THE internalmedicinecenter OF FORT WORTH

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____State:_____Zip Code:_____Email:_____

Main Contact#:_____Alternate#:_____Work#:_____

Date of Birth:_____/_____/_____Sex: ○ Male ○ Female SS# : _____

Marital Status : ○ Single ○ Married ○ Divorced ○ Widowed Occupation: _____

Patient Referred By:_____Spouse's Name: _____

Spouse's Date of Birth:_____/_____/_____Main Contact#:_____Alternate#:_____

Emergency Contact:_____Relationship:_____Phone#:_____

Patient Ethnicity

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other:_____(Please Specify)

What is the patient's language of preference? ○ English ○ Spanish ○ Other:_____(Please Specify)

Insurance Information

Primary Insurance:_____Policy/ID#_____

Name of Policy Holder:_____DOB:_____/_____/_____Group/Acct #:_____

Employer:_____Employer Address: _____

City:_____State:_____Zip Code:_____Work #: _____

Secondary Insurance:_____Policy/ID#:_____

Name of Policy Holder:_____DOB:_____/_____/_____Group/Acct #:_____

Employer:_____Employer Address: _____

City:_____State:_____Zip Code:_____Work #: _____

Complete – Only if Patient is a Minor

Parent/Guardian Name:_____Relationship:_____

Parent/Guardian Name:_____Relationship:_____

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GENERAL CONSENT FORM

Patient Name:_____ **Date of Birth:**_____/_____/_____

Assignment of Benefits. I authorize Angelo Vu, D.O.,P.A., (The Internal Medicine Center of Ft Worth) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that IMC will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for IMC to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, IMC may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at IMC's expense.

Patient Initials: _____

Electronic Prescription. I understand IMC utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone Calls. By providing contact information, I authorize IMC, 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 voicemail; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize IMC to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #:_____ Secondary Phone #: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

FINANCIAL POLICY

Patient Name:_____Patient Date of Birth:_____/_____/_____

Please read prior to receiving services.

The Internal Medicine Center of Ft Worth recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, IMC will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

- **MEDICARE:** IMC providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

- **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-paying patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of IMC.

FINANCIAL POLICY

- **SECONDARY INSURANCE:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage.

- **PROMPT PAYMENT DISCOUNTS:** IMC offers a prompt payment discount to patients who do not have insurance and who pay in full at or before the time of service. Prompt payment discounts cannot be applied to co-pays or deductibles. Patients paying at the time of visit should be aware that additional charges related to the visit may be billed at a later time.

- We offer the opportunity to establish a reasonable payment plan if you are not able to pay in full at the time of service. If you have an outstanding balance, we expect you to make payment or payment arrangements before your next scheduled appointment. Non-payment may result in discharge from the practice.

- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. At this time were are not accepting Medicaid and you will be responsible for all services rendered.

- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(817) 568-8700.**

- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment atleast 24 hours prior to your appointment date.

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

IMC firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies, please call us at (817) 568-8700.

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

NAME: _____ **D.O.B.** ____/____/____
LAST FIRST M.I.

REASON FOR VISIT TODAY: _____

ALLERGIES (Include medications, foods, xray dyes) or ☐ NONE KNOWN

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ NONE

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				
4				
5				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip: _____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ NONE

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ NONE

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual cycle: _____

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of _____ packs/day for _____ years. I quit in _____ (year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor) _____

Have you ever used intravenous drugs? ☐ Yes ☐ No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack			
Diabetes			
Breast cancer			
Colon cancer			
Other history			

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

NAME: _____ **D.O.B.** ____/____/____
LAST FIRST M.I.

Please check "X" the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General	Fatigue / Tired	☐ Yes	☐ No
	Fever / Chills	☐ Yes	☐ No
	Headache	☐ Yes	☐ No
	Weight Loss	☐ Yes	☐ No
	Weight Gain	☐ Yes	☐ No
	Other: _____		
Eyes	Difficulty Seeing	☐ Yes	☐ No
	Other: _____		
Head	Dry Mouth	☐ Yes	☐ No
Ears	Hearing Problems	☐ Yes	☐ No
Nose	Hoarseness	☐ Yes	☐ No
Throat	Lumps/Swelling in Neck	☐ Yes	☐ No
	Sore Throat	☐ Yes	☐ No
	Trouble Swallowing	☐ Yes	☐ No
	Other: _____		
Cardiac (Heart)	Chest Pain	☐ Yes	☐ No
	Irregular Heart Beat	☐ Yes	☐ No
	Pain with Walking	☐ Yes	☐ No
	Shortness of Breath	☐ Yes	☐ No
	Swelling in Feet/Ankles	☐ Yes	☐ No
	Other: _____		
Neuro	Dizziness	☐ Yes	☐ No
	Fainting	☐ Yes	☐ No
	Headache	☐ Yes	☐ No
	Memory Loss	☐ Yes	☐ No
	Numbness	☐ Yes	☐ No
	Weakness	☐ Yes	☐ No
	Other: _____		
Respiratory	Cough	☐ Yes	☐ No
	Shortness of Breath	☐ Yes	☐ No
	Use of Inhalers	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No
	Other: _____		
Gastro-Intestinal	Abdominal Pain	☐ Yes	☐ No
	Blood in Stool	☐ Yes	☐ No
	Change in Bowel Habits	☐ Yes	☐ No
	Constipation	☐ Yes	☐ No
	Heartburn	☐ Yes	☐ No
	Loss of Appetite	☐ Yes	☐ No
	Nausea	☐ Yes	☐ No
	Vomiting	☐ Yes	☐ No
	Other: _____		

Males Only	Blood in Urine	☐ Yes	☐ No
	Difficulty Achieving Erection	☐ Yes	☐ No
	Foul Odor in Urine	☐ Yes	☐ No
	Pain in Testicles	☐ Yes	☐ No
	Trouble Urinating	☐ Yes	☐ No
	Other: _____		
Females Only	Breast Discomfort	☐ Yes	☐ No
	Irregular Bleeding	☐ Yes	☐ No
	Painful Intercourse	☐ Yes	☐ No
	Post Menopausal Bleeding	☐ Yes	☐ No
	Trouble Urinating	☐ Yes	☐ No
	Vaginal Discharge	☐ Yes	☐ No
Musculoskeletal			
	Back Pain	☐ Yes	☐ No
	Joint Pain	☐ Yes	☐ No
	Muscle Pain	☐ Yes	☐ No
	Swelling	☐ Yes	☐ No
	Other: _____		
Skin	Bruising	☐ Yes	☐ No
Hair	Hair Loss	☐ Yes	☐ No
Nails	Nail Problems	☐ Yes	☐ No
	Rash	☐ Yes	☐ No
	Skin Changes	☐ Yes	☐ No
	Other: _____		
Mental Health	Anxiety	☐ Yes	☐ No
	Depression	☐ Yes	☐ No
	Difficulty Sleep/Concentrating	☐ Yes	☐ No
	History of Phy/Mental Abuse	☐ Yes	☐ No
	Mood Swings	☐ Yes	☐ No
	Stress	☐ Yes	☐ No
	Suicidal	☐ Yes	☐ No
	Other: _____		

Recent Tests/ (Give month/year of last exam in right column.
Health Maintenance Check left column if date is estimated.)

- ☐ Bone Density: _____
- ☐ Colonoscopy: _____
- ☐ Diabetic Foot Exam: _____
- ☐ Eye Exam: _____
- ☐ Mammogram: _____
- ☐ Pap Smear: _____
- ☐ Physical: _____
- ☐ PSA: _____
- ☐ Tetanus Shot: _____