

Stonebridge Adult Medicine, P.A.

REGISTRATION FORM

(Please Print)

Date:

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____ Mr. Miss Mrs. Ms. Marital status (circle one)
Single / Mar/ Div/ Sep/ Widow

Is this your legal name? Yes No If not, what is your legal name? _____ (Former name): _____ Date of Birth: ____/____/____ Age: ____ Sex: M F

Street Address: _____ Social Security Number: _____ Home Phone Number: _____

Daytime Phone Number: _____ City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____ Work Phone Number: _____

Chose clinic because/Referred to clinic by (please check one box): Dr. Insurance Plan Hospital
 Family Friend Close to home/work Yellow Pages Other

Other family members seen here: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Date of Birth: ____/____/____ Address (if different than patient): _____ Home Phone Number: _____

Is this person a patient here? Yes No

Occupation: _____ Employer: _____ Employer Phone Number: _____

Is this patient covered by insurance? Yes No

Primary Insurance Company Name: _____

Subscriber's Name (If not patient): _____ Subscriber's S.S. Number: _____ Birth Date: ____/____/____ Group Number: _____ Policy Number: _____ Co-payment: _____
\$

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's Name: _____ Group Number: _____ Policy Number: _____

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone number: _____ Work phone number: _____

The above information is true to the best of my knowledge. I authorize Stonebridge Adult Medicine, P.A. to apply for benefits on my behalf for covered services rendered by its physicians. I request my insurance benefits be paid directly to the physician or Stonebridge Adult Medicine, P.A.. I understand that I am financially responsible for any balance. I also authorize Stonebridge Adult Medicine, P.A. or the insurance company to release any information required to process my claims.

Patient signature

Date

Stonebridge Adult Medicine, P.A. Patient Financial Policies

Thank you for choosing Stonebridge Adult Medicine, P.A. for all of your medical needs. We look forward to providing a complete package of medical treatment and financial services to assist you. We do file your charges with your insurance carrier as a benefit to you. Reimbursement should be received within 45 days in most cases although some exceptions do apply. **It is ultimately the patient's responsibility to know and understand what services are covered under their individual insurance policy. Patients without insurance coverage are required to pay the balance in full at the time of service.** We do not file claims to any Workers Comp programs or on claims for automobile-related accidents.

Common insurance claim denials include, but are not limited to:

- Pre-existing medical condition(s)
- Patient responsible for meeting policy deductible before insurance will pay
- Insurance not in effect at the time of service
- Coverage by more than one plan in which coordination of benefits has not been arranged
- Policy maximum has been reached
- No referral for the service (if the policy requires you to list a primary care physician that is not one of our physicians)
- Medical services rendered is not covered by the insurance policy

Professional services are rendered to the patient, not an insurance company. Insurance companies can deny claims for a variety of reasons and the above are only the most common denial reasons. **Any unpaid balance remains the patient's responsibility.**

You can assist in the following ways to expedite your claim and reduce denials:

- You will be asked at every visit to verify your information and make any applicable changes. **It is your responsibility to inform us of any demographic and insurance changes.** If you have two insurance carriers, please advise the receptionist and provide a copy of both insurance cards.
- Medicare patients – If you have switched from traditional Medicare to a Medicare replacement policy (Secure Horizons, Evercare, etc.), please inform the reception staff at the time of service.

If any changes in your insurance information coverage is not provided and/or received within the insurance carrier timely filing period, the patient will become responsible for any balance of the account. **Co-pays are always due at the time of service.**

We accept the following payment types:

- Cash
- Check (returned check fee is \$25.00)
- Visa
- Mastercard
- Discover
- American Express

No show, cancellation, and late patient policy:

You will receive a phone call reminder a day or two prior to your scheduled appointment. If you need to cancel an appointment, we ask that you do so within 24 hours of your scheduled appointment time. If you arrive late to your scheduled appointment, we will attempt to see you at the next available time slot if the schedule permits. Any patient that excessively abuses this policy is subject to dismissal from our practice.

I have read and understand the above patient policies. I understand that this office will file an insurance claim on my behalf based on the information I provide. Stonebridge Adult Medicine, P.A. and I will receive an Explanation of Benefits (EOB) from my insurance carrier(s) that will detail any payments, deductions, and adjustments per my insurance plan's guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company as applicable by state and / or federal law.

Patient Signature

Date

Stonebridge Adult Medicine, P.A.

**Consent to Use and Disclose Protected Health Information
Patient Consent Form**

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Stonebridge Adult Medicine, P.A. originates and maintains health records describing health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future treatment. This information is utilized to plan your care and treatment, to bill for services provided to you, to communicate with other healthcare providers, and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals. Your protected health information will be used by Stonebridge Adult Medicine, P.A. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES

Stonebridge Adult Medicine, P.A. is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. You have been provided a copy of or access to the Notice of Privacy Practices and understand that you have the right to review the notice prior to signing this consent. These policies and procedures are defined in the "Privacy Policy and Procedure" manual in our office and the "Notice of Privacy Practices" brochure provided to you. Please review it carefully.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, Stonebridge Adult Medicine, P.A. may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or your physician if you would like additional information or clarification.

I request the following restrictions of the use and/or disclosure of my personal health information:

It is a violation of the federal privacy standards if Stonebridge Adult Medicine, P.A. agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Practices brochure, please consult with a practice representative at the location and contact information listed in the Privacy Policy and Procedure manual.

YOU MAY REVOKE THIS CONSENT AT ANY TIME

You may revoke this consent at any time; however, Stonebridge Adult Medicine, P.A. requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES

Stonebridge Adult Medicine, P.A. reserves the right to change or modify the privacy practices outlined in the Privacy Policy and Procedure manual and the Notice of Privacy Practices brochure. Stonebridge Adult Medicine, P.A. will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

SIGNATURE

By signing below, you indicate you have reviewed this consent form, received the brochure entitled "Notice of Privacy Practices", and given permission to Stonebridge Adult Medicine, P.A. to use and disclose your health information in accordance with this consent and the notice provided.

Name of Patient (print or type)

Signature of Patient

Date

Patient Legal Representative (if applicable)

Signature of Patient Legal Representative

Date

Signature of Witness

Date

Stonebridge Adult Medicine, P.A.

Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Receive Information:

Any health information Stonebridge Adult Medicine, P.A. collects or receives about you may be disclosed to the following persons:

Name of person / relation

Name of person / relation

Name of person / relation

Use and Disclosure of Information:

____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Stonebridge Adult Medicine, P.A.

____ I do not authorize any information to be disclosed to any other parties except those parties outlined in the *Notice of Privacy Practices*.

If you have an answering machine or voice mail, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Stonebridge Adult Medicine, P.A.

_____ YES _____ NO _____ N / A

If "NO", how may we contact you regarding this information?

Expiration Date of Authorization

This authorization does not expire unless revoked or terminated by the patient or patient's legal representative in writing.

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative

Print Name of Witness

Stonebridge Adult Medicine, P.A.
3550 Parkwood Blvd., Suite 100
Frisco, TX 75034
Phone (214) 618-9715 * Fax (214) 618-9716

Mission Statement

Stonebridge Adult Medicine, P.A. is committed to providing patients with high-quality health care. We believe that providing optimal care is not only about the medical advice and treatment we dispense, but more importantly about the relationships we have with our patients. We continue to strive to deliver comprehensive, patient centered, timely, cost efficient care to our patients in order to optimize their quality of life.

Our Physicians

Our physicians are primary care doctors specialized in Internal Medicine. All of our physicians are board certified by the American Board of Internal Medicine. We provide preventative care and management of chronic illnesses such as diabetes, high blood pressure, and cholesterol, as well as acute care to patients 18 years or older.

Office Hours

For your convenience, our office is open Monday through Friday with morning and afternoon appointments available. In most cases, we have same day appointments available for your urgent care needs. If you are unable to keep an appointment please give 24 hour notice of your cancellation so we can provide the opportunity for another patient to be seen in your time slot.

Referrals

If a physician refers you to a specialist or schedules additional diagnostic testing, we will provide the referral from your insurance company if necessary. We require at least three business days advanced notice to be able to provide quality medical care and referral evaluation. We will also work with the specialist or testing facility to coordinate your medical care. Patients are ultimately responsible for understanding their insurance policy's guidelines for specialty care and any costs associated with care received beyond our practice.

Prescriptions and Refills

We are always happy to provide prescription refill requests to our patients when medically approved. We require at least three business days advanced notice to be able to provide quality medical care and prescription evaluation. You may visit or call your pharmacy to request any refills you may need. Unfortunately, refills cannot be called in on weekends or holidays. We strongly encourage you to notify your pharmacy or our office at least 3 days before your prescription runs out. Your health is our top priority; therefore, refills will be authorized as needed provided you follow up in the office as recommended by the physician.

In Case of Emergency

We realize that emergency situations arise. If you require urgent medical care, call us anytime at (214) 618-9715 and the office will try to arrange for a same day appointment with your physician or the first available physician. If the problem is life threatening, call 911 or proceed to the nearest emergency room for treatment.

In an effort for my physician to provide me with optimal medical care, I understand the above policies and procedures.

Patient Signature

Date

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision – Halos	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
<p>MUSCLE/JOINT/BONE</p> <p>Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>WOMEN only</p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>

CONDITIONS Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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MEDICATIONS List medications you are currently taking.

ALLERGIES To medications or substances

Pharmacy Name _____ Phone _____

Stonebridge Adult Medicine, P.A.
3550 Parkwood Blvd., Suite 100
Frisco, TX 75034
(214) 618-9715 – phone
(214) 618-9716 – fax

Patient Name: _____

Date of Request: _____ Date of Birth: _____

Records requested from the following physician / facility:

Name: _____

Phone: _____

Fax: _____

Please forward the following:

_____ All medical records _____ Test only (specify) _____

Please fax to the attention of:

Paul Hui Wang, M.D.

By signing below, I am providing written consent for Stonebridge Adult Medicine, P.A. to obtain copies of my medical records. I also agree that photocopied signatures are valid for obtaining medical records.

Patient Signature

Witness Signature