PERSONAL INFORMATION

Patient: _____
Last First MI

Address: _____
Street City State Zip

Home Telephone: _____ Cell Phone: _____

Social Security#: _____ Driver's License #: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other _____

Employer: _____ Work #: _____

Work Address: _____ Email: _____

In case of emergency notify: _____

Relationship: _____ Phone #: _____ Alternate#: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Name of Insured: _____ Relationship to Patient: _____

Identification #: _____Group #: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Insurance Telephone Number (Benefits line or Member's Services): _____

Who referred you to your office? _____

Acknowledgement of receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in this notice. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Signature of Responsible Party: _____ **Date**: _____

Address:
977 Raintree Circle, Ste 110,
Allen, Texas 75013

www.allenfamilyfirst.com

Phone: (972) 678-4600
Fax: (972) 678-4602

Allen FAMILY FIRST Clinic

Patient Health History Form

Name: _____ Date: _____

Gender: ☐ Male ☐ Female Age: _____ Date Of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other _____

Currently Living: ☐ Alone ☐ With Family ☐ With Friends ☐ With Significant Other

Occupation: _____ ☐ Currently Working ☐ Retired

Health History (Check if you have experienced any of the following)

_____ Abnormal EKG
_____ Alcoholism
_____ Anemia
_____ Anxiety
_____ Arthritis/Sore Joints
_____ Asthma/ Hay Fever
_____ Bleeding/Bruising
_____ Broken Bones
_____ Bronchitis/Emphysema
_____ Cancer
_____ Cataracts
_____ Chemical Dependency
_____ Chest Pain
_____ Circulation Problems
_____ Deafness/Dizziness
_____ Depression/Sadness
_____ Diabetes
_____ Difficultly Sleeping
_____ Ear Infections
_____ Epilepsy/Seizures
_____ Fatigue/Tiredness
_____ Forgetfulness
_____ Gall Stones
_____ Glaucoma
_____ Gout
_____ Head Injury
_____ Headache (frequent)
_____ Heart Attack/Heart Disease
_____ Heart Murmur
_____ Hemorrhoids/Rectal Problems
_____ Hepatitis A, B, or C
_____ Hernia
_____ High Blood Pressure
_____ High Cholesterol
_____ HIV/AIDS
_____ Jaundice
_____ Kidney/Bladder Problems
_____ Leg or Foot Pain
_____ Liver Disease
_____ Night Sweats
_____ Phlebitis/Blood Clots
_____ Psychiatric Care
_____ Sexually Transmitted Disease
_____ Shortness Of Breath
_____ Sinus Trouble
_____ Skin Disease/Psoriasis/Eczema
_____ Stomach Problems/Ulcers
_____ Stool/Bowel Problems
_____ Stroke
_____ Thyroid Problems
_____ Tuberculosis/ Positive TB Test
_____ Weight Loss or Gain

Allergies ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

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Medications

(List all medications including over the counter)

Medications	Dose	Times Per Day

Habits: Do you… if yes, how much?			**Immunizations/ Vaccination History**
Smoke Tobacco	☐ No	☐ Yes…_____ Packs/Day	Last Flu shot: _____
Chew Tobacco	☐ No	☐ Yes…_____Tins/Day	Last Hepatitis B: _____
Drink Caffeine	☐ No	☐ Yes…_____Cups/Day	Last MMR: _____
Drink Alcohol/Wine	☐ No	☐ Yes…_____ Drinks/Day	Last Pneumonia: _____
Drink Beer	☐ No	☐ Yes…_____Cans/Day	Last Tetanus: _____
Gamble	☐ No	☐ Yes…_____	
Use Street drugs	☐ No	☐ Yes…_____	
Exercise	☐ No	☐ Yes…_____	

Hospitalizations (including surgeries)	Serious Illness (not requiring hospitalizations)

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Men Only		Women Only	
Pain/Lumps in testicles?	___N ___Y	Last Pap Smear? _____ Abnormal?	___N ___Y
Penile (penis) itching/burning/discharge?	___N ___Y	Last Mammogram _____ Abnormal?	___N ___Y
Prostate disease or problems?	___N ___Y	Age period started _____	
Problems with urine stream?	___N ___Y	Ovarian Cysts?	___N ___Y
Wake in night to use bathroom?	___N ___Y	Sexual problems/concerns?	
Sexual problems/concerns?	___N ___Y	Vaginal itching/burning/discharge?	___N ___Y
Do you feel safe in your home?	___N ___Y	Wake in night to use bathroom?	___N ___Y
Do you have a living will?	___N ___Y	Number of Pregnancies _____ # of births _____	
		Number of miscarriages _____ # of abortions _____	
		Birth Control Method: _____	
		Do you feel safe at home?	___N ___Y
		Do you have a living will?	___N ___Y

Family History

Check if yes and list the family member associated.

Alcoholism	_____	Family Member	_____
Allergies	_____	Family Member	_____
Anemia	_____	Family Member	_____
Arthritis	_____	Family Member	_____
Asthma	_____	Family Member	_____
Birth Defect	_____	Family Member	_____
Cancer	_____	Family Member	_____
Colon/Bowel issues	_____	Family Member	_____
Congenital Heart defect	_____	Family Member	_____
Diabetes	_____	Family Member	_____
Emphysema	_____	Family Member	_____
Epilepsy	_____	Family Member	_____
High blood pressure	_____	Family Member	_____
Kidney disease	_____	Family Member	_____
Leukemia	_____	Family Member	_____
Liver Disease	_____	Family Member	_____
Mental Illness	_____	Family Member	_____
Migraines	_____	Family Member	_____
Nervous breakdown	_____	Family Member	_____
Obesity	_____	Family Member	_____
Rheumatic Fever	_____	Family Member	_____
Sickle Cell Anemia	_____	Family Member	_____
Stomach Ulcers	_____	Family Member	_____
Stroke	_____	Family Member	_____

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Confidential Communications Authorization

Patient's name: _____ Date of Birth: _____

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal law, and outlining my rights regarding my health information.
I requested that all communications to me (by telephone, mail, or otherwise) by Dr. Chanda Reddy DO and staff are handled as follows:
I understand that in the event I wish this document would be changed, I will inform the office staff personally and sign a new document.

Confidential Voicemail Authorization

Phone number: _____

May we leave a detailed message: (Example: Billing, Labs, etc.) Yes _____ No _____

I give permission for Allen Family First clinic to provide my personal health information to:

Name: _____ (relationship to patient): _____

Name: _____ (relationship to patient): _____

Text & E-Mail Authorization

For detailed messages Ex. Billing, labs, etc.

Email: _____ _____ I do **NOT** wish to receive emails.

Phone number: _____ _____ I do **NOT** wish to receive detailed text messages.
Text messages are not secure

Mailing address

_____
(Street Address)

_____
(City, State, Zip)

_____ _____ _____
Patient's Printed Name Patient's Signature Date

_____ _____ _____
*Legal Representative's Printed Name Legal Representative's Signature Date

_____
*If Representative, Specify Relationship to Patient.

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FINANCIAL OFFICE POLICY

Thank you for choosing our practice as your healthcare provider. Your clear understanding of our Financial Policy is important to our professional relationship. Please speak with the office manager if you have any questions regarding this policy.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. Such payments include coinsurance, co-payments, deductibles, and non-covered services for participating insurance companies. We accept cash, credit/debit cards and personal checks. There is a $25.00 service charge on all returned checks. If the patient is a minor, the parent/guardian who brings the child in for a visit is the responsible party.

INSURANCE/ FINANCIAL AGREEMENT

If we are contracted with your insurance company, we will file your claims for you. However, your insurance policy is contracted between you and your insurance company. It is important you understand your policies previsions. We cannot guarantee payment of your claims as the insurance company only "quote" benefits, they never guarantee benefits. I understand that I am required to give my current Insurance card, driver's license, and billing information for insurance to be filed on my behalf. If accurate billing and insurance information is not given, then I will be responsible for services denied by my insurance company as "non-covered" or "not medically necessary." Also, if you have an HMO plan it is your responsibility to update the PCP information. I authorize the treatment of the person named below and agree to pay for all fees for such treatment. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pending of such claims and that all proceeds of insurance will be assigned to this office. I authorize the release of any medical information necessary to process insurance claims and request payment of Government benefits either to me or the party that accepts assignment below.

REFERRALS

If you are on an insurance plan that requires referral, it is your responsibility to let us know. The referral must be requested from your primary care physician at least 3- 5 days before your specialist appointment.

FORMS/PRESCRIPTIONS

School/Camp/Physical forms may be mailed, faxed, or dropped off to our office. We require 24-48 hours notice for completion. We are happy to mail, fax or hold them for you to pick them up. For written prescriptions, please call 24 hours in advance of pickup to notify our office.

MEDICAL RECORDS

We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Medical records will be completed within 15 business days as mandated by the Texas Medical Board and may be subject to a processing fee as determined by the Board. I have read and understand Allen Family First Clinic's Financial Policy. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collection.

APPOINTMENTS

We work hard to see our patients on time and your appointments are very important to us. We understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 24-hour notice for cancellations. We ask that you arrive 25 minutes early for new patient appointments and 5 minutes early for regular scheduled appointments. If you are going to be more than 10 minutes late, please call ahead and let us know. Late arrivals, more than 15 minutes late, may be required to reschedule the appointment.

Signature of Responsible Party: _____ **Date:** _____

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Complete Physical Exam

The new ICD-10 code restricts a Complete Physical Exam to the following (with CPT codes):

Urinalysis (81001), CBC (85025), Chemistry Panel-kidney/liver function, blood sugar, electrolytes (80053), Thyroid tests- TSH (84443)/T4 (84436), Lipid Panel (80061), PSA (84153), Pap smear (88142), Stool cards (82270), EKG (93000)

This is **TYPICALLY** what insurance companies will cover during a Wellness Exam. **We STRONGLY SUGGEST YOU VERIFY WITH YOUR INSURANCE COMPAY THAT THESE TESTS WILL BE PAID FOR PRIOR TO YOUR VISIT.**

According to the new rules, no other condition can be diagnosed, evaluated, discussed, treated, etc., during this visit. Unfortunately, this means any issue that requires a prescription, testing, therapy, orders, imaging, etc., requires a separate appointment and cannot be done concurrently during a CPE. All the above must be documented in the medical record and cannot occur during a Wellness Exam. These incudes (but is not limited to):

HYPERTENSION, ALLERGIES, SORE THROAT, SINUS INFECTION, BACK PAIN, KNEE/HIP PAIN, INSOMNIA, ED, ANXIETY, DEPRESSION, HEARTBURN, HEADACHES, ABDOMINAL PAIN, DIARRHEA, CONSTIPATION, ARTHIRITIS, MUSCULOSKELETAL/JOINT PAIN, SLEEP APNEA, RASH, PINK EYE, ETC.

We apologize, but due to legal requirements any issues beyond the stated CPE absolutely requires a separate appointment with no exceptions. Insurance review and audit charts, and I must remain in accordance with all rules.

Some insurers will cover testing for vitamin D (82306), HIV (86701), Testosterone (84402), and Celiac Disease (82784, 83516, 86255). Check your carrier if you desire these tests.

There are two exceptions to the aforementioned. First, a previously diagnosed chronic condition can be evaluated, during a CPE with a separate office visit that may require an additional charge. An example would be checking uric acid for a patient who takes medication for gout. Second, a condition discovered during a CPE may require additional testing or treatment. For instance, a diagnosis of an enlarged prostate can be treated during a CPE. Again, there will likely be additional charges for the proper billing procedure.

We realize this is a hassle, but I must observe concurrent regulations to maintain my license and contracts with plans. Please call the office before your appointment for any questions or clarification. We appreciate your understanding in this matter is beyond our control.

Patient Initials: _____ Date: _____

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