Son N. Giep, M.D., P.A.
Board Certified in Internal Medicine

PATIENT INFORMATION

Name _____ Birth date _____/_____/_____ Age _____

Address _____ City _____ Zip _____

SSN _____ Sex _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Fax # _____

Employer Address _____ City _____ Zip _____

Who referred you? _____

EMERGENCY INFORMATION

Emergency Contact 1 _____ Phone _____ Relationship _____

Emergency Contact 2 _____ Phone _____ Relationship _____

Emergency Contact 3 _____ Phone _____ Relationship _____

PRIMARY INSURANCE INFORMATION

☐ Private Pay (Cash) ☐ PPO ☐ HMO ☐ Medicare ☐ Other _____

Insurance Company _____

Address _____ City _____ Zip _____

Insured's Name _____ Birth date _____

Insured's SSN _____ Group # _____

Insured's Employer _____

How long at above employer? _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____

Address _____ City _____ Zip _____

Insured's Name _____ Birth date _____

Insured's SSN _____ Group # _____

Insured's Employer _____

AUTHORIZATION

I authorize release of my medical information to process claims. I request that payment of medical benefits be made to Dr. Son Giep and I understand that this is automatic in case of hospitalization. This assignment of benefits will remain effective until revoked by me in writing.

Patient Signature _____ Date _____

Son N. Giep, M.D.

Patient Medical History

Name _____ Age _____ Occupation _____

Chief Complaint _____

FAMILY HISTORY

Has any relative had:

	YES	NO
Cancer of the breasts, female organs, colon or melanoma		
Tuberculosis (in last five years)		
High blood pressure		
Kidney trouble (other than kidney stones)		
Heart disease		
Anesthesia complication		

PERSONAL HISTORY

Weight _____ Height _____

Exercise: Do you exercise at least 20 minutes, three times a week? ☐ Yes ☐ No

Alcoholic Beverages: ☐ Never ☐ Occasionally ☐ Moderately ☐ Daily

Do you smoke? ☐ Yes ☐ No If yes, # of packs per day: _____

If you have quit, how long has it been? _____

Have you used, previously used or had problems with:

☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Other recreational drugs

MEDICAL HISTORY

Have you ever had:

	YES	NO
Asthma or breathing problems		
Anemia (longer than 3 months)		
Tuberculosis		
High blood pressure		
Heart disease or murmur		
Diabetes		
Depression		
Thyroid disorder		
Ulcer or stomach problems		
Hepatitis, jaundice		
Hospitalization for psychiatric reasons		
Other:		

	YES	NO
Colon trouble or bowel disorder		
Kidney trouble		
Venereal disease		
Varicose veins or Phlebitis		
Bleeding disorders		
Seizures, loss of consciousness		
Visual disturbance		
Treatment for nervous disorder		
Cancer		
Blood transfusions		
Alcohol abuse		
Drug abuse		

Please explain "YES" answers: _____

_____

IMMUNIZATIONS

Have you had a tetanus shot in the last 10 years? ☐ Yes, on this date _____ ☐ No

Have you had a pneumonia shot in the last 10 years (only age 50 and older)? ☐ Yes, on this date _____ ☐ No

Have you had any other immunizations in the past? _____

OTHER

Last dental exam _____ Dentist name _____

Last eye exam _____ Eye doctor name _____

Surgeries (include dates):
Drug allergies:
Medications: Please list all medications you are currently taking and include dosage.

Patient Signature: _____ Date: _____

General Office Policies and Procedures for Patients
Son N. Giep, M.D., P.A.

TESTING: You should expect to receive notification for results of any testing, including labs and radiology, within one week. We will attempt to contact you, but in the event that we are unable to contact you, it is your responsibility to obtain your results. If you are scheduled for a visit to go over your results, including physicals, we will plan to review your results at the time of your visit and will not attempt to contact you in advance. If you miss the appointment, it is your responsibility to reschedule the visit to go over the results.

TREATMENT: We make the best efforts to diagnose and treat your condition based on the information we have. Sometimes, however, diseases and conditions evolve. If you do not improve, or if your condition worsens or changes, it is your responsibility to inform us so we may re-evaluate your condition and diagnosis.

COMMUNICATION: When you contact us, we will make our best efforts to answer you in a timely manner. The most common reasons we are unable to answer patients are inaccurate contact information and patients who indicate on their privacy form to only leave a message to call back. If you are unable to reach us after leaving two messages, please contact our schedulers or office manager.

FEEDBACK: Please let us know how we are doing. We appreciate both positive and negative feedback to make your experience with us better.

I have read and understand the above statements.

_____ ____/____/____
Signature Date

Son N. Giep, M.D.
Internal Medicine

Payment Policy

1. We will file insurance for our PPO, HMO and other managed care patients. However, all managed care copayment and/or deductible and coinsurance amounts are due at the time of service. Any disallowed/uncovered amounts are due from the patient. It is your responsibility to make sure that Son Giep, M.D., is in your managed care network. There will be a $15 fee added to your account if the copay/coinsurance is not paid at the time of service.
2. We accept assignment and will file insurance for our Medicare patients. However, any calendar-year deductible amounts (to the extent of the visit amount) are due at the time of service. We will also file secondary insurance after payment from Medicare. If there is no secondary insurance, the patient will be billed for any remaining balance.
3. There will be a $25 fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount. Payments will be expected in the form of cash, money order or credit card.
4. Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. We will attempt to verify coverage, though that is not a guarantee of payment until your insurance has processed the claim.
5. For all accounts that must be sent to a collection agency, a $50 fee will be added to those account balances for processing. For all account balances in excess of 90 days past due, a late fee of $50 will be added to the balance (even if the delay is due to the insurance company). It is ultimately the patient's responsibility to ensure the doctor received payment for service rendered.
6. We will file insurance for our HMO/EPO/POS patients. However, you must have assigned the doctor you are seeing in this office to be your Primary Care Physician (PCP) prior to your appointment. The assignment of the PCP must be effective the day of your appointment. If you have not assigned Dr. Giep as your PCP, you agree to be responsible for the balance of your visit. If you have not changed your PCP to Dr. Giep because you are not sure if you want to assign him yet, you must assume responsibility for the balance of that visit. Payment will be due at the time services are rendered. No exceptions will be made.
7. If any patient is owed a refund, all claims must be processed and paid in full before the overpayment is refunded.

Precertification/Referral Authorization

1. Precertification of hospital: We must be notified within 24 hours of any hospital admission so we may precertify your hospital visit/stay. Failure to do this may result in reduction of benefits. We will not be responsible for any reduction of benefits if this is not done.
2. Referrals: Due to large numbers of referral requests, we must be notified at least 5 days prior to your appointment in order to obtain a referral to a specialty care provider. Patients who see specialty care providers first, then call afterward to request a referral number risk reduction in benefits because most insurance companies do not backdate referrals. We will not be responsible for any reduction of benefits for any "after the fact" referral requests.
3. When referred, it is the patient's responsibility to verify the physician or facility is in their insurance network.

Authorization

I have read this agreement and understand the provisions outlined. I agree to be responsible for any balance present on my account. If my insurance denies payment because Dr. Giep was not listed as my Primary Care Physician at the time of service, I will assume full responsibility of the charges incurred for that visit and will pay in full.

I authorize release of medical records to determine liability for payments or treatment and to obtain reimbursement.

I assign all medical benefits for office visits and hospital stays to Son Giep, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

Patient Signature _____ Date _____

Notice of Privacy Practices
Patient Consent Form

Plano Internal Medicine Associates
6300 West Parker Road
MOB 2, Suite 220
Plano, Texas 75093

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you will obtain a revised copy during your next office visit.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name (Patient or Representative)

_____ ___/___/___

Signature Date

_____

Relationship to Patient (if other than patient)

Witness: _____

Printed Name

_____ ___/___/___

Signature Date

Son N. Giep, M.D., P.A.
6300 West Parker Road, Suite 220
Plano, Texas 75093
(972) 981-8215

Cancellation/No-Show Policy

Patients who do not cancel or reschedule their appointment at least one business day prior to their scheduled visit may be charged a fee of **$25**. This fee also applies to any patients who do not show up for their scheduled appointment.

While the office will make reasonable attempts to confirm appointments one to two days in advance of the appointment date, it remains the patient's responsibility to keep appointments in compliance with this policy. *Exceptions will be made for medical or family emergencies.* Please note that insurance companies cannot be billed for missed sessions.

Also, please be advised that your appointment time is the scheduled time for you to be seen. Please be present with any necessary paperwork or insurance updates completed prior to that time. If you are late for your appointment, the office may ask you to reschedule out of consideration for those patients scheduled after you.

I have read, understand and agree to comply with the above policy.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

Patient Record of Disclosures
Plano Internal Medicine Associates

In general, the HIPAA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential disclosures of PHI will be made by alternative means, such as sending correspondence to the individual's office instead of their home.!

I wish to be contacted in the following manner (check all that apply)

- ☐ Home Telephone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Mobile Telephone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work address
  - ☐ OK to fax this number _____
- ☐ Other (please specify)

  _____

On a routine basis this office is able to release the following:

- ☐ Billing Information
- ☐ Medical Records

To be discussed with: _____

(Contact name, relation and phone # of a family member, personal representative or other person)

_____ _____/_____/_____

Patient Signature Date

_____ _____ _____/_____/_____

Printed Name Social Security Number Date of Birth

We must take several steps to verify the identity of callers. We may ask for one or more of the following pieces of information about the patient: date of birth, last four digits of their social security number, health insurance carrier, treating physician and/or mailing address.

Patient Consent for Use of E-mail Communications

E-mail offers an easy and convenient way for patients and medical staff to communicate. In many instances, e-mail is more convenient than telephoning our office. However, there are some important differences:

*E-mail should never be used for an urgent or emergency problem.

*E-mail should never be used for time-sensitive issues.

*E-mail is not confidential and should not be used for sensitive information. Due to the nature of e-mail, third parties my have access to messages. Your employer has the legal right to read your e-mail if he or she chooses. Most system operators have access to all e-mails going through the system. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

*All e-mails will become part of your permanent medical record.

*You may not receive an immediate response. It may take a full business day for the medical staff to respond to e-mails.

I understand that Dr. Son Giep and staff will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above e-mail policy.

By signing below, you are agreeing that we may send medical related correspondence to you via e-mail, and that we may respond to your e-mails to us via e-mail.

_____ _____

Patient signature/Date Patient e-mail address

_____

Witness/Date