Texoma Primary Care Associates

5810 Collin McKinney Pkwy, Ste 202 McKinney TX 75070
Ph 972-919-0721 Fax # 972-919-0725

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

First	**MI**	**LAST**
SSN		
Street Address:		
City	**State**	**Zip**
Home Telephone #		**Preferred Y N**
Cell Phone #		**Preferred Y N**
Birth Date:		
Sex		**Marital Status**
MALE FEMALE		
Ethnicity (Circle One):		
White African American Asian		
American Indian or Alaska Native Pacific Islander		
Patient Email Address		
Emergency Contact Name		**Relationship to Patient**
Emergency Contact Cell Phone #		
Employer Name		
Work Telephone #		

PRIMARY INSURANCE INFORMATION

Primary Insurance Name		
Claim Address		
City	**State**	**Zip**
Group Number		
Policy (ID) Number		
Subscriber Name		**Relationship to Patient**
Subscriber Date of Birth		
CoPay Amount ($)		

SECONDARY INSURANCE

Secondary Insurance Name		
Claim Address		
City	**State**	**Zip**
Group Number		
Policy (ID) Number		

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RESPONSIBLE PARTY INFORMATION

First	MI	Last
Street Address		
City	State	Zip
Home Telephone #		
Relationship to Patient		
Account Email Address		

Subscriber Name	Relationship to Patient
Subscriber Date of Birth	
Subscriber Employer	
Subscriber Employer Phone #	

(Please attach hand written sheet for any additional insurance information)

How were you referred to our practice (Insurance, friend / family, internet, advertisement, doctor referral, etc.)?

PHARMACY INFORMATION

Pharmacy Name		
Pharmacy Address		
Pharmacy City	State	Zip
Pharmacy Telephone #		

I verify that the above information is true to the best of my knowledge.

I also agree to allow Texoma Primary Care Associates Provider and its Staff to obtain and / or share my medical information to/with all concerned individuals and / or organizations (including Pharmacies) as required, within the extent allowable and described in the HIPPA Notice of Privacy Practices, for the purpose of providing the patient, appropriate medical care and conducting all transactions related to the medical care, including financial and business transactions.

(Signature of Patient / Legal Guardian) **Date**

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Medical History

Physician/Nurse Practitioner: _____Date: _____

Patient Name: _____Reason for Visit: _____

Personal Medical History			**Previous Surgeries/Serious Injuries (When?)**
Diabetes (Type _____)	N	Y: Date _____	_____
High Blood Pressure	N	Y: Date _____	_____
Cancer (Type_____)	N	Y: Date _____	_____
Stroke	N	Y: Date _____	_____
COPD	N	Y: Date _____	_____
High Cholesterol	N	Y: Date _____	_____
GERD	N	Y: Date _____	_____
Arthritis	N	Y: Date _____	_____
Gout	N	Y: Date _____	_____
Sleep Apnea	N	Y: Date _____	_____
Asthma	N	Y: Date _____	**Local Pharmacy**_____
Thyroid Disorder	N	Y: Date _____	_____
Allergic Rhinitis	N	Y: Date _____	**Mail Pharmacy**_____
Other	N	Y: Date _____	_____

Last Physical/Wellness Exam Date: _____

Patient Social History

Use of Alcohol: Daily Weekly Monthly Occasionally Rarely Never

Use of Tobacco: Daily Previously, but Quit (Age Stopped_____) Never

Use of Drugs: Never Type/Frequency _____

Marital Status: Single Married Divorced Separated Widowed Occupation:

_____

Family Medical History

	Age	Diseases	If Deceased, Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Son	_____	_____	_____
Daughter	_____	_____	_____

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Patient Name: _____ Date of Birth: _____

ALLERGIES (Medications and Dyes)	
Item(s) that you are *allergic* to:	**Reaction(s) you have had from the *medication*, you are allergic to:**

MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS			
Drug Name (Brand name, or generic name)	**Dosage**	**Times taken within 24 Hours**	**Reason for taking Medication**

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Patient Name: _____ Date of Birth: _____

Do you **currently** have any problems related to the following systems?

REVIEW OF SYSTEMS	
CONSTITUTIONAL: No Yes □ □ Chills □ □ Fatigue □ □ Fever □ □ Weight Gain □ □ Weight Loss	**GENITOURINARY:** No Yes □ □ Dysuria (painful urination) □ □ Hematuria (blood in urine) □ □ Urinary frequency
HEENT: No Yes □ □ Ear pain □ □ Eye pain □ □ Sinus pressure □ □ Sore throat	**INTEGUMENTARY (SKIN):** No Yes □ □ Hair loss □ □ Rash
RESPIRATORY: No Yes □ □ Cough □ □ Shortness of breath □ □ Wheezing	**NEUROLOGICAL:** No Yes □ □ Dizziness □ □ Extremity numbness □ □ Headache
CARDIOVASCULAR: No Yes □ □ Chest Pain □ □ Edema	**PSYCHIATRIC:** No Yes □ □ Anxiety □ □ Depression □ □ Insomnia
GASTROINTESTINAL: No Yes □ □ Abdominal Pain □ □ Blood in stools □ □ Constipation □ □ Diarrhea	**Musculoskeletal:** No Yes □ □ Back pain □ □ Joint pain □ □ Neck pain

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Patient Name: _____ Date of Birth: _____

Health Maintenance Flow Record

Test	Date Performed	Normal or Abnormal?
Bone Density		
Colonoscopy		
Eye Exam		
Foot Exam		
Echocardiogram		
Endoscopy		
EKG		
Spirometry		
Stress Test		

Male Patients Only

PSA Blood Test		

Female Patients Only

Mammogram		
Pap Smear		

Immunizations

Hep A vaccine	
Hep B vaccine	
Twinrix	
HPV vaccine	
Meningococcal vaccine	
MMR vaccine	
Pneumonia vaccine	
Tetanus vaccine	
Varicella vaccine	
Shingles vaccine	

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Statement of Patient Financial Responsibility

Patient Name: _____DOB: _____

Texoma Primary Care Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Texoma Primary Care Associates, for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Texoma Primary Care Associates, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Texoma Primary Care Associates, through its appropriate personnel, to perform or have performed upon me, or the above- named patient, appropriate assessment and treatment procedures.

I further authorize Texoma Primary Care Associates, to release to appropriate agencies, any information acquired in the course of my or the above- named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Texoma Primary Care Associates will notify you in writing, via certified mail, if you are discharged

from care. I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

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Self-Pay

I do not have health insurance and will be responsible for services rendered here at Texoma Primary Care Associates. I agree to pay Texoma Primary Care Associates, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Patient/Guarantor Signature _____ **Date** _____

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MEDICAL INFORMATION RELEASE CONSENT FORM

Patient Name:_____

Patient DOB:_____

I, _____give _____
(Patient name) **(name of Parent, Spouse, etc.)**

and / or _____

permission to inquire and receive information contained in my medical record at Texoma Primary Care Associates. In addition, the above-named person may inquire and receive information from the staff at Texoma Primary Care Associates regarding my presence in the office, any test results, any testing or physician visits ordered by my primary care physician, and/or dates of treatment.

Texoma Primary Care Associates will give the information only to the person(s) named above (apart from medical use by physician and clinical staff) and will not be held liable for doing so.

You may also leave me a voice-mail per the following selection:

_____My Home: _____

_____My Cell: _____

_____My Work: _____

Please leave a: _____Detailed Message

_____Message Only asking me to return your call

This authorization remains valid unless revoked by me in writing.

Patient Signature:

Witness:

Date:

Patient Name: _____

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ACKNOWLEDGEMENT of receipt of HIPPA Notice of Privacy Practices

I / We acknowledge that I have received, read and understood the **HIPPA Notice of Privacy Practices** from Texoma Primary Care Associates.

_____

(Patient or Parent / Guardian Signature)

_____ _____

(Patient or Parent / Guardian Name) **(Date)**

Patient Name: _____

Texoma Primary Care Associates

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Dear patient,

Welcome to Texoma Primary Care Associates. We are so pleased to have you as our patient. Our practice is committed to providing the best treatment to you, our patients.

Our Physician, mid-level providers PA/NPI are board-certified. O u r providers are specialists with extensive training in the diagnosis and treatment of medical issues in adults. As your Physician, our Providers can provide you with your annual wellness exam, screening for diseases such as breast, prostate and colon cancer, as well as determine your risk for cardiovascular disease. In addition to treatment of acute illnesses
such as the flu and colds, they also manage chronic illnesses like asthma, high blood pressure, diabetes and elevated cholesterol. Our Providers will coordinate your care with other specialists when additional care is needed.
Texoma Primary Care Associates provides quality care to its patients, in a friendly and professional environment. The office has EKG, Flu Test, Rapid Strep Test, Urine Analysis, ABI test and Covid-19 test, as available services on- site.
This facility also embraces an "open access policy" which means we reserve same day appointments for patients who are sick "today." We don't think you should have to wait a week to be seen for a sore throat or fever!

The following pages contain information about our office policies and procedures. Please review them and feel free to ask any questions you may have.

Sincerely,

Texoma Primary Care Associates

Patient Name: _____

Texoma Primary Care Associates

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OFFICE POLICIES

It is our goal to provide all of our patients with the best service possible. We know that your time is valuable, and we respect that. Below is a copy of our office policies, please take the time to read them and become familiar with them. We appreciate your consideration in complying with these policies, as adhering to them will allow us to better care for your needs.

HOURS:

We are open Monday, Tuesday, Wednesday, Thursday from 8:30 am to 5:00 pm and Friday 8:30 am to 12:00 PM. We are open on every other Saturdays from 9am to 12pm. We are closed on Sundays. You can contact the physician after hours for urgent needs only. **However, if you need the physician to call you after hours for something that cannot wait until the next business day, you WILL be charged a $40.00 Physician After Hour Consultation Fee.**

APPOINTMENTS:

We see patients by appointment only. Any patient arriving late for an appointment by fifteen minutes or more will be asked to either reschedule or to wait until the physician can work you in. This is to help keep patients seen as close to their scheduled appointment time as possible. **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 appointment is missed and proper notice was not given, a $35.00 charge may be billed to your account. If the appointment is missed on a Saturday, a $50.00 charge will be billed to your account.** 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. Please bring your current insurance card and a list of your medications (prescription and over-the-counter), including dosage and directions, to each appointment. Remember to see the front desk staff to check out before leaving the office.

REFILLS:

Prescriptions are filled during office hours only. If you need to have written prescriptions filled out by the physician, please call the office 72 hours in advance of needing the refills to avoid a lengthy wait time. For refills through your pharmacy, please have them fax requests to 972-919-0725. Please allow 48-72 hours for refill requests to be done.

REQUESTS FOR MEDICAL RECORDS AND FORMS:

If you need your medical records or if you wish to have a copy sent to another physician, we will be happy to make these available. Please allow fifteen business days for the record request to be processed. There may be a $35 charge for the completion of FMLA, disability, medical records 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.

REFERRALS AND PRE-CERTIFICATIONS:

Your insurance may require a referral from your physician in order for you to see a specialist. Your insurance may also require a pre-certification of office or outpatient services. Our staff will help our patients through this process and will answer any questions you may have. If you need a referral from the physician, please allow three business days for it to be completed.

FEES:

All co-pays and deductibles are due at the time of your visit. The front desk will let you know if your insurance plan is accepted. If we are on your medical insurance, we will gladly file the claim for you. Our office uses Southwest Billing Services, you agree to give consent to be contacted by Southwest Billing services. You might get a bill from them for your part of responsibility. We accept cash, check, Visa, MasterCard and American Express

X_____
Signature Date

Patient Name: _____

Texoma Primary Care Associates

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INCLEMENT WEATHER:

In the event of inclement weather, we will make every attempt to notify you as soon as possible if our office will be closed. If you have not heard from us, please call the office at 972-919-0721.

EMERGENCIES:

If you have a true medical emergency, call 911 or go to the Emergency Center of the nearest hospital. Ask them to contact our office at 972-919-0721.

Payment Policies

Thank you for choosing Texoma Primary Care Associates. We are committed to providing quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibilities for services rendered, we have developed this payment policy.

INSURANCE:

We participate in most insurance plans, including Medicare. Please bring your up-to-date insurance card with you to each visit. 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. It is patient's responsibility to verify if our provider or clinic is in -network**.**

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 & DEDUCTIBLES:

All co-payments 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 and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address multiple problems during a physical exam. We accept cash, check, Visa, MasterCard and American Express.

CLAIM SUBMISSION:

We are contracted with Southwest Billing services, Southwest Billing will submit your claims and assist you in any way reasonably 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. And you may receive a bill from Southwest Billing Services.

X_____

Signature Date

Patient Name: _____

Texoma Primary Care Associates

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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 insurers. Medical complaints dealing with mental health issues such as anxiety, depression, attention deficit disorder, and stress-related problems might not be covered by your insurance. If you are seeing our doctor for any of these problems, you may want to contact your insurance company to see if they are covered if seen by any physician other than an approved mental health provider. 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 120 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 will 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.

MISSED APPOINTMENTS:

For any missed appointment that was not cancelled at least 24 hours ahead of time, our policy is to charge $35.00 to your account. This charge is $50.00 in case the appointment was on a Saturday. These charges are not covered by insurance companies and will be billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. Patients arriving more that 15 minutes late to an appointment will be asked to either reschedule or to wait until the physician can work you in.

FORMS:

There is a $35 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.

RETURNED CHECKS / DENIED CREDIT CARD:

There is a $35 charge for any checks that are returned or Credit Card Payments that are denied. You will still be responsible for the original charged amount IN ADDITION to this $35 penalty.

AFTER HOURS:

Our Hours of Operation are mentioned above. If you need the physician to call you **after hours** for something that cannot wait until the next business day, you **WILL** be charged a **$35.00** ***Physician After Hour Consultation Fee***. By leaving a message for the Physician to call you back after hours, you agree to pay these charges. The patient or the responsible party will be required to pay these charges.

_____

Print Full Name

_____ _____

Signature of Patient / Legal Guardian) **Date**

Patient Name: _____

Texoma Primary Care Associates

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ACKNOWLEDGEMENT of receipt of New Patient Policies Package

I / We have received, read and understood the **New Patient Policies Package** from Texoma Primary Care Associates.

_____
(PATIENT OR PARENT/GUARDIAN SIGNATURE)

_____ _____
(PATIENT OR PARENT/GUARDIAN NAME) **(DATE)**

Patient Name: _____

Texoma Primary Care Associates

5810 Collin McKinney Pkwy, Ste 202 McKinney TX 75070
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Release of Medical Records

Patient Name: _____D.O.B._____
Telephone number:_____SSN/Medical Record :_____

Release Information from
Specify Provider/Organization Name and Facility Address

Organization Name: _____
Address: _____

1. **Information authorized for disclosure**, if included in my records,
   - Progress notes including history and physical
   - Laboratory results, x-ray imaging reports (Mammogram, CT, MRI, etc.)
   - Entire Medical record
   - Treatment From (date) _____To (date)_____

2. I understand that the information to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services and treatment or testing for alcohol or drug abuse.

3. I authorize the disclosure of the listed information to send to the following individual or organization:

   Name: **Texoma Primary Care Associates**
   Dr Umesh Kumar MD
   Address 5810 Collin McKinney Pkwy, Ste 202 McKinney TX 75070
   Phone: **972-919-0721** Fax: **972-919-0725**
   For the purpose of: _____

4. I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to the office. I understand that the cancellation will not apply to the information that has already been released under this organization. I understand that this cancellation will not apply to my insurance company when law gives my insurer the right to consent a claim under my policy number.

5. Unless I cancel it sooner, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date appearing at the bottom.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain medical treatment. However, information will not be released to the above indicated individual or organization without my signature.

Signature of patient or legal representative: _____; **Date: _____**

Patient Name: _____

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If signed by legal representative, relationship to patient: _____

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and/or other individuals he/she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical conditions. This consent is valid for each visit I make to Texoma Primary Care Associates PLLC unless revoked by me in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation;
2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to Texoma Primary Care Associates infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested, at the expense of Texoma Primayr Care Associates if any of those situations occur during your treatment period.

Patient's Printed Name Date of Birth

Patient/Legal Representative's Signature Date

Relationship to Patient

Witness (*Office Staff)* Date