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

Date_____ Primary Care Dr. _____

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

DOB _____ SS#_____ Driver's License # _____

Address:_____ City/State/Zip _____

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

E-Mail: _____ Consent to send SMS/Calls/Portal: □ Yes □ No

Language: □ English □ Spanish Race:_____ Ethnicity:_____
Legal Sex: □ Male □ Female Pronouns: □ He/him □ She/her □ They/them
Marital Status: □ Married □ Divorced □ Single □ Widowed □ Other: _____

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 _____

Secondary Insurance Name_____ Insurance Phone _____

Policy Holder's Name _____ DOB _____ SS# _____

ID# _____ Group #_____ Relationship to the insured _____

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 & Consent to choice of Law and Jurisdiction, HIPPA policy, ACO participation, CCM, CoCM and RPM policy 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. 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.**
- Any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a NO SHOW and will be charged a **$25.00 fee**.
- 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.
- Any patient that arrives 15 minutes after appointment time without reason, or 30 minutes after appointment time with a valid reason may be rescheduled at the discretion of the provider.

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.pima1.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**. There is a fee $25 for Prior Authorization for a non-covered medicine.

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 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 on 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.
- 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 will try our best to resolve any billing related problem satisfactorily.

NAME:_____ DOB: _____/_____/_____

PIMA Office Procedures and Financial Policy continued

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 in your insurance carrier. If you fail to provide your current insurance card in a 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 the 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.
We do not participate in any form of Medicaid or plans with dual assignment of Medicaid. If you have a dual plan, any balance remaining after payment is received from insurance will then be the responsibility of the patient.

"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.

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**.

FMLA and other forms
Our office will be happy to complete FMLA paperwork and other forms that are similar. Please be advised there is a $50 fee charged for these forms.

NAME:_____ DOB: _____/_____/_____

PIMA Office Procedures and Financial Policy continued

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 also participate in NUDJ Health for Remote Patient Monitoring and Collaborative care Management which is a team-based approach provides infrastructure enabling providers to integrate lifestyle wellness into patient care and Athena health foR Chronic care management program. 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 a copy of the Office Procedure and Financial Policy, Release of Information, Litigation Policy & Consent to choice of Law and Jurisdiction, HIPPA policy, ACO participation, CCM, CoCM and RPM policy set forth by PIMA 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: _____/_____/_____

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*****).**

EMERGENCY CONTACT	
First Name:	Last Name:
Phone #:	Relationship to patient:

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.

First Name:	Last Name:
Phone #:	Relationship to patient:
First Name:	Last Name:
Phone #:	Relationship to patient:
First Name:	Last Name:
Phone #:	Relationship to patient:
_____Initials ☐ I do **NOT** give Permian Internal Medicine and its staff permission to release any of my medical or billing 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: _____/_____/_____

Litigation Policy & Consent to Choice of Law and Jurisdiction

Drs Suresh or Kalpana Prasad or any of our SURESH PRASAD MD, PA's Provider will NOT see any patient which could result in him/her 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 hereby acknowledge and agree that I have chosen to seek medical treatment, or I have chosen to seek medical treatment for my minor child _____ ("My Child"), at SURESH PRASAD MD, PA, a Texas professional Association (the "Association") located in Odessa, Texas.

By signing below, I expressly consent to the **EXCLUSIVE** jurisdiction in the state of Texas and agree that any dispute, claim or civil action of any kind that I may have, either on my own account or as the parent or guardian of my child, against the Association, its officers, directors, employees or staff (collectively, the "Association"), arising out of or related to the medical treatment, lack of medical treatment, or other claimed departure from accepted standards of health care provided by the Association to myself or to my child, **SHALL ONLY** be governed by and interpreted under the laws of the State of Texas.

I further acknowledge and agree that venue over any litigation arising out of or related to the medical treatment, lack of medical treatment or other claimed departure from accepted standards of healthcare provided by the Association to myself or to my child **SHALL ONLY** be proper in Ector County, Texas. However, in the event a court of law determines that federal jurisdiction is appropriate, I expressly agree that such action or suit **SHALL ONLY** be proper in the United States District Court for the Western District of Texas, Midland/Odessa division.

I understand that this means **TEXAS LAW, NOT ANY OTHER STATE LAW** will govern any dispute I may have with the Association and that any lawsuit between the Association and me, individually or as the parent or guardian of my child, may only be filed in Texas.

It is the intent of the Association and me that all the rights hereunder shall bind and inure to the respective successors and assigns of the Association, my child, and me.

I have read and understand SURESH PRASAD MD, PA "Litigation Policy & Consent to Choice of Law and Jurisdiction

X _____ _____

Signature of Patient or Responsible Party Date:

Permian Internal Medicine Associates

403 Pittsburg Avenue **Odessa, Texas 79761**
Phone (432)332-3400 **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 Heath 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 extreme 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 fro 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 Date
(Patient or Legal Custodian/Authorized Representative)

_____ _____
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.)
2. Injections/Vaccinations
3. EKG/24-hour Holter Monitor
4. Continuous Blood Sugar Monitor (IPRO)
5. Home Sleep Study
6. 24-hour Ambulatory Blood Pressure
7. Pulmonary Function Test
8. Vascular Studies
9. Annual Wellness Visit
10. Ear Lavage

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 ASSCOCIATES *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 QUESTONNAIRE 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:

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

PAST SURGICAL HISTORY:

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

FAMILY HISTORY:

RELATION	ALIVE ?	AGE	HEALTH PROBLEMS	CAUSE OF DEATH
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:

□ Chickenpox	Date: _____	□ Meningococcus	Date: _____
□ Flu Shot	Date: _____	□ MMR (Measles, Mumps, Rubella)	Date: _____
□ Gardasil/HPV	Date: _____	□ TD (Tetanus and Pertussis)	Date: _____
□ Hepatitis A	Date: _____	□ DTP (Tetanus, Diphtheria, Pertussis)	Date: _____
□ Hepatitis B	Date: _____	□ Shingrix (after age 50)	Date: _____
□ Pneumococcal (PPSV23)	Date: _____	□ 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:

Suresh Prasad MD, FACP

ABIM Certified in Sleep Medicine
www.pima1.com
403 Pittsburg Ave | Odessa, TX 79761
Phone: (432) 332-3400 | Fax: (432) 332-6500

Please fax this form with referral to: 432-332-6500

Patient's Screening Questionnaire

Name:_____ **DOB:**_____ **Referring provider:**_____

The following table contains symptoms, risk factors, behaviors and other items associated with sleep problems. Check all that apply to you, even if something occurs only once in a while. If you have a bedpartner or there is someone who has observed your sleep, ask that person to help you complete this form.

SLEEP APNEA
- □ Snoring
- □ Excessive Daytime Sleepiness
- □ Waking up Gasping/choking
- □ Stops breathing
- □ Sleepy during afternoon
- □ Coughing
- □ Wake up with headaches
- □ Wakes with dry mouth
- □ Non-refreshing sleep after full night sleep
- □ Snorting
- □ Sweating during sleep
- □ Heart pounding during sleep
- □ Atrial fibrillation (Afib)
- □ Heart disease
- □ Stroke
- □ Age 65 or older
- □ High blood pressure
- □ Diabetes
- □ Overweight
- □ Recent weight gain
- □ Family history of sleep apnea
- □ Previous sleep study
- □ Current CPAP use
- □ Previous CPAP use
- □ Current oral appliance use

INSOMNIA
- □ Difficulty falling asleep
- □ Difficulty staying asleep
- □ Waking too early
- □ Not getting enough sleep
- □ Irregular sleep schedule
- □ Mind racing
- □ Travel time zones
- □ Pain or discomfort
- □ Depression
- □ Anxiety
- □ Job stress
- □ Relationship problems
- □ Shift work

DAYTIME PROBLEMS
- □ Feeling sleepy
- □ Tired, no energy
- □ Irritable/moody
- □ Difficulty concentrating
- □ Inattentiveness
- □ Memory Problems
- □ Dozing off unintentionally
- □ Napping on purpose
- □ Sleepy while driving
- □ Accident due to sleepiness
- □ Dozing off at work/school
- □ Falling asleep while driving

PARASOMNIA
- □ Sleep walking
- □ Sleep talking
- □ Sleep terrors
- □ Sleep eating
- □ Vivid dreams
- □ Acting out dreams
- □ Very restless sleep
- □ Teeth grinding
- □ Whole body jerks before falling asleep
- □ Body rocking before falling asleep

RESTLESS LEGS
- □ Urge to move legs when trying to sleep
- □ Tingling or crawly feeling in the legs
- □ Urge to move is worse when seated/lying
- □ Moving legs helps relieve discomfort
- □ Symptoms worse in evening or at bedtime

Have you ever had the following kinds of weakness develop suddenly during an emotional situation? *(For example, when laughing, or if angry or an exciting situation, etc.?)*

□ Knees buckling □ Head Nodding □ Mouth opening □ Falling Down

SLEEP SCHEDULE:

Bedtime _____ am / pm, Wake-up _____ am / pm?

How long does it usually take you to fall asleep after the lights are off? _____ minutes

On average, how many times do you awaken during the night? _____ times

EPWORTH SLEEPING SCALE: Do you feel very sleepy or fall asleep during these situations?

(**0**=No chance of dozing, **1**=slight chance, **2**=moderate chance, **3**=high chance)

Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting inactive in a public place	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic or at a red light	**0**	**1**	**2**	**3**

Total: _____

(TO BE FILLED BY PROVIDER)

Related Examination Findings

Blood Pressure Reading: _____

Neck Circumference: _____ **inches**

BMI : _____

Mallampatti:

1 2 3 4

Edema: □ Yes □ No

Stop Bang Score: _____/_8____

Related Co-morbid Condition

- □ Hypertension
- □ **Stroke/TIA**
- □ **COPD**
- □ **Congestive Heart Failure**
- □ **Pulmonary Hypertension**
- □ **Parkinsonism**
- □ **Dementia**
- □ **Cardiac Arrhythmia/ Atrial Fib**
- □ REM Behavior Disorder
- □ Sleep talking
- □ Sleep walking
- □ Bruxism (Grinding Teeth)
- □ Unspecified Insomnia
- □ Diabetes
- □ Neuro Muscular Disorder
- □ Epilepsy/Seizures
- □ Leg jerking

_____
Physician Signature

Home#:_____ **Cell#:**_____ **Work#:**_____

Patient Signature: _____ **Date:** _____

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Adult Consent Form

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Gender: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your immunization records. With your consent, your immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, my immunization information may by law be accessed by: a Texas physician, or other health-care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ **I am a FIRST RESPONDER.** ☐ **I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas Immunization Registry.

Individual (or individual's legally authorized representative):

Printed Name _____ Signature _____ Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunizations

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