PERMIAN INTERNAL MEDICINE ASSOCIATES (PIMA)

403 PITTSBURG AVENUE, ODESSA, TEXAS 79761
Phone (432) 332-3400 Fax (432) 332-6500 www.pima1.com
Portal del Paciente: http://9460.portal.athenahealth.com

Fecha _____ Doctor/a Primario _____

IMFORMACIÓN DEL PACIENTE

Apellido _____ Nombre _____ 2do.Nom._____
Fecha de Nacimiento _____ SS#_____
No. De Licencia _____
Dirección: _____ Cuidad/Estado/Código Postal _____
No. de Casa (_____)_____ No. De Celular (_____)_____ Otro No.(_____)_____
Correo Electrónico: _____
Consentimiento Para Envío de SMS/Llamadas/Portal: □ Si □ No

Idioma: □ Ingles □ Español Raza:_____ Ethnicidad:_____
Sexo Legal: □ Hombre □ Mujer Pronombres: □ El □ Ella □ Otro
Estado Civil: □ Casado/a □ Divorcido/a □ Soltero/a □ Vuido/a □ Otro
Empleador/Escuela _____ Dirreción: _____
¿Es el paciente menor de edad? Si No (En caso afirmativo, la persona que acompaña al menor es el garante.)
Información Del Garante:
Nombre _____ Fecha De Nacimiento _____
SS# _____
Dirección _____ Tel. _____ Relación _____

**** *NECESITAMOS HACER UNA COPIA DE SU TAJETA/S DE SEGURO Y LICENCIA* ****

Seguro Primario_____ Tel. de Seguro _____
Nombre en la Póliza _____ Fecha de Nacimiento _____
SS# _____
ID# _____ Grupo #_____ Relación con Asegurado _____

Seguro Secundario_____ Tel. de Seguro _____
Nombre en la Póliza _____ Fecha de Nacimiento _____
SS# _____
ID# _____ Grupo #_____ Relación con Asegurado _____

Divulgación De Interés:
Dres. Suresh y Kalpana Prasad tienen participación de propiedad en ORMC y como resultado pueden beneficiarse financieramente de la remisión de servicios a ORMC en forma de mayores dividendos/distribuciones. Háganos saber si tiene alguna inquietud con respecto a la relación entre los Dres. Instalación de Prasad y ORMC. Tiene opción de usar un centro de atención médica alternativo.

Reconocimiento De "Telehealth":
Los servicios de telemedicina implican el uso de equipos de videoconferencia interactivos seguros y audio que permiten a los proveedores brindar servicios de atención médica a los pacientes cuando se encuentran en diferentes sitios. Una copia del reconocimiento está disponible para mí. Todas mis preguntas han sido respondidas a mi satisfacción.

Asignación y Liberación:
Yo, el abajo firmante, certifico que yo (o mi dependiente) tenemos cobertura de seguro. Asigno directamente a SURESH PRASAD MD, PA; dba Permian Internal Medicine Associates (PIMA); todos los beneficios del seguro, si son pagaderos a mí por los servicios prestados**. Entiendo que soy financieramente responsable de todos los cargos, ya sean pagados o no por el seguro**. Autorizo al consultorio del médico a divulgar toda la información necesaria para garantizar el pago de los beneficios.

Reconocimiento:
Reconozco que se me ha puesto a disposición una copia del procedimiento de la oficina y la política financiera, la divulgación de información, la política de litigios y el consentimiento para la elección de ley y jurisdicción, la política HIPPA, la participación de la ACO, la política CCM, CoCM y RPM establecida por PIMA. Mi firma a continuación indica que estoy de acuerdo con los términos proporcionados.

X_____ _____
Firma De Paciente o Garante Fecha

PIMA Office Procedures and Financial Policy

NOMBRE:_____ FECHA DE NACIMIENTO: _____/_____/_____

Permian Internal Medicine Associates (PIMA) se dedica a brindar atención y servicio de calidad a cada uno de nuestros pacientes. Entendemos que las cuestiones relacionadas con el seguro médico se han vuelto cada vez más complejas y, con eso en mente, creemos que una comprensión completa tanto de los procedimientos de nuestro consultorio como de nuestra política financiera es un elemento esencial de su atención y servicio. Por lo tanto, se adopta el siguiente Procedimiento de Oficina y Política Financiera, ejecutado con su firma.

CITA / CANCELACIÓN::

- Llamada telefónica automatizada o personal de la oficina le llamará y le recordará su cita entre 24 y 48 horas antes de la cita, además de entregarle una tarjeta con la fecha y hora al realizar el pago.
- En caso de no poder asistir a su cita, le solicitamos que llame con al menos 24 horas de anticipación para que se le pueda dar el horario a otro paciente. Si no recibimos ninguna información sobre usted, el personal de la oficina se comunicará con usted para darle la oportunidad de reprogramar la cita. Si no recibimos ninguna noticia suya, esto aparecerá en su expediente como "NO SHOW". **Tres citas consecutivas de "NO SHOW" resultarán en la terminación de la relación médico-paciente.**
- Cualquier paciente que no se presente o cancele/reprograme una cita y no se haya comunicado con nuestra oficina con al menos 24 horas de anticipación se considerará NO SHOW y se le cobrará una **tarifa de $25.00**.
- Como ocurre con cualquier consultorio médico, pueden ocurrir retrasos debido a situaciones de emergencia imprevistas. Tenga paciencia con nosotros mientras superamos estos tiempos. Se le brindará el mismo cuidado y dedicación durante su cita. Lo mantendremos informado sobre el tiempo de retraso anticipado; sin embargo, no dude en reprogramar su cita si es necesario.
- Tratamos de atender a nuestros pacientes establecidos si están enfermos, aunque no tengan una cita programada. Teniendo esto en cuenta, es posible que tengas que esperar más que el paciente que ya tiene una cita programada.
- La mayoría de las veces intentamos atender a nuestros pacientes cuando inician sesión, pero es posible que tengamos que atender a un paciente enfermo fuera de servicio.
- Cualquier paciente que llegue 15 minutos después de la hora de la cita sin motivo, o 30 minutos después de la hora de la cita con un motivo válido, podrá ser reprogramado a discreción del proveedor.

RECARGAS DE MEDICAMENTOS:

Traiga todos los medicamentos en sus frascos originales a cada visita. Si necesita una receta para uno de sus medicamentos habituales, **preferimos que solicite un resurtido en el momento de su visita al consultorio o que lo solicite a través del portal del paciente**. También puede comunicarse con su farmacia con dos semanas de anticipación y pedirles que envíen una solicitud a nuestra oficina. Las solicitudes de reabastecimiento de medicamentos se pueden procesar en línea desde el Portal del Paciente de Athena. Puede acceder al portal del paciente desde nuestra página web www.pima1.com o **http://9460.portal.athenahealth.com**. Tenga en cuenta que NO abrimos los sábados y domingos y no se realizan recargas durante estos días, ni tampoco los días festivos. **Podemos negarle el reabastecimiento de su receta si no ha estado en nuestro consultorio durante más de 6 meses, a menos que se haya programado una cita de seguimiento en consecuencia.** Hay un cargo de $25 por autorización previa para un medicamento no cubierto.

SUSTANCIAS CONTROLADAS:

- Nuestra oficina generalmente NO prescribe ningún medicamento que pueda requerir una receta "triplicada".
- **La prescripción o resurtido de un medicamento narcótico, medicamento para bajar de peso, medicamento contra la ansiedad y pastilla para dormir se realizará únicamente en el momento de una visita al consultorio** o durante el horario habitual. **No se llenará más allá de un período de 30 días a la vez** para la mayoría de las circunstancias. **No se reabastecerán sustancias controladas si no ha estado en nuestro consultorio durante más de 90 días**.
- Los pacientes también aceptan no compartir, vender ni intercambiar ninguno de estos medicamentos con nadie. Los pacientes no deben intentar obtener ninguna de estas sustancias controladas de ningún otro médico a menos que se haya hablado, documentado y acordado previamente con el proveedor de PIMA. Si recibimos cualquier notificación/alerta de una farmacia de que se han realizado múltiples resurtidos del medicamento con potencial abuso que involucran a múltiples proveedores, se terminará la relación médico-paciente. Si necesita medicación adicional, se le solicita que busque un especialista en el tratamiento del dolor o un psiquiatra.

RESULTADOS DE LABORATORIO/RADIOLOGÍA:

Espere 7 días hábiles para TODOS los resultados de laboratorio y radiología, incluidas radiografías, tomografías computarizadas, resonancias magnéticas, etc. Nuestro personal intenta ser diligente en los resultados de laboratorio e imágenes correspondientes. Sin embargo, si le han realizado análisis de laboratorio y/o alguna imagen y **no ha recibido los resultados dentro de dos semanas, es su responsabilidad comunicarse con nuestra oficina para obtener los resultados**. **Es posible que no reciba una llamada de nuestra oficina o que reciba una llamada telefónica automática, si sus resultados de laboratorio son normales/ninguno preocupante y se colocará en el portal del paciente.** Puede acceder sus resultados en el portal de paciente.

Póliza Financiera:

- Los copagos deben pagarse al registrarse. Los balances pasados se cobrarán ANTES de ver al médico en el consultorio. El paciente puede ser reprogramado si no se paga el balance o no se han cumplido los arreglos previos. Aceptamos con gusto dinero en efectivo, cheques, giros postales, créditos para cuidados y todas las principales tarjetas de crédito, así como cheques posfechados. También podemos tener archivada la información de su tarjeta de crédito para pagos recurrentes autorizados por usted. **Si su balance es más de $200, es posible que se le solicite que firme un plan de pago. El impago de las cuotas puede dar lugar a la terminación de la relación médico-paciente.**
- Como cortesía para nuestros pacientes, participamos en muchos de los planes de seguros. Sin embargo, usted es responsable del pago de los servicios. Tenga en cuenta el beneficio específico de su plan. Si su compañía de seguros no paga a tiempo, usted será responsable de pagar el balance. Es su responsabilidad conocer y comprender el paquete de beneficios asociado con su plan, incluidos copagos, coseguros, deducibles, requisitos, servicios no cubiertos y restricciones.
- Habrá un cargo por todos los cheques devueltos. Los cheques devueltos se remitirán a la agencia de cobro externa, que los enviará al secretario del distrito/condado para su cobro.
- NO participamos en Medicaid, Cartas Personales de Protección o Seguro de Compensación Laboral.
- Aunque se hace todo lo posible para verificar el seguro y la fuente del pagador antes de su cita, a veces esto puede no ser posible. Si no podemos verificar la fuente del pagador, le brindaremos la oportunidad de pagar el servicio prestado como "OUT OF POCKET". Los detalles de los cargos están disponibles con el personal de la oficina. Si es necesario, habrá una oportunidad para reprogramar la cita.
- NO realizamos facturación interna, pero uno de nuestro personal de recepción estará encantado de explicarle cualquier pregunta sobre su saldo. Haremos todo lo posible para resolver satisfactoriamente cualquier problema relacionado con la facturación.

NOMBRE:_____ FECHA DE NACIMIENTO: _____/_____/_____

PIMA Office Procedures and Financial Policy continued

"TELEMEDICINE"/TELEMEDICINA

- Los servicios de "Telemedicine" implican el uso de equipos y dispositivos de videoconferencia interactivos seguros que permiten a los proveedores de atención médica brindar servicios de atención médica a los pacientes cuando se encuentran en diferentes sitios.
- Se aplica el mismo estándar de atención a una visita de telemedicina que a una visita en persona.
- No estaré físicamente en la misma habitación que mi proveedor de atención médica. Se me notificará y se obtendrá mi consentimiento para cualquier persona que no sea mi proveedor presente en la habitación.
- Existen riesgos potenciales por el uso de la tecnología, incluidas interrupciones del servicio, interceptaciones y dificultades técnicas.
    - Si se determina que el equipo de videoconferencia y/o la conexión no son adecuados, entiendo que mi proveedor de atención médica o yo podemos suspender la visita de telemedicina y hacer otros arreglos para continuar la visita.
- 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.

NOMBRE:_____ FECHA DE NACIMIENTO: _____/_____/_____

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:

NOMBRE:_____ FECHA DE NACIMIENTO: _____/_____/_____

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: