Son N Giep, M.D., P.A.

PATIENT MEDICAL HISTORY

Name:_____ **Age:**_____ **Occupation:** _____

Chief Complaint: _____

VITALS **Weight:**_____ **Height:**_____ **Blood Pressure:**_____/_____ **Temp:** _____

FAMILY HISTORY

Has any relative had:	Cancer of breasts, female organs, colon, melanoma	Yes	No
	Tuberculosis in the last 5 years	Yes	No
	Diabetes	Yes	No
	High blood pressure	Yes	No
	Kidney trouble (other than kidney stones)	Yes	No
	Heart Disease	Yes	No
	Anethesia complication	Yes	No

Exercise: Do you exercise at least 20 minutes, 3 times a week? Yes No

Alcoholic Beverages:_____Never _____Occassionally _____Moderately _____Daily

Smoking: Do you smoke? Yes No

If yes, how many packs per day? _____

If you quit, how long has it been? _____

Drug Use: Have you used, previously used, or had problems with any of the following:

_____Marijuana _____Heroin _____Cocaine _____Other Recreational Drug :_____

MEDICAL HISTORY Have you ever had any of the following:

Asthma or breathing problems	Yes	No	Colon trouble or bowel disorder	Yes	No
Anemia (longer than 3 months)	Yes	No	Kidney trouble	Yes	No
Tuberculosis	Yes	No	Venereal disease	Yes	No
High Blood Pressure	Yes	No	Varicose veins or Phlebitis	Yes	No
Heart Disease or murmur	Yes	No	Bleeding disorders	Yes	No
Diabetes	Yes	No	Seizures, loss of consciousness	Yes	No
Depression	Yes	No	Visual disturbance	Yes	No
Thyroid disorder	Yes	No	Treatment for nervous disorder	Yes	No
Ulcer or stomach problems	Yes	No	Cancer	Yes	No
Hepatitis, jaundice	Yes	No	Blood transfusions	Yes	No
Hospitalization for psychiatric reasons	Yes	No	Alchol abuse	Yes	No
Other _____			Drug Abuse	Yes	No

Please explain "Yes" Answers: _____

IMMUNIZATIONS and OTHER

Have you had a tetanus shot in the last 10 years? Yes, Date_____ No

(Only age 50 and over) Have you had a pneumonia shot in the last 10 years? Yes, Date_____ No

Have you had any other immunization in the past? _

Last Dental Exam:_Dentist Name: _____

Last Eye Exam: _____ Eye Dr Name: _____

SURGERIES *(Please include Dates)*

_____

DRUG ALLERGIES: _____

MEDICATIONS: ***Please list all medications you are currently taking including dosage***

_____

_____

_____

Patient Signature:_____ **Date:** _____

Son N. Giep M.D., P.A.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS _____ CITY/STATE_____ZIP _____

SSN: _____ SEX: Female Male MARITAL STATUS: _____

HOME # _____ WORK # _____ CELL # _____

RACE: _____ ETHNICITY _____ PREFERRED LANGUAGE_____

EMPLOYER: _____

ADDRESS_____ CITY/STATE_____ZIP _____

WHO REFERRED YOU? _____

WOULD YOU LIKE INFORMATION ON OUR PATIENT PORTAL: YES NO

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my provider or those under his/her supervision.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to the physician indicated above for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay, coinsurance or balance due that my provider is unable to collect from my insurance carrier.

INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to the physician on my behalf. Failure to provide the correct and accurate information regarding insurance in order to file claims accurately and timely could result in claim denial therefore may result in patient responsibility. I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement. All copays, deductibles, and/or coinsurance for all commercial insurance, Medicare and Medicare Replacement plans are due at the time of services rendered according to insurance contract provisions.

CANCELLATION/ NO SHOW POLICY/LATE:

Our office policy requires patients who request to cancel or reschedule their appointment to call our office at least 24 hours prior to their scheduled visit. A $50.00 No Show/Cancellation Fee may be assessed to you if the office is not contacted according to the policy. This fee also applies to any patients that do not show up for their scheduled appointment. Please note insurance companies cannot be billed for missed appointments late fees assessed. If you are late, there is a possibility the office may ask you to reschedule out of consideration for those patients scheduled after you.

PATIENT'S SIGNATURE/ _____ DATE _____
AUTHORIZED REPRESENTATIVE

Son N. Giep M.D., P.A.

TREATMENT

We make the best effort to diagnose and treat your condition(s) based upon the information we have. Sometimes, however, diseases and conditions may evolve. If you do not improve or your condition worsens and/or changes, it is your responsibility to inform us so we may re-evaluate your condition and diagnosis.

RESEARCH PROGRAMS

The physician(s) or staff may ask if you would like to participate in a clinical trial or research program. These may be sponsored programs. Please note the physician(s) and/or patients may be compensated for services rendered in connection with these programs. You are not obligated to participate in any of these programs. Your permission will be obtained prior to your participating in any of the programs that your provider may believe is appropriate for you. Please feel free to ask the staff and/or provider(s) if you have any questions regarding the research programs.

PAYMENT POLICY:

I understand and acknowledge the following:

- Verification of benefits given to us by your insurance company is not a guarantee of payment.
- We cannot guarantee payment of your claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.
- There is a $35 fee assessed for any returned check. You will subsequently receive a bill for this amount. Payment will need to be made in cash, money order, or VISA/MC. If payment is not received by the due date, you information will be turned over to the Collin County District Attorney. Any returned check will immediately restrict any future acceptance of checks as payment on your account.
- Late fees may apply to accounts past due 90 days.
- If your policy is an HMO, you are responsible for contacting your insurance prior to your visit and assigning the provider you are scheduled with. Failure to do so may result in claim denial and you will be responsible for the balance due on account. The HMO Policy will also be provided to you.
- If any patient is owed a refund, all claims on the account must be processed and paid in full before overpayment is refunded.

POLICY FOR MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Plano Internal Medicine Associates, PA, designated provider(s), or those under his/her supervision and/or representatives to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Plano Internal Medicine Associates, PA to that effect in writing.

I certify I understand the following:

- Email should never be utilized for an urgent or emergency problem.
- Providers are not required to communicate via email; this is at the discretion of the provider.
- Email should never be used for time sensitive issues.
- Email is not confidential and should not be used for sensitive information.
- All emails will become part of the permanent medical record.
- Email responses may not receive an immediate response. Responses may take a full business day or more.
- The provider(s) will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond the office's control.
- I agree that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

PATIENT'S SIGNATURE/ AUTHORIZED REPRESENTATIVE _____ DATE _____

Son N. Giep M.D., P.A.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: *(check all that apply)*

_____Home Telephone O OK to leave message with detailed information O Leave message with call back number only

_____Work Telephone O OK to leave message with detailed information O Leave message with call back number only

_____Mobile Telephone O OK to leave message with detailed information O Leave message with call back number only

_____Written Mail O OK to mail to my home address

_____ Email address O _____

NOTICE OF PRIVACY PRACTICES AND HIPAA RELEASE OF INFORMATION:

I certify and acknowledge that I have read and been made available a copy of the Notice of Privacy Practices. I understand the Notice of Privacy Practices provides information on how we may use and disclose protected health information (PHI). The Notice contains information regarding your rights under the law. 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 PHI about you for treatment, payment, or healthcare operations. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 199 (HIPAA). This authorization expires at the end of each calendar year or is revoked by the patient in writing.

I understand that PHI may be disclosed or used for treatment, payment, or healthcare operations. The practice has the Notice posted and available for the patient to review. The practice reserves the right to restrict the uses of their information but the practice does not have to agree to those restrictions. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

Finally, you may revoke this authorization in writing at any time by sending written notification to Plano Internal Medicine Associates, PA Attn: Practice Manager. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

PLEASE CHOOSE ONE: _____ I do not wish my information to be disclosed to any person.

_____ I give permission to disclose and discuss any information related to my medical condition(s) scheduling and billing to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name: _____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

IN CASE OF EMERGENCY - CONTACT INFORMATION

NAME: _____ PHONE: _____

I certify with the signature below that I have read all the information, acknowledge and understand Son N. Giep M.D., P.A. Patient Registration Form Disclosures & Consents.

This complete and full Disclosure and Consent Form assignment will remain in effect until revoked by me in writing. A photocopy and/or electronic copy of this instrument will have the same validity as the original.

PATIENT'S SIGNATURE/ _____ DATE _____
AUTHORIZED REPRESENTATIVE

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

Routine Preventive Exams (Annual Physicals) Q & A

insurance plans, as determined by your policy or your employer, have vastly different benefits for routine preventive exams. In some cases, insurance will not cover routine care at all (or "well patient" or "preventative care" office visits). The exam is prevention focused, not problem focused.

Q: What is the purpose of a routine preventive exam (annual physical)?

The purpose of a routine preventive exam is to identify potential health problems in the early stages when they may be easier and less costly to treat.

Q: What is the definition of a routine preventive exam?

A routine preventive exam is technically defined as periodic comprehensive preventive medicine evaluation and management, and includes the following:

- **Past medical, social, and family history**
- **Complete physical exam and review of body systems**
- **Review of current medications – (refills on current medications or prescribing new medications is not covered as a preventive service.)**
- **Immunizations**
- **Counseling/anticipatory guidance/risk factor reduction interventions**
- **Review of age/gender appropriate screening tests.**

Q: Why did I receive a bill after my routine preventive exam when it was supposed to be covered at 100%?

This exam is prevention focused, not problem focused. If you have a new health problem or other diagnoses that need to be addressed during your preventive office visit, e.g. high blood pressure, diabetes, skin rash, or headaches, your provider may bill part of the exam at 100 percent for your annual preventive exam and part of your office visit for treatment of your diagnosis. The portion of your visit related to the treatment of your diagnosis would apply toward your deductible and coinsurance. If your provider feels that the majority of the time was spent with medical concerns, the entire visit may be considered a medical treatment visit and would not be billed as preventive. It's important to note that your healthcare provider has the right to code and bill as they see the service from his or her viewpoint. Your plan provides coverage based on how your provider codes/bills each procedure.

Q: Will my provider address only what my health plan covers for a routine preventive exam?

Your provider does not know your health plan benefits and sees many patients with various insurance plans throughout the day. You are responsible for knowing what services are covered under your health plan. Review your Summary of Benefits prior to your preventive exam or call your plans Customer Service for your benefit information.

By signing below, I understand that I may be charged an additional office visit if care is extended outside of the scope of a preventive visit.

Print_____ Sign _____ Date_____