Hillcrest Internal Medicine

Patient Basic Information

Name: *

First Name Last Name

Preferred Name:

Date of Birth: *

Month Day Year

Gender: *

Marital Status: *

Employment Status:

Occupation: *

Current Employer:

Primary Language: *

Race: *

Ethnicity: *

Drivers License #:

Patient Contact Information

Address: *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Cell #: *

Work #:

Home #:

How would you like to be contacted by phone?

Primary #:

- ◯ Cell
- ◯ Home

Who will pay for co-payments or outstanding balances due? *

- ◯ Patient
- ◯ Another Person

Emergency Contacts

Name *

First Name Last Name

Relationship to Patient: *

Phone #: *

Name

First Name Last Name

Relationship to Patient:

Phone #:

Name

First Name Last Name

Relationship to Patient:

Phone #:

Your Current Physicians

Please indicate if the patient is under the care of another physician. This may include primary care physician or specialists.

◯ No current physicians to report.

Name:

Type:

Specialty:

Name:

Type:

Specialty:

Name:

Type:

Specialty:

Medical History Form

What is the patient's chief complaint?

Indicate the medical reason for patient's visit. *

- ◯ Anxiety
- ◯ Coughing/Sneezing
- ◯ Diabetes
- ◯ General Medical Exam
- ◯ Respiratory issues
- ◯ Stomach issues
- ◯ Back Pain
- ◯ Depression
- ◯ Fatigue
- ◯ Joint Pain
- ◯ Sleep issues
- ◯ Substance use
- ◯ Other: _____

Approximate date it started: *

Month Day Year

Past Medical History of Diseases or Conditions

Report past medical diseases or conditions that you've had. Where applicable, add dates and notes.

◯ No medical diseases to report.

Type:	Year (if applicable):	Comments:
Type:	**Year (if applicable):**	**Comments:**
Type:	**Year (if applicable):**	**Comments:**

Type:	Year (if applicable):	Comments:

Type:	Year (if applicable):	Comments:

Past Surgical History

Report surgeries and procedures that you've had along with the year you've had them.

◯ No surgeries or procedures to report.

Type:	Year:	Physician:	Comments:

Type:	Year:	Physician:	Comments:

Type:	Year:	Physician:	Comments:

Type:	Year:	Physician:	Comments:

Type:	Year:	Physician:	Comments:

Family History

Report medical diseases or conditions in your family.

◯ No family history of diseases to report.

Related Person:	Age:	Deceased:	Significant Health Problem:

Related Person:	Age:	Deceased:	Significant Health Problem:

Related Person:	Age:	Deceased:	Significant Health Problem:

Social History

Do you smoke? *

◯ YES
◯ NO

If so, how many packs of cigarettes per day?

Years smoking cigarettes:

Do you regularly consume alcoholic beverages? *

◯ YES
◯ NO

If so, how many alcoholic drinks do you consume per day?

Medication and Supplement Dosages

Please list the name of the patient's medication including prescription, non-prescription, herbal, vitamins, home remedies, eye drops, nutritional supplements, and inhalers. WARNING: Our providers will not be able to see the patient if you do not list ALL medications.

○ No medications to report.

Medication: **Frequency:** **Comments:**

Medication: **Frequency:** **Comments:**

Medication: **Frequency:** **Comments:**

Medication: **Frequency:** **Comments:**

Medication: **Frequency:** **Comments:**

Pharmacy Location: **Pharmacy Phone Number:**

Pharmacy Name

Street Address

State

City

Zip Code

Allergies

Report any medication or non-medication related allergies you have. Report environmental allergies, and food sensitivities also. Where applicable, add reactions.

◯ No allergies to report.

Allergy:	Reaction:	Comments:

Allergy:	Reaction:	Type a question

Allergy:	Reaction:	Comments:

Allergy:	Reaction:	Comments:

Allergy:	Reaction:	Comments:

Vital Signs

Height (Feet): *	Weight (Inches): *	Weight (In pounds): *

Systolic Blood Pressure (higher end of your reading):

Diastolic Blood Pressure (lower end of your reading):

Review of Systems

General: *

- ☐ None to report
- ☐ Fever
- ☐ Unintended Weight Loss

Ear/Nose/Throat: *

- ☐ None to report
- ☐ Hearing loss
- ☐ Ear Ache
- ☐ Chronic Sinus Problem
- ☐ Nose Bleeds
- ☐ Swollen Glands in Neck

Eyes: *

- ☐ None to report
- ☐ Eye disease or injury
- ☐ Double vision
- ☐ Glaucoma

Respiratory: *

- ☐ None to report
- ☐ Chronic Cough
- ☐ Spitting up blood
- ☐ Asthma or wheezing

Endocrine: *

- ☐ None to report
- ☐ Hormone problem
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Heat or cold intolerance

Cardiovascular: *

- ☐ None to report
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Swelling of feet
- ☐ Swelling of Ankles
- ☐ Swelling of Hands
- ☐ Ankles
- ☐ Hands

Gastrointestinal: *

- ☐ None to report
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Heartburn
- ☐ Stomach ulcer

Neurological: *

- ☐ None to report
- ☐ Headaches
- ☐ Lightheaded or dizzy
- ☐ Stroke
- ☐ Tremors
- ☐ Head injury

Psychiatric: *

- ☐ None to report
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia (sleeplessness)

Hematologic/Lymphatic: *

- ☐ None to report
- ☐ Bleeding or bruising tendency
- ☐ Anemia
- ☐ Past transfusion

How did you hear about us?

What is the primary reason you chose us?

Insurance: Did you find us through your insurance?

- ◯ YES
- ◯ NO

Online Search: Which website had the most impact on your decision?

- ◯ Basic Search
- ◯ Google Reviews
- ◯ Yelp Reviews
- ◯ Healthgrades Reviews
- ◯ Facebook Reviews
- ◯ Vitals Reviews
- ◯ RateMDs Reviews
- ◯ uCompare Healthcare Reviews

Doctor Referral: Which doctor referred you?

Advertisement: Which ad campaign did you notice?

- ◯ Email campaign
- ◯ Regular mail campaign
- ◯ Newspaper advertisement
- ◯ Radio advertisement

Friend Referral: Please list your friends name.

Other: What other factors influenced your decision?

Legal Forms

Notice of Privacy Practices

HILLCREST INTERNAL MEDICINE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE July 17, 2021

This Notice of Privacy Practices (the "Notice") tells you about the ways we may use and disclose your protected health information ("medical information") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Hillcrest Internal Medicine including its providers and employees (the "Practice").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;

- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;

- Notify affected individuals following a breach of unsecured medical information under federal law; and

- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment.

We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing healthcare to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment.

We may use and disclose medical information about you so that we may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations.

We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance.

We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review.

We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing And Peer Review.

We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives.

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders And Health Related Benefits And Services.

We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. [Patient Portal] [Email reminders.]

I. Business Associates.

There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved In Your Care Or Payment For Your Care.

We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required By Law.

We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert An Imminent Threat Of Injury To Health Or Safety.

We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ And Tissue Donation.

If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an

organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research.

We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is “de-identified.”

O. Military And Veterans.

If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers’ Compensation.

We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers’ compensation insurance or a state workers’ compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks.

We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).

- To report births and deaths.

- To report suspected child abuse or neglect.

- To report reactions to medications or problems with medical devices and supplies.

- To notify people of recalls of products they may be using.

- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- To provide information about certain medical devices.

- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities.

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters.

If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security And Intelligence Activities.

In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners And Funeral Home Directors.

We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates.

If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing Of Related Health Services.

We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient’s right to have the recipient’s name removed from the sender’s mailing list.

X. Fundraising.

We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures Of Medical Information.

Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations.

There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing And Sale Of Medical Information.

Most uses and disclosures of “psychotherapy notes,” uses and disclosures of medical information for marketing purposes, and disclosures that constitute a “sale of medical information” under HIPAA require your authorization.

C. Right To Revoke Authorization.

If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right To Inspect And Copy.

Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice’s HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right To Amend.

If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right To An Accounting Of Disclosures.

You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice’s HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice’s HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right To Request Restrictions.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won’t be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice’s HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan’s decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right To Request Confidential Communications.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice’s HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right To A Paper Copy Of This Notice.

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice’s HIPAA Officer at the address set forth in Section VI below.

G. Right To Breach Notification.

In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Hillcrest Internal Medicine

Attn: HIPAA Officer

12720 Hillcrest Rd, Ste 625

Dallas, TX 75230

469-830-9600

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

Acknowledgement of Notice of Privacy Practices

Hillcrest Internal Medicine

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Hillcrest Internal Medicine and associated physicians are committed to securing the privacy of your health information. We have made available to you a copy of the notice which provides information about how its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

REQUIRED **Initial Here*** I acknowledge that I have received a copy of Hillcrest Internal Medicine's Notice of Health Information Practices.

Your relationship to the patient? *

Financial Policies

Hillcrest Internal Medicine

Welcome to our practice and thank you for choosing Hillcrest Internal Medicine to care for you and/or your loved ones. We are committed to providing you with the highest-quality care and exceptional customer service. Because some of our patients have had questions regarding patient and insurance responsibilities for services rendered, we have developed this financial policy. Our billing office is located in Dallas and can be reached at 469-608-8581 if you need assistance.

FINANCIAL RESPONSIBILITY

REQUIRED **Initial Here*** I hereby authorize payments from Medicare or other insurance companies of medical benefits directly to Hillcrest Internal Medicine and/or the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I do appoint Hillcrest Internal Medicine to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Hillcrest Internal Medicine. I further understand that should by account become delinquent, I shall pay the reasonable fees or collection expenses, if any. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier. The duration of this authorization is indefinite and continues until revoked in writing.

INSURANCE

We participate in most insurance plans. Please bring your up-to-date insurance card with you to each visit. It is your responsibility to make sure that our providers are on your specific plan and in-network for you. If you are insured by a plan we accept, but do not have an up-to-date insurance card, payment in full is required until we can verify your insurance coverage. If you are not insured by a plan we do business with, payment is required in full at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

PROOF OF INSURANCE

We must obtain a copy of your driver's license and a current valid insurance card to provide proof of insurance. If your health insurance changes, please notify us before your next visit so we can make the appropriate changes to help you maximize your benefits. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES

All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second copay if you address other problems during a physical exam or at the same time you have a procedure scheduled. We accept cash, check, Visa, MasterCard and Discover.

CLAIM SUBMISSION

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any reason, our office cannot be responsible for that bill. It is your responsibility as the patient to pay the denied amounts in full. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. It is your responsibility to know if our providers are in-network for your insurance plan and what your specific insurance plan's benefits are.

NON-COVERED SERVICES

Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. As with all non-covered services, you will be expected to pay in full whatever the insurance companies do not reimburse.

NONPAYMENT

If your account is over 90 days past due, you will receive a letter stating that the balance should be paid in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. Should this occur, you will be notified by certified mail and will have 30 days to find a new physician.

Acceptance Of Financial Policies

REQUIRED **Initial Here*** I have read and received a copy of the financial policies for Hillcrest Internal Medicine.

Your relationship to the patient? *

Office Policies

Hillcrest Internal Medicine

CONSENT TO TREAT

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. At this point in your care, no specific treatment plan has been recommended. 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 or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician 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. 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 understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

PHONE CALLS

By providing contact information, I authorize Hillcrest Internal Medicine, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

MISSED APPOINTMENTS

If you cannot keep your appointment, you will need to reschedule your appointment 24 hours in advance. This will allow us to schedule another patient in that time slot. If any office visit appointment is no-showed, cancelled with less than 24 hours' notice or rescheduled due to late arrival the following charge may be billed to your account depending on the appointment type.

Office visit $50.00 Fee

Annual Wellness Visit $100.00 fee

This charge is not payable by your insurance company. If multiple appointments are missed and we identify a problem with you keeping appointments, we will not be able to provide care for you at this office.

FORMS

There is a $25 charge for the completion of FMLA, disability and other forms. Since insurance companies do not cover this service, this charge is your responsibility. Payment is due at the time the forms or requests are dropped off at the clinic.

AUTHORIZATION

REQUIRED **Initial Here*** I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

I hereby authorize employees and agents (including physicians, physician assistants, and nurse practitioners) of this medical office to render routine medical care to me, the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) I hereby authorize employees and agents of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, medical care will not be provided except in a case of emergency.

Your relationship to the patient? *

Confidential Communications

Please make selections below on the best means of communication between Hillcrest Internal Medicine and you, our patient.

Preferred Mode of Verbal Communication: * **Permission to: *** **Preferred Mode of Written Communication: ***

Required Authorization

REQUIRED **Initial Here*** I authorize Hillcrest Internal Medicine to use the above means of communication and, if this changes, I may submit the change in writing at any time.

Designation of Representative(s)

You are authorized to disclose your health information to people other than yourself, as such person is involved in your healthcare or payment relating to your healthcare. By providing us with first and last names of persons below, you authorize Hillcrest Internal Medicine to share medical information with these persons.

◯ No representatives to report.

Name: **Phone Number:**

Name: **Phone Number:**

Name: **Phone Number:**

Medical Records Release

Hillcrest Internal Medicine

Release Of Information From Hillcrest Internal Medicine

REQUIRED **Initial Here*** Authorization is hereby granted to release of information contained in my medical record as may be necessary for medical treatment or to process and complete my insurance claims. I understand that this release of information may include information regarding communicable diseases such as, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand this authorization will remain in effect until/unless I revoke it in writing.

Release Of Information To Hillcrest Internal Medicine

REQUIRED **Initial Here*** I authorize Hillcrest Internal Medicine to retrieve my complete medication profile from my insurance, pharmacy, or other third party source. I understand this information will be kept confidential and used only to aid in my ongoing treatment. I understand this authorization will remain in effect until/unless I revoke it in writing.

Your relationship to the patient? *

Please sign and date at the bottom indicating that you agree to these policies.

Notice of Privacy Practices

Acknowledgement of Notice of Privacy Practices

Financial Policies

Office Policies

Confidential Communications

Designation of Representative(s)

Medical Records Release

Please sign by typing your name in the box below: *

Month Day Year