MEDICO M.D.

MEDICAL DENTAL

PATIENT INFORMATION

First Name: _____MI: ___ Last Name: _____SSN#:_____

Date of Birth: _____ Sex: ____ Gender Identity: _____Sexual Orientation: _____

Marital Status: S___ M___ D___ W___ Email Address: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone:_____Employer/Occupation:_____

ACCOUNT RESPONSIBILITY (If different than above)

Who is responsible for this account? _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____

Cell Phone: _____ Date of Birth: _____ SSN#: _____

MEDICAL INSURANCE

Name of Primary Insurance Company:_____

Subscriber Name: _____ Group # _____

Member ID: _____ Subscriber Date of Birth: _____

Name of Secondary Insurance Company: _____

Subscriber Name: _____ Group # _____ Member ID: _____

Subscriber Date of Birth: _____ Medicare ID (If on Medicare):_____

Payment Policy

Patients are required to pay total amount due at the time of service to see a primary care provider or have testing/procedures performed. Please note that your balance may be more than the above stated amounts and will be determined based on actual services rendered during your office visit. We can offer payment plan if needed.

By signing below, you state that you have read and understand the above cash pay policy.

Patient/Guardian Signature: _____

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CLINIC BILLING AND EXPECTATIONS

Please sign below to indicate you have read and understand the following:

1. **Responsibility for payment of your account always remains with you**; and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if your claim is related to the following, AUTO RELATED OR THE RESPONSIBILITY OF A THIRD-PARTY PAYOR.

2. Copays and other estimated out of pocket amount due are to be collected at the time of service.

3. If you need to set up a payment plan or have additional questions please contact billing department @ (469) 250-6780.

4. Medico MD may need to contact you for additional information or to collect any amounts you may owe. You give your express agreement and consent to allow Medico MD to call you at any telephone number provided or obtained, without limitation of wireless.

5. A $25.00 fee will be charged to your account if you do not cancel your appointment 24 hours in advance. After three no show appointments, you will be subject to discharge from Medico MD.

6. There is a $35.00 fee for all returned checks and for stop payments.

7. No credit will be extended to patients having a past due account.

8. If you arrive more than five minutes late to an appointment, you may be asked to reschedule or have extended wait times.

9. Medico MD requires 2 business days to respond to all medication refill requests. Medications will not be refilled after clinic hours. Please contact your pharmacy to initiate refill requests.

CONSENT FOR TREATMENT

By signing below, you state that you have read and understand the above **CLINIC BILLING AND EXPECTATIONS.**

I am requesting Medico MD to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Medico MD does not guarantee any outcome for any services or treatments, either stated or implied.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian): _____Date:_____

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Acknowledgment Privacy Policy Offered

My health information may be created or reviewed by Medico MD and may be in the form of written or electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, prescriptions, and similar types of related health information.

I understand that I have the right to receive and review a written description of how Medico MD will handle my health information. This written description is known as a **Notice of Privacy Practices**. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Medico MD and my right regarding my health information. I may obtain a copy of the **Notice of Privacy Practices** at the reception desk or view it on the clinic website.

Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following.

I give permission to Medico MD to leave messages regarding:

☐ Appointments ☐ Billing information ☐ Limited medical information

☐ **Home** ☐ **Mobile** ☐ **Work**

And/Or with the following person(s):

Name:_____ Relationship: _____ Phone number:_____

Name:_____ Relationship: _____ Phone number:_____

Name:_____ Relationship: _____ Phone number:_____

This release will be revoked by written permission only.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian): _____Date:_____

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Today's date_____

Name [print]_____Date of Birth_____

Social History:

Education Level: _____ Employer_____

Marital Status (Circle One): Single Married Divorced Widowed

Average per day:

Alcohol_____ Tobacco (Packs Per Day) _____ Years _____

Caffeine_____ Recreational Drugs_____

Current Diet (Circle One): Diabetic Low Fat Other_____

Exercise Type: _____ Frequency:_____

Medical History:

Medications	**Diagnosis/ Reason for medication**	**Specialist/prescriber?**

Implanted medical devices, or other medical devices ie CPAP, Oxygen:

_____

Prior Hospitalizations & Illnesses:

_____

_____

Allergies (Medications, Food, Environmental) AND description of reaction:

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Medical History

Vaccines	Year	Screenings	Year	Other Tests	Year
Flu		Colonoscopy		DEXA Scan	
Tetanus (Tdap)		Mammogram		Stress Test	
Pneumonia		Pap Smear		Other:	
Shingles		Eye Exam			

For Women:

Age of first period: _____ First day of last period: _____

# of Pregnancies: _____ # of Births: _____

Surgical History:

Surgery	Year	Specialist

Family History:

Diagnosis	Relative (Specify Paternal or Maternal)	Age at Diagnosis
Cardiac (heart attack, stroke, etc)		
High Blood Pressure		
Cancer (specify type)		
Diabetes		
Mental Health		
Other		

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Medical History Cont.

Have you had any of the following issues <u>IN THE LAST 3 MONTHS</u>?

Systemic:	weight change, fevers, fatigue, etc
Head:	headache, sinus pain, etc
Eyes:	vision change, redness, pain, etc
Neck:	pain, muscle tightness, lumps, etc
Breast:	lumps, pain, skin change, etc
Neurological:	dizziness, fainting, confusion, numbness or tingling, etc
Musculoskeletal:	muscle aches, joint pain, weakness, etc
Hematological:	bruising, easy bleeding, anemia, etc
Psychological:	depression, anxiety, trouble sleeping, etc
Genitourinary:	change in urine, incontinence, genital discharge, etc
Gastrointestinal:	vomiting, diarrhea, constipation, blood in stool, stomach pain, etc
Cardiovascular:	chest pain, racing heart, fainting, palpitations, etc
Pulmonary:	shortness of breath, wheezing, cough, etc
Ears/Nose/Throat:	sore throat, stuffy nose, snoring, sneezing, etc
Endocrine:	excessive thirst, hair loss, excessive sweating, etc
Skin:	rash, itching, sores, etc

Any concerns you would like to discuss with provider? We may not be able to address all concerns at first visit.

_____

_____

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Authorization for Release of Medical Records

I, _____, do hereby give my permission to have my Medical Records released from _____ and sent to:

Medico M.D. Medical & Dental

8150 Springwood Dr., 150B, Irving Tx 75063

medicalrecords@medicomdtx.com

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file.

Please be sure to include all X-Rays, Labs, and relevant progress notes.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will expire in 90 days from the date of my signature.

I here by authorize the release of all necessary medical records to Dr. Nathan Nguyen or any provider under his supervision within Medico MD.

I understand that my records are confidential and may be disclosed only as authorized in this consent.

Patient Signature: _____ Date: _____

Phone Number: _____

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As a general rule, WE DO NOT MANAGE CHRONIC PAIN and will not routinely prescribe narcotics or other controlled substances (Tramadol, Codine, Hydrocodone, Soma, etc). We recognize many people live with chronic pain and understand the necessity of controlling such symptoms. We also recognize chronic pain management as a specialized field of medicine and believe long-term treatment of chronic pain should be addressed by a board-certified pain management physician in an accredited pain management center.

As a general rule, WE DO NOT PRESCRIBE CONTROLLED SUBSTANCES FOR THE LONG-TERM TREATMENT OF ANXIETY. Anti-Anxiety drugs such as Xanex, Klonopin, Ativan, and Valium may be prescribed for the short-term treatment of acute anxiety or on an infrequent "as needed" basis but will not be prescribed for long-term use. Family practice providers are experienced in the diagnosis and management of anxiety and depression and see patients with these issues on a daily basis. Anti-Depressants and certain other anti-anxiety medications are not controlled substances and will be prescribed as needed.

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

_____ _____

Signature of Patient or Responsible Party Date