SON N. GIEP M.D., P.A.

PATIENT MEDICAL HISTORY

NAME: _____ **DATE OF BIRTH**: _____

CHIEF COMPLAINT: _____

MEDICAL HISTORY: − Please list any medical conditions including high blood pressure, diabetes, heart disease, cancer, high cholesterol, asthma, and depression:

_____

_____

_____

_____

OTHER MEDICAL PROVIDERS: (Involved in Your Care):

_____

_____

_____

_____

SURGICAL HISTORY: (please include dates if known):

_____

_____

_____

FAMILY HISTORY: − List any cancer, heart disease, diabetes, bleeding or clotting disorders in your family and relationship to yourself:

Condition	Relationship

SOCIAL HISTORY:

Do you smoke: Yes ____ No____ if yes, how many packs/day _____and for how many years: _____

Do you drink alcoholic beverages? Yes _____No_____ if yes, how many drinks per week on average: _____

Do you do any Illicit drugs? Yes ____No____ if so, please list here_____

Marital Status: _____Do you have children? Yes ____No____ how many? _____

Occupation_____

Are you on a special diet? Yes _____ No_____ Explanation: _____

Ethnicity: _____

PATIENT'S SIGNATURE/ AUTHORIZED REPRESENTATIVE _____ **DATE** _____

SON N. GIEP M.D., P.A.

DRUG ALLERGIES AND REACTIONS: _____

_____

_____

_____

VACCINATIONS:

Flu shot	Yes _____	No_____	Date: _____
Tetanus	Yes _____	No_____	Date: _____
Pneumonia	Yes _____	No_____	Date: _____
Shingles	Yes _____	No_____	Date: _____
HPV	Yes _____	No_____	Date: _____
COVID	Yes _____	No_____	Date: _____
			Date: _____

HEALTH MAINTENANCE:

Date of Last Pap Smear (female only) _____
Date of last Mammogram (female only) _____
Date of last Colonoscopy _____
Date of last Bone density_____

MEDICATIONS:

Medication	Frequency of intake	Dosage

PATIENT'S SIGNATURE/ AUTHORIZED REPRESENTATIVE _____ **DATE** _____

SON N. GIEP M.D., P.A.

PATIENT INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS _____ **CITY/STATE**_____**ZIP** _____

SSN: _____ **SEX:** **Female** **Male** **MARITAL STATUS:** _____

HOME # _____ **WORK #** _____ **CELL #** _____

RACE: _____ **ETHNICITY** _____ **PREFERRED LANGUAGE**_____

EMPLOYER: _____

ADDRESS_____ **CITY/STATE**_____**ZIP** _____

WHO REFERRED YOU? _____

PHARMACY INFORMATION: _____

IF YOU, WOULD YOU LIKE ACCESS TO OUR PATIENT PORTAL, PLEASE INCLUDE EMAIL BELOW

_____

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my provider or those under his/her supervision.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to the physician indicated above for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay, coinsurance or balance due that my provider is unable to collect from my insurance carrier.

INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to the physician on my behalf. Failure to provide the correct and accurate information regarding insurance in order to file claims accurately and timely could result in claim denial therefore may result in patient responsibility. I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement. All copays, deductibles, and/or coinsurance for all commercial insurance, Medicare and Medicare Replacement plans are due at the time of services rendered according to insurance contract provisions.

CANCELLATION/ NO SHOW POLICY/LATE:

Our office policy requires patients who request to cancel or reschedule their appointment to call our office at least 24 hours prior to their scheduled visit. A $50.00 No Show/Cancellation Fee may be assessed to you if the office is not contacted according to the policy. This fee also applies to any patients that do not show up for their scheduled appointment. Please note insurance companies cannot be billed for missed appointments/late fees assessed. If you are late, there is a possibility the office may ask you to reschedule out of consideration for those patients scheduled after you.

PATIENT'S SIGNATURE/ _____ **DATE** _____
AUTHORIZED REPRESENTATIVE

SON N. GIEP M.D., P.A.

TREATMENT

We make the best effort to diagnose and treat your condition(s) based upon the information we have. Sometimes, however, diseases and conditions may evolve. If you do not improve or your condition worsens and/or changes, it is your responsibility to inform us so we may re-evaluate your condition and diagnosis.

PAYMENT POLICY:

I understand and acknowledge the following:

- **Verification of benefits given to us by your insurance company is not a guarantee of payment.**
- **We cannot guarantee payment of your claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.**
- **There is a $35 fee assessed for any returned check. You will subsequently receive a bill for this amount. Payment will need to be made in cash, money order, or VISA/MC. If payment is not received by the due date, your information will be turned over to the Collin County District Attorney. Any returned check will immediately restrict any future acceptance of checks as payment on your account.**
- **Late fees may apply to accounts past due 90 days.**
- **If your policy is an HMO, you are responsible for contacting your insurance prior to your visit and assigning the provider you are scheduled with. Failure to do so may result in claim denial and you will be responsible for the balance due on account. The HMO Policy will also be provided to you.**
- **If any patient is owed a refund, all claims on the account must be processed and paid in full before overpayment is refunded.**

POLICY FOR MAIL, CALL, TEXT OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, texts, and e-mail. I hereby authorize Son N Giep M.D., P.A., designated provider(s), or those under his/her supervision and/or representatives to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Son N Giep M.D., P.A., to that effect in writing.

I certify I understand the following:

- **Email should never be utilized for an urgent or emergency problem.**
- **Providers are not required to communicate via email; this is at the discretion of the provider.**
- **Email should never be used for time sensitive issues.**
- **Email is not confidential and should not be used for sensitive information.**
- **All emails will become part of the permanent medical record.**
- **Email may not receive an immediate response. Responses may take a full business day or more.**
- **The provider(s) will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond the office's control.**
- **I agree that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.**

PATIENT'S SIGNATURE/ _____ DATE _____
AUTHORIZED REPRESENTATIVE

SON N. GIEP M.D., P.A.

If Son N. Giep M.D., P.A. needs to contact you (the patient) it is okay to:

Home Telephone: **(circle one)**
OK to leave message with detailed information **Leave message with call back number only.**

Mobile Telephone **(circle one)**
OK to leave message with detailed information **Leave message with call back number only.**

Yes / No (circle one) Sent a text message to following number.

_____

NOTICE OF PRIVACY PRACTICES AND HIPAA RELEASE OF INFORMATION:

I certify and acknowledge that I have read and been made available a copy of the Notice of Privacy Practices. I understand the Notice of Privacy Practices provides information on how we may use and disclose protected health information (PHI). The Notice contains information regarding your rights under the law. The terms of our Notice may change. If we change our Notice, you will obtain a revised copy during your next office visit. You have the right to request that we restrict PHI about you for treatment, payment, or healthcare operations. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 199 (HIPAA). This authorization expires at the end of each calendar year or is revoked by the patient in writing.

I understand that PHI may be disclosed or used for treatment, payment, or healthcare operations. The practice has the Notice posted and available for the patient to review. The practice reserves the right to restrict the uses of their information, but the practice does not have to agree to those restrictions. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

Finally, you may revoke this authorization in writing at any time by sending written notification to Son N Giep M.D., P.A. Attn: Practice Manager. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

PLEASE CHOOSE ONE: _____ **I do not wish my information to be disclosed to any person.**

_____ **I give permission to disclose and discuss any information related to my medical condition(s) scheduling and billing to/with the following family member(s), other relative(s) and/or close friend(s):**

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

IN CASE OF EMERGENCY - CONTACT INFORMATION

NAME: _____ PHONE: _____

I certify with the signature below that I have read all the information, acknowledge and understand SON N GIEP M.D., P.A. Patient Registration Form Disclosures & Consents.

This complete and full Disclosure and Consent Form assignment will remain in effect until revoked by me in writing. A photocopy and/or electronic copy of this instrument will have the same validity as the original.

PATIENT'S SIGNATURE/ _____ DATE _____
AUTHORIZED REPRESENTATIVE

SON N. GIEP M.D., P.A.

General Office Policies and Procedures for Patients

TESTING: You should expect to receive notification of results of any testing, including labs and radiology, within one week. We will attempt to contact you, but if we are unable to contact you, it is your responsibility to obtain your results. If you are scheduled for a visit to go over your results, including physicals, we will plan to review your results at the time of your visit and will not attempt to contact you in advance. If you miss the appointment, it is your responsibility to reschedule the visit to go over the results.

TREATMENT: We make the best efforts to diagnose and treat your condition based on the information we have. Sometimes, however, diseases and conditions evolve. If you do not improve, or if your condition worsens or changes, it is your responsibility to inform us so we may re-evaluate your condition and diagnosis.

COMMUNICATION: When you contact us, we will make our best efforts to answer you in a timely manner. The most common reasons we are unable to answer patients are inaccurate contact information and patients who indicate on their privacy form to only leave a message to call back. If you are unable to reach us after leaving two messages, please contact our schedulers or office manager.

FEEDBACK: Please let us know how we are doing. We appreciate both positive and negative feedback to make your experience with us better.

I have read and understand the above statements.

PATIENT'S SIGNATURE/ _____ DATE _____
AUTHORIZED REPRESENTATIVE

SON N. GIEP M.D., P.A.

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Relationship to Patient (if patient unable to sign) _____

PATIENT'S SIGNATURE/ AUTHORIZED REPRESENTATIVE _____ **DATE** _____

SON N. GIEP M.D., P.A.

Physical Exams (Routine Preventative Exams)

Insurance plans, as determined by your policy or your employer, have vastly different benefits for routing preventative exams. In some cases, insurance will not cover routine care at all (or "well patient" or "preventative care" office visits). In all cases, this exam is prevention focused, not problem focused.

Q: What is the purpose of a routine preventative exam (annual physical)?

Physical Exams can help you identify potential health problems in the early stages when they may be easier and less costly to treat.

Q: What is included in a routine preventative exam?

A routine preventative exam includes the following:

- Past medical, social, and family history
- Complete physical exam and review of body systems
- Review of current medications (**refills on current medications or prescribing new medications is not covered as a preventative service**)
- Immunizations
- Counseling/anticipatory guidance/risk factor reduction interventions
- Review of age/gender appropriate screening tests

Q: Why did I receive a bill after my routine preventative exam when it was supposed to be covered at 100%

This exam is prevention focused, not problem focused. If you have a new health problem or other diagnoses that need to be addressed during your preventative office visit (e.g. high blood pressure, diabetes, skin rash, or headaches) you may be billed part of the exam at 100 percent for your annual preventative exam and part of your office for treatment of your diagnosis. The portion of the visit related to the treatment of your diagnosis would apply toward your deductible, and coinsurance. If the provider feels that much of the time was spent with medical concerns, the entire visit may be considered a medical treatment visit and would not be billed as preventative. It's important to note your healthcare provider has the right to code and bill as they see the service from his or her viewpoint. Your plan provides coverage based on how your provider codes/bills each procedure.

Q: Will my provider address only what my health plan covers for a routine preventative exam?

Your provider does not know your health plan benefits and sees many patients with various insurance plans throughout the day. **You are responsible for knowing what services are covered on your health plan**.
Review your Summary of Benefits prior to your preventative exam or call your plan's Customer service line for benefit information.

By signing below, I understand that I may be charged an additional office visit if care is extended outside of the scope of a preventative visit.

PATIENT'S SIGNATURE/ AUTHORIZED REPRESENTATIVE _____ **DATE** _____