# Personal Information Form

PERSONAL MD®

## PATIENT INFORMATION

Last Name: First Name: MI: DOB: ___Male ___ Female

Home Address City: State: TX Zip:

Phone #1: ( ) __ Cell __ Home __ Work | Phone #2: ( ) __ Cell __ Home __ Work

Emergency Contact: Relationship: Phone: ( )

## CONTROLLED SUBSTANCE POLICY

Please Note: If you are taking a controlled substance regularly for any conditions, please note that Personal MD has unique policies regarding use and administration of these medications. Please see our controlled substance policy on the Personal MD website. http://www.personalmd.net

How did you hear about Personal MD? ___ Current Patient ___ Internet ___ Other Physician ___ Print Publication ___ Other _____

## PREFERRED METHOD OF COMMUNICATION

Please tell us how to communicate with you by checking the appropriate options.

**Personal MD uses a default of home phone and letter to home address unless otherwise stated below.**

___Home Phone ___Cell Phone ___Work Phone

___Letter ___In Clinic Only ___ Other _____

___ OK to leave a message with detailed information. ___ Leave a message with call-back number only.

## COMMUNICATION WITH OTHER PEOPLE

I hereby give permission to ***Personal MD Family Healthcare, P.A.*** to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s):

Name _____ Relationship ___ Spouse ___ Child ___ Legal Guardian ___ Other _____

Name _____ Relationship ___ Spouse ___ Child ___ Legal Guardian ___ Other _____

___ **DO NOT** communicate my information with other people.

## COMMUNICATION BY E-MAIL

Please check the appropriate Yes or No answer below:

___**Yes** ___ **No -** Send me receipts for auto billing by email ___**Yes** ___ **NO –** Communicate with me by email.

**If Yes,** Please give us your Preferred Email: _____

Please Write Neatly

## HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA)

**ACKNOWLEDGMENT OF THE RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES EFFECTIVE DATE OF NOTICE: JANUARY 1, 2020**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Personal MD is furnishing you with a copy of this notice, which provides information about how Personal MD and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

**By signing this form, you acknowledge that you have been give access to a copy of Personal MD's *Notice of Health Information Practices (HIPAA)*.**

PRINT NAME:

SIGNATURE: DATE:

## FOR OFFICE USE ONLY

Pt ID #:

Summary of Policies. A full copy of our policies are located at personalmd.net

PERSONAL MD®

## Cancelation and missed appointments

To help accommodate the needs of our patients that wish to be seen on a timely basis and ensure available appointment times, we request that our patients comply with our cancellation and no-show policies.

Due to the unique nature of Personal MD and our scheduling system, we do not double-book or overbook our schedule. When you secure an appointment time, that time is placed on hold for you and cannot be used by another patient. We understand that circumstances can change from the time you schedule your appointment and the actual appointment. We ask that you please communicate with us as best as possible. If you must cancel an appointment, please notify us within **3 hours** of your scheduled appointment. Patients who do not show for routine scheduled appointment will be charged **$50** toward their account. Patients who do not show for an extended appointment, such as a physical examination or procedure, will be charged **$75** toward their account.

Signature: _____

## E-mail and Electronic Communications

Personal MD Family Healthcare, P.A. (Personal MD) and its physicians and providers fully support an electronic patient experience through implementation of a common electronic health record platform. Personal MD provides a Patient Portal Secure Access for individual seen in our practice at no charge. Through this portal, patients can send secure email communications to their provider or other Personal MD staff members. Each secure communication is recorded and kept as part of the patient's permanent medical record. Attachments such as pictures, PDF's, and the like are not allowed in this secure communication system. Log-In credentials can be obtained directly from our office.

Each Personal MD staff member also has a non-secure traditional email. Communications sent via a company or personal e-mail **are not** considered secure and **are not** recorded in your medical record and **are not** kept for later reference.

Text communication between you and your provider **is not** considered a secure form of communication and the details of your exchange with your provider or staff member **is not** always recorded in your medical record or kept for later reference.

Signature: _____

## Controlled Substance Policy

Chronic pain, Anxiety, Depression, Weight Loss, and Hormone Therapy as well as other conditions are often treated by using controlled substances. It is the role of the primary care clinician to try and diagnose the cause of your medical condition and recommend life changes or treatments designed to help your condition. If you and your provider determine that a part or all of your treatment requires a medication that is currently labeled as a controlled substance or is changed by the FDA to a controlled substance in the future, regular appointments will be required to monitor how you are responding to your treatment and make adjustments if needed. Controlled substances will **only be prescribed during a face-to-face visit** with your provider. This will be done during a routine scheduled visit between you and your provider. By policy, Personal MD will not send in digital copies, faxed copies, or other communications with your pharmacy for a controlled substances. For further details regarding our controlled substance policy please review our complete substance prescription policy on our website at www.personalmd.net/forms.html.

Signature: _____

## Telemedicine Policy and Consent

In order to better serve your needs, healthcare services are available using telecommunication or informaiton technology ("Telemedicine"). Telemedicine involves the use of real-time evalaution, diagnosis, consulation, and treatment of helath conditions using interactive telecommunciation technology allowing the healthcare provider to see and communicate with you in real-time. By signing below you acknowledge the benefits and limitations outlined in our full Telemedicine policy located on our website at www.personalmd.net.

Signature: _____

# PATIENT AGREEMENT & DISCLOSURE STATEMENT

TERMS

- I acknowledge and understand that I am voluntarily becoming a Personal MD Family Healthcare, P.A. ("Personal MD") patient and that this agreement is non-transferable.
- I have had the opportunity to ask questions and receive answers regarding charges and services offered by Personal MD including.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance and that it provides only the health care services specifically described in the *Personal MD Patient Services Guide*.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of Personal MD including but not limited to emergency room, hospital and specialty services, and that Personal MD will not bill insurance carriers for any services provided by Personal MD.
- I acknowledge and understand that Personal MD must maintain a record of my health information and must protect the privacy of my health information as per the terms of the *Notice of Privacy Practices*. I understand and acknowledge that this policy is available for my review at any time at www.PersonalMD.net or upon request.
- I acknowledge and agree to pay my monthly care fee on or before its due date. In the event that I am unable to pay my fee(s) on time, I understand that I will be charged a **$25 late fee** and that my service agreement may be terminated.
- I acknowledge and understand that **I may terminate this *Agreement* at any time and for any reason by filing out the offical online cancelation form at** www.PersonalMD.net**.** Monthly fees will continue to accrue until this form is received. Any pre-paid monthly care fees will be prorated to the date Personal MD has received my termination and refunded to me within ten (10) business days.
- In addition, I acknowledge and understand that Personal MD may terminate this *Patient Agreement* by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and refunded to me within ten (10) business days. Personal MD will not terminate this *Patient Agreement* solely on the basis of health status.
- I acknowledge and understand that Personal MD may add or discontinue services or may increase my fee schedule at any time (but no more than once per year), and that I will be given, in writing, at least sixty (60) days notice of such fee schedule changes.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the *Medicare Opt-out Agreement* for review and signature before my first appointment. *(The Opt-out Agreement does not prevent me from receiving current or future Medicare benefits from non-Personal MD providers; neither I nor my Personal MD health care provider(s) will seek reimbursement from Medicare for the medical services I receive from Personal MD.)*

RIGHTS & RESPONSIBILITIES

- I understand that I have the right to choose my personal health care clinician and to change my clinician at any time, for any reason. I understand that all reasonable efforts will be made to accommodate my request, but only if my new clinician's patient panel is open to new patients.
- I understand that I have the right to receive accurate and easily understood information about Personal MD's health care services, health care professionals and health care facilities. If I speak a language different from my clinician, have a physical or mental disability or do not understand something, I understand that Personal MD will make its best effort to provide assistance so I can make informed health care decisions. If I require interpreter services beyond what can be provided by Personal MD, professional interpreters may be provided at an additional cost to me.
- In the event of membership termination, I must give a 30-Day notice before the program and program fees will end. Care will be continued until the last active date of the contract. I understand that I must find a new healthcare provider once my program is terminated.
- I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.
- I also understand that I am responsible for communicating clearly and respectfully with my clinician. Abuseive or rude language toward any Personal MD employee is consdired grounds for termination.
- I understand that I have the right to know all of my treatment options and to participate in my health care decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions.
- I understand that I have the right to speak in confidence with my Personal MD provider(s) and to have my health care information protected.
- I understand that Personal MD will not disclose my information without my authorization or without a legal obligation to do so as outlined in my HIPAA notice. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider(s) amend my record if I feel it is inaccurate or incomplete by contacting the Personal MD Management Department. I understand that there may be charges for printing/copying fees if I desire to have a copy of my records for personal use.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care clinician(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities.
- I agree to first bring any complaints to the attention of Personal MD staff and to participate in the Personal MD complaint and grievance process. Unresolved complaints may be brought to the attention of the Office of the Insurance Commissioner for the State of Texas by calling the Consumer Advocacy department at: (800) 578-4677 (TDD 512-322-4238).
- In order to receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to my Personal MD health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Personal MD health care clinician(s) of any health care services I receive outside of Personal MD (such as emergency room, specialist, or hospital services).
- I understand that I am responsible for not exposing myself or others to disease or danger. I understand that I can receive information from my Personal MD health care clinician(s) about protecting the health and safety of myself and others.

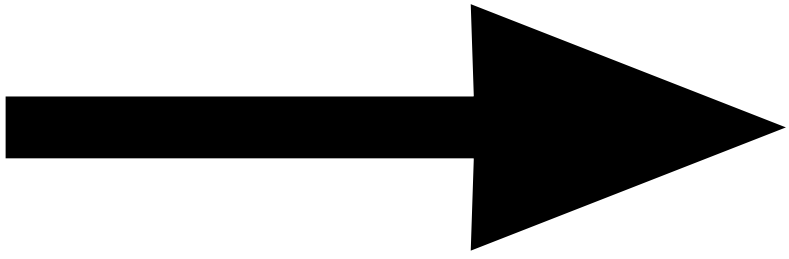
By my signature below, I agree to become a Personal MD patient and I agree to the terms outlined in this Patient Agreement

| | |
|---|---|
| Print Name: | Date: |
| Signature: | Signature by: ___ Patient ___ Parent ___ Legal Guardian |

The following Membership Registration form is only intended for patients who desire a Personal MD provider to be their primary care physician. All primary care patients must be enrolled in a membership program offered by Personal MD.

If you are establishing care at Personal MD for a speciality service such as hormone therapy, weight loss therapy, or aesthetic treatment, you do not have to register as a member understanding that you will only be treated for the speciality service you are requesting.

Please ask a staff member for details.



# Membership Registration Form

PERSONAL MD®

| GUARANTOR /PRIMARY MEMBER INFORMATION | | |
|---|---|---|
| Last Name: | First Name: | DOB |
| Billing Address | City: | State: TX Zip: |
| Phone #1: ( ) __ Work __ Cell ___ Home | Phone #2: ( ) __ Work __ Cell __ Home | |

| MEMBERSHIP INFORMATION | |
|---|---|
| Membership Program: ___ Personal MD Medical Care | Is this is a Corporate Contract ___ Yes ___ No |
| | Employer (If corporate): |

| BILLING INFORMATION | |
|---|---|
| Monthly Billing Date: ___ 1st ___ 15th (To cancel Monthly Billing - Simply fill out a cancellation form with 30-days written notice) | |
| Payment Options: ___ Checking Account | ___ Credit Card |
| Name on Account: | Card Type: ____ Visa ____ Master Card ___ Discover |
| Bank Name | Card #: |
| Account #: | Expiration Date: _____/_____ CVV (3 digit code): _____ |
| Routing #: | Billing Zip Code: |

| ADDITIONAL MEMBERS: 1st member: $80/month \| Additional: Adults: $80/month, Kids: $40/month \| Family Max: $250/month | | |
|---|---|---|
| Name: | Relationship: | Date of Birth: |
| Name: | Relationship: | Date of Birth: |
| Name: | Relationship: | Date of Birth: |
| Name: | Relationship: | Date of Birth: |

## AUTHORIZATION

- Your monthly PMD Medical Care fee covers the services described in the Personal MD Patient Services Guide. At times, however, your care may require durable medical supplies or third-party services that are not covered by your monthly care fee. To streamline your appointment check-out, please note that by providing the above billing information you authorize Personal MD to automatically charge your card or draw on your bank account for any incidental items at the time of service. In all cases, incidental items are charged at or near our cost and will be discussed with you in advance.
- By signing below, I hereby authorize Personal MD to contact me using the information I have provided above. By signing below, I hereby authorize Personal MD to initiate charges to my credit card, debit card or bank account for my periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my care fee plus the care fees of any individuals on my account.
- This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until Personal MD has received written notification from me of its termination in such time and in such manner as to afford Personal MD and my financial institution a reasonable opportunity to act on it.
- I understand that my participation in Personal MD is continuous and that, by signing below, I authorize recurring credit/debit card charges until I notify Personal MD in writing that I wish to terminate my membership. Termination forms are provided online.
- I understand that a $25 fee will be charged to me for declined credit card, debit card, or bank account transaction(s) that are not honored.

A photocopy or scanned copy of the above information is to be considered an original. I understand that I am financially responsible for all charges accumulated from visits to Personal MD Family Healthcare, P.A. I understand that Personal MD Family Healthcare, P.A. does not accept any insurance of any kind and will not file to your insurance carrier after your visit to Personal MD Family Healthcare, P.A. I also understand that being seen in our office for medical care is consent to receive treatment. I hereby authorize Personal MD medical provider(s) to treat myself or if a minor, my child, as deemed medically necessary.

| SIGNATURE OF GUARANTOR/ACCOUNT HOLDER | |
|---|---|
| Date: | Total Amount to Be Billed Monthly: |
| Print Name: | Signature: |