technology, including service interruptions, interception, and technical difficulties.
 - If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
 - I may revoke my right at any time by contacting Permian Internal Medicine at 432-332-3400
- The laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- My health care information may be shared with other individuals for scheduling and billing purposes.
 - I understand that my insurance carrier will have access to my medical records for quality review/audit.
 - I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
 - I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
- I have received and acknowledged the Telemedicine Informed Consent provided to me.

INSURANCE

- **An Insurance card MUST be made available to us BEFORE you are seen as a patient and every time you have change your insurance carrier. If you fail to provide current insurance card in timely fashion, you will be responsible for the entire denial amount.** Even though we may estimate what your insurance will pay, it is the insurance company that makes final determination of your responsibility. You are responsible for any amount NOT paid by insurance less the amount written off due to a contract that we have with your insurance company.
- If applicable, our office will submit insurance claims. You agree to allow our practice to “accept assignment” of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of the postmark.

“IN-NETWORK” is referred to as the insurance companies in which we have a contractual agreement. If PIMA or its providers are “in-network”, we have agreed upon a pay scale with the insurance company. In other words, we have agreed to a discounted rate for subscribers to the insurance carrier with whom we are contracted. Any balance after the insurance company has made payment per the contracted agreement will be the responsibility of the patient. It is your responsibility to find out from your insurance company whether your provider is in your insurance network or not.

“OUT OF NETWORK / NON-PARTICIPATING” means that we do NOT have a contract with your insurance company or plan. In these cases, we will bill your insurance company as a courtesy. Please be aware that in these situations you may incur more out of pocket expenses for services compared to services provided in-network.

“ACCEPT ASSIGNMENT” means that we agree to accept payment from the insurance company for services rendered. Any balance remaining after payment is received from insurance will then be the responsibility of the patient.

“SELF PAY” is the term used for patients that present without insurance information. Self-pay patients will be required to pay the estimated cost for services prior to services being rendered.

REFERRALS / PRECERTIFICATION

If your insurance company requires a referral or authorization, you are responsible for obtaining it PRIOR to your scheduled appointment. As a courtesy, PIMA will assist you in meeting any pre-certifications required by your insurance. Keep in mind, however, that all charges will still be your responsibility.

PAST DUE ACCOUNTS

- **If you have missed paying your balance and 3 billing cycles have passed and your account becomes past due, we will take all necessary steps to collect this debt.** If your account is referred to a collection agency, you agree to pay additional costs incurred. Until the balance is paid in full, or adequate payment arrangements are made, PIMA reserves the right to cancel your privilege to make charges against your account. Future visits would then need to be paid in full at the time of service. Most of the balances are small and can be cleared up easily by coming to the office.

NAME: _____ **DOB:** ____/____/____ **DATE:** ____/____/____

PIMA Office Procedures and Financial Policy continued

- We will also turn your account to an outside collection agency if you have not made an effort to pay your outstanding balance, which may affect your credit score.

TREATMENT OF A MINOR

If a patient is a minor (under 18 years of age), the parent of guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for payment due at the time of service, as well as for providing required referrals and insurance cards.

MOTOR VEHICLE PLANS

In most cases, we consider this a private matter between you and your automobile insurance carrier. Your medical insurance company may not cover for services; therefore we will expect payment at each and every visit. ALL balances will be the responsibility of the patient. **PIMA does NOT file claims to auto insurance carriers or accept liens.**

EVALUATION BY PHYSICIAN ASSISTANT (PA) or NURSE PRACTITIONER (NP):

You may be requested be followed by a PA/NP to avoid longer waiting time and quicker appointments depending upon severity of your diseases. Physician assistants (PA) or Nurse Practitioner (NP) have a generalist medical education and their practice closely coordinated with the physicians. Each PA/ NP's scope of practice is defined by the supervising physician's delegation decisions, consistent with the PA/ NP's education and experience, facility policy, state laws. PA/NP provide a care in variety of practice settings, not only can PA/NP perform a range of diagnostic and therapeutic procedures, but they also enhance coordination of care and patient satisfaction.

EMERGENCY/HOSPITAL CARE:

If you have an emergency, please call 911 or go to the nearest emergency room. You will be seen there by the emergency room physician. Should you need hospitalization, they will contact a Hospitalist. Please note that Dr. Suresh Prasad, Dr. Kalpana Prasad or their PAs/ NPs do NOT go to the hospital to check on their patients. All of their patients will be seen by the Hospitalist, if they have any questions, concerns about your health they usually talk to the respective providers while you are in the hospital. Any patient who gets admitted in the hospital will be seen by a physician/Hospitalist on a daily basis, but there is NO fixed time for them to make rounds at the hospital.

GENERAL CONCENT FOR CARE AND TREATMENT CONSENT:

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right to discuss the treatment plan with your providers about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. Both Physicians are also honorary clinical faculty at Texas Tech University, we may have medial students and Residents, NP-S, or PA-S from time to time as an observer. **Our providers also participate in an Evolent Care Partners, an Accountable Care Organization** which is a Medicare Shared Savings Program. An ACO is a group of doctors, hospitals, and/or other health care providers working together with Medicare to give you better, more coordinated service and health care. We share important information and resources about your individual needs and preferences.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I also give a consent for HIV testing when and if deemed medically necessary. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Acknowledgment:

I acknowledge that the OFFICE PROCEDURE & FINANCIAL POLICY set forth by Permian Internal Medicine Associates has been made available to me. My signature below indicates that I agree to the terms provided and understand that such terms may be amended from time to time without notification to the patient/guarantor.

X _____
Signature of Patient or Responsible Party

Date

Permian Internal Medicine Associates

RELEASE OF MEDICAL INFORMATION TO FAMILY:

NAME: _____ **DOB:** ____/____/____ **DATE:** ____/____/____

RELEASE OF MEDICAL RECORDS:

- We **MUST** have an authorization from the patient or guardian before we release any information about the patient. We will only release the medical information to the person who is authorized by the parent/guardian (*family member or **Emergency Contact OTHER THAN YOURSELF***). **Please specify emergency contact.**

Name: _____ Cell: _____ Home: _____

Release of Information

*Information regarding my medical treatment and billing information at Permian Internal Medicine Associates may be released to the persons listed below. I understand that this **AUTHORIZATION TO RELEASE PATIENT INFORMATION** will remain in effect until changed, in writing, at my request.*

Name	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I do NOT give Permian Internal Medicine and its staff permission to release any of my medical information (including LAB, XRAY, MRI, STRESS TEST(S), ETC.) **to anyone.**

X _____
Signature of Patient or Responsible Party

Date:

Permian Internal Medicine Associates

Suresh Prasad MD, FACP

403 Pittsburg Ave

Phone (432)332-3400

Kalpana K. Prasad MD, FACP

Odessa, Texas 79761

Fax (432)332-6500

NAME: _____ **DOB:** ____/____/____ **DATE:** ____/____/____

LITIGATION POLICY

Drs. Suresh and Kalpana Prasad, will NOT see any patient which could result in him\her or any of his\her employees being involved in any type of litigation. This includes testimony as a fact witness, testimony as an expert witness, written or oral deposition, or any type of contact whatsoever with an attorney.

If you have retained an attorney, or if you are considering attorney involvement in connection with the medical condition for which you wish to be treated, please understand that you will NOT be seen under any circumstances – NO EXCEPTIONS.

I have read and understand Drs. Suresh and Kalpana Prasad’s “LITIGATION POLICY”.

X _____
Signature of Patient or Responsible Party Date:

Permian Internal Medicine Associates

403 Pittsburg Avenue
Phone (432)332-3400

Odessa, Texas 79761
Fax (432)332-6500

PROVIDER RELEASE OF MEDICAL RECORDS FORM

Patient Name: _____ DOB: _____ SS #: _____

I request and authorize Permian Internal Medicine Associates to:

() Release the following **information to:** Name of Facility/Person _____

() Release the following **information from:** Address _____

City, State, Zip _____

Phone \ Fax: _____

Release for the purpose of:

- () Continued Care by other Health Care Provider
- () Insurance
- () Attorney
- () School
- () Personal Review

- () Complete Medical Records
- () Lab Results
- () Specific Specialty
- () X-Ray Results
- () Other (Please Specify) _____

I understand and agree that the information I am authorizing to be released may include:

- AIDS\HIV test results, diagnosis, treatment and related information
- Drug Screen Results and information about drug or alcohol use and treatment; or
- Mental Health Information

I further understand that I may revoke this authorization at any time by notifying PERMIAN INTERNAL MEDICINE ASSOCIATES (OR RELEASING FACILITY) in writing except to the extent that action has been taken in reliance on it. Unless earlier revoked this authorization expires 365 days from the day signed or 365 days from the Day after the last PIMA visit or after all insurance of third party claims have been paid or satisfactory resolved, whichever occurs last.

Release from liability, I release and agree to hold harmless PIMA (OR RELEASING FACILITY) and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accord with this authorization. I understand PIMA (OR RELEASING FACILITY) cannot be held responsible for use of re-disclosure of information by third parties.

To the receiving part of this information, it has been disclosed to you for the sole purpose(s) stated in this authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by Federal Regulation.

If the Health Services (INCLUDING EXAMINATIONS AND DRUG SCREENING) are being provided at the request of and/or being paid by my employer (OR PROSPECTIVE EMPLOYER), I understand and agree that all records and information related to the Health Care Services provided to me may be given directly to my employer and if I wish to obtain such information, I should contact my employer\prospective employer.

To make copy of the medical records for personal copy or the permanent transfer of your record, there will be a charge of \$25 for the first 20 pages and then \$.50 for each additional page thereafter. Records in electronic format shall be a charge of no more than: \$25 for 500 pages or less; \$50 for more than 500 pages. In addition, the actual cost of mailing/shipping will also be charged as per the rule to Texas Administrative Code 165.2 Records will be mailed once payment has been received

I certify that this form has been fully explained to me and that I have read it or had it read to me and I understand its contents.

x _____
Signature of Patient or Responsible Party Date:

Witness \ Translator Print Name Print Name and Relationship to Patient

Office Use Only:

Received by: _____ on _____. Called/ Faxed: _____ on _____



Suresh Prasad MD, PA.
DBA Permian Internal Medicine Associates
403 Pittsburg Ave
Odessa, TX 79761
Tel: 432-332-3400
Fax: 432-332-6500

Acknowledgement of Notice of Privacy Practices
For Use and Disclosure of Protected Health Information (HIPAA)

Patient Name

Date of Birth

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain patient rights regarding my protected health information.

I understand that Permian Internal Medicine Associates may use or disclose my protected health information for treatment, payment, or health care operations, which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

I understand that I have the right to read the *Notice of Privacy Practices* before signing this agreement. If I ask, Permian Internal Medicine Associates will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*.

X _____
Signature
(Patient or Legal Custodian/Authorized Representative)

Date

Relationship to Patient if signed by another party

Date

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our Notice at any time by contacting: Permian Internal Medicine Associates 403 Pittsburg Ave, Odessa, TX 79761. (432) 332-3400.



Suresh Prasad MD, PA.
DBA Permian Internal Medicine Associates
403 Pittsburg Ave
Odessa, TX 79761
Tel: 432-332-3400
Fax: 432-332-6500

Telemedicine Informed Consent

If you as a patient or we as providers are not able to do face-to-face visits because of the COVID-19 pandemic, or any other reason, you may be requested to schedule a Telemedicine visit.

Telemedicine services involve the use of secure interactive audio or videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
 - a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
 - a. I may revoke my right at any time by contacting PERMIAN INTERNAL MEDICINE at 432-332-3400
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
 - a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
 - b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
 - c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand.

Patient/Parent/Guardian Printed Name

Patient/Parent/Guardian Signature

Permian Internal Medicine Associates

403 Pittsburg Ave

Odessa, Texas 79761

Phone (432)332-3400

Fax (432)332-6500

Advanced Beneficiary Notice of Non-Coverage (ABN)

Date:

Patient Name:

DOB:

Insurance Company:

MR#:

The majority of insurance companies/ and or Medicare will only pay for services that they deem "medically necessary and reasonable". Should your insurance company determine a particular test is "medically unnecessary and unreasonable", under their standard, they will deny payment for the service.

As your Healthcare Provider, we feel that **one or more of the services/procedures listed below may be of your medical interest, if medically necessary, to be decided after your evaluation by a provider.** We also understand that your insurance company may deny coverage of the services.

I, Mr. /Ms. /Mrs. _____ have been notified by my physician and/or staff that in my case, it is possible that my insurance company will deny payment for the service identified. **Should my insurance company deny my payment, I agree to be personally responsible for payment.**

Services/Procedures that might NOT be covered by my insurance company include (but not limited to):

- | | |
|---|--------------------------------------|
| 1. Lab (Blood Test, Urine Test, Pap smear etc.) | 6. 24-hour Ambulatory Blood Pressure |
| 2. Injections/Vaccinations | 7. Pulmonary Function Test |
| 3. EKG/24-hour Holter Monitor | 8. Vascular Studies |
| 4. Continuous Blood Sugar Monitor (IPRO) | 9. Annual Wellness Visit |
| 5. Home Sleep Study | |

OPTIONS: Check only **ONE** box. **WE CAN NOT CHOOSE A BOX FOR YOU.**

I want the test listed above only if medically recommended by my provider. I want my insurance company to be billed but also understand that I may be asked to pay for the services **at the Date of Service.** I understand that if my insurance should not pay, I may be financially responsible for payment. Should it be determined that I am financially responsible, I do have the option to appeal with my insurance company. Should my insurance company pay after my appeal, I understand that I may receive a full refund of any payment that I have made to my physician, less the co-pay or deductible.

I want the test(s) listed above. **I DO NOT** want my insurance company to be billed. Should I be asked to pay for the services today, I agree to do so. With this decision, **I RELINQUISH** my option of appealing with my insurance company.

I DO NOT want the test(s) listed above. I understand with this decision, I am **NOT** responsible for any payment and have relinquished my option to appeal with my insurance company. I also understand that by **NOT** having the test(s) that is recommended by my physician, I release Permian Internal Medicine and staff from any liability.

X _____
Signature of Patient or Responsible Party

Date:

NAME: _____ DOB: ____/____/____ DATE: ____/____/____

PERMIAN INTERNAL MEDICINE ASSOCIATES HISTORY QUESTIONNAIRE (1).

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

Please check all that apply and list disease onset.

PAST MEDICAL HISTORY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg/ Foot Ulcers |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Cancer and type | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Underactive Thyroid |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia or Reflux Disease | <input type="checkbox"/> Overactive Thyroid |
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Reflux or Ulcers | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes – Insulin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes – Non- Insulin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Others: _____ |

PAST SURGICAL HISTORY:

<u>SURGERY</u>	<u>YEAR</u>	<u>SURGERY</u>	<u>YEAR</u>
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

FAMILY HISTORY:

<u>RELATION</u>	<u>ALIVE ?</u>	<u>AGE</u>	<u>HEALTH PROBLEMS</u>	<u>CAUSE OF DEATH</u>
Father	Y/N	_____	_____	_____
Mother	Y/N	_____	_____	_____
Brother/Sister	Y/N	_____	_____	_____
Brother/Sister	Y/N	_____	_____	_____
Other: _____	Y/N	_____	_____	_____
Other: _____	Y/N	_____	_____	_____
Other: _____	Y/N	_____	_____	_____

SOCIAL HISTORY:

Please circle all that apply.

Current Employment: _____ Position: _____

Marital status:	Married	Single	Divorced	Widowed
Number of Kids/ Sex:	M/F	M/F	M/F	M/F
Exercise:	None	Minimal	Moderate	Frequently
Caffeine (coffee/ soda):	None	Minimal	Moderate	Heavy consumption
Tobacco Consumption:	Never smoker	Past tobacco user	Current tobacco user	Packs/ cans per day? _____ years
Alcohol Consumption:	None	Occasionally	Moderate intake	Heavy intake/ Drinks per day? _____ years
Illicit Drug Use:	Never	Past drug user	Current drug user	Drugs used? _____

NAME: _____ DOB: ____/____/____ DATE: ____/____/____

PERMIAN INTERNAL MEDICINE ASSOCIATES HISTORY QUESTIONNAIRE (2)

ALLERGIES:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY

REACTION

1. _____
2. _____
3. _____

FAVORITE PHARMACIES:

Local: _____ Mail Order: _____

MEDICATIONS:

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs.

DRUG NAME

DOSAGE

FREQUENCY TAKEN

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

IMMUNIZATION HISTORY:

Immunizations and most recent date:

- | | | | |
|--|-------------|--|-------------|
| <input type="checkbox"/> Chickenpox | Date: _____ | <input type="checkbox"/> Meningococcus | Date: _____ |
| <input type="checkbox"/> Flu Shot | Date: _____ | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | Date: _____ |
| <input type="checkbox"/> Gardasil/HPV | Date: _____ | <input type="checkbox"/> TD (Tetanus and Pertussis) | Date: _____ |
| <input type="checkbox"/> Hepatitis A | Date: _____ | <input type="checkbox"/> DTP (Tetanus, Diphtheria, Pertussis) | Date: _____ |
| <input type="checkbox"/> Hepatitis B | Date: _____ | <input type="checkbox"/> Shingrix (after age 50) | Date: _____ |
| <input type="checkbox"/> Pneumococcal (PPSV23) | Date: _____ | <input type="checkbox"/> Prevnar (once in lifetime) PCV13: 65+ | Date: _____ |

QUALITY MEASURES/HEALTH MAINTANANCE :

	DATE:	Doctor/ Clinic:
Annual Wellness Exam (Yearly)	_____	_____
Dental (Annually)	_____	_____
Eye (Annually)	_____	_____
Podiatry Exam (Annually)	_____	_____
Colonoscopy (every 3-10 years)	_____	_____
PSA	_____	_____
Mammogram (1-2 yearly)	_____	_____
Pap smear/Pelvic Exam (1-3 yearly)	_____	_____
Bone Density (DEXA Scan)	_____	_____
Ankle-Brachial Index	_____	_____
EKG/Stress Test	_____	_____
Urine for M/C or 24° urine for protein	_____	_____

My signature below certifies that I have completed this questionnaire accurately and to the best of my ability.

X _____
Signature of Patient or Responsible Party

Date: