# 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