Physician
M. Yates

Originating Clinic
TPG-Slide

TEXAS PHYSICIANS GROUP
Primary Care Clinic
Affiliate of Lubbock Heart & Surgical Hospital

Chart #

Date

General Consent for Treatment

Welcome to our clinic!

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo thesuggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designers as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at the practice. I understand that if additional testing, invasive or intervention procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

_____ _____

Signature of Witness Date

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PATIENT INFORMATION SHEET

Chart #

Date

Name:_____ Gender:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____

Social Security #:_____ - ____ - _____ Email:_____

Date of Birth:_____ Age:_____ Marital Status:_____

Employer:_____ Emp. Phone:_____

Referring Physician:_____ Ref. Phys. Phone:_____

Primary Physician:_____ Primary Phys Phone:_____

Spouse or Parent Information

Name:_____ Relation:_____

Employer:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Emergency Notification Outside of Home

Name:_____ Relation:_____

Employer:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Insurance Information

Primary **– Insurance Company:**_____

Insured's Name:_____ **DOB:**_____

Secondary **– Insurance Company:**_____

Insured's Name:_____ **DOB:**_____

NOTICE

Patient Billing
for
Texas Physicians Group
(Affiliate of Lubbock Heart and Surgical Hospital)

Lubbock Heart and Surgical Hospital is the owner of the Ancillary Service Center at Texas Physicians Group

This means that patients may potentially receive notice of *two separate filings* of insurance claims for services rendered by the primary care physicians and the hospital.

1. One claim will represent physician fees; and
2. An additional claim will be for hospital outpatient EKGs, lab tests and/or radiology exams.

Depending on your insurance coverage, patients may experience:

1. One co-insurance and deductible for **physician** services; and
2. An additional co-insurance and deductible for **hospital** ancillary services.

- Our office makes every effort to send patients' labs to their respective insurance's “preferred” lab.
- The “preferred” status changes from time to time.
- Patients are encouraged to inform us if there have been any insurance changes since the last visit to our office at TPG-Slide (Dr. Yates).

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Acknowledgment of Receipt of Notice of Privacy Practices

I,_____, acknowledge that I have received a copy of TPG/LHH Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to Patient

TPG ONLY

TPG/LHH made the following good faith efforts to obtain the above-referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgment, including the reasons (if known) why the written acknowledgment was not obtained.)

_____

_____

_____ _____
TPG Representative Date

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Chart #

Date

Authorization for Payment and/or Release of Information to Private or Supplemental Group Insurance

_____
Patient Name

_____
Address

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician or physicians for services as described below, but not to exceed the reasonable and customary charge for those services.

_____ _____
Signed (insured person, parent, or legal guardian) Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby also authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

_____ _____
Signed (insured person, parent, or legal guardian) Date

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Texas Physicians Group/Lubbock Heart Hospital**, for any services furnished to me by that Professional Association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents information needed to determine benefits or the benefits payable for the related services.

_____ _____
Signed (only if you have Medicare) Date

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FINANCIAL POLICY

We want to thank you for choosing Texas Physicians Group for your medical care. We have developed this financial policy to clarify our billing practices and to avoid any confusion in the future.

For your convenience, we accept payment by cash, check, VISA, MasterCard, Discover, or debit card.

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit.

All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Medicare Patients: All of our physicians, physician's assistants, and nurse practitioners are Medicare providers, and we will submit your bill to Medicare for you. However, you are responsible for payment of your Medicare deductible each year. If you have secondary insurance, we will submit your claim to your secondary insurance as a courtesy to you if you provide us with accurate information. If we do not receive payment from your secondary payor within 60 days after the Medicare payment has been received, it will be your responsibility to make payment at that time. For patients without secondary insurance, you will be required to pay 100% of your co-insurance at the time the service is rendered.

Patients with Managed Care/PPO Plans: You will be asked to pay any deductible or co-pay due per your plan prior to the service being rendered. It will not be waived as long as the physician has rendered the service.

Patients with No Insurance: You will be asked to pay for each visit at the time of service.

Broken appointments: Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We would appreciate a 24-hour notice of cancellation when possible.

Form Completion: All forms requiring medical review and physician signature, including, but not limited to, FMLA, disability, etc. are subject to an administrative fee of $25.00. These charges are not covered by insurance and must be paid before completion of the form.

Lastly, it is the patients' responsibility to notify the front desk of any changes in insurance coverage before the service is rendered. Any charges denied because of termination of coverage when we have not been informed, or because of a per-existing condition, will be billed directly to the patient upon receipt of denial from the insurance company.

Nonpayments: If you account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, your physician will treat you on an emergency basis only.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date

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Health Insurance Portability and Accountability Act (HIPAA)

Consent for Special Disclosure of Protected Health Information

Please check Yes or No for the following:

I, _____, consent to TPG/LHH employees identifying themselves and leaving messages on my answering machine (if I have one), for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call TPG/LHH.

☐ Yes ☐ No

I consent to TPG/LHH employees identifying themselves and leaving a message with those who answer my home phone for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to contact TPG/LHH.

☐ Yes ☐ No

I consent to TPG/LHH employees contacting me at work, if applicable, for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call TPG/LHH.

☐ Yes ☐ No

If using the Virtual Waiting Room, per the agreement concerning its use at the time of registration, I consent to be contacted via phone by TPG/LHH employees identifying themselves and leaving a message with those who answer my phone for the purposes of appointment confirmation; then by text regarding waiting room times, arrival times, and appointment reminders.

☐ Yes ☐ No

I consent to TPG/LHH employees disclosing my private health information such as test results and billing information with a designated family member or personal representative.

☐ Yes ☐ No

If yes, please designate the person(s) to whom such information may be disclosed:

Name:_____

Address:_____

Phone#(s):_____

Relation:_____

Name:_____

Address:_____

_____

Phone #(s)_____

Relation:_____

Name:_____

Address:_____

_____

Phone #(s)_____

Relation:_____

***Patient Signature:_____ Date:_____**

***Witness Signature:_____ Date:_____**

Patient Update Form

Physician Marissa Yates, M.D. Patient Type

First Names MI Last Name Primary Phone

Reason for Visit

MEDICATION ALLERGIES

Are there any changes to your medication allergies? Y☐ N☐

If yes, please detail your allergies and reaction below i.e. Rash, Hives, Anaphylaxis

Medication Allergy 1		Medication Reaction 1	
Medication Allergy 2		Medication Reaction 2	
Medication Allergy 3		Medication Reaction 3	
Medication Allergy 4		Medication Reaction 4	

Do you Drink Y☐ N☐ If yes, how much? How Often?

Do you Smoke? Y☐ N☐ If yes, how much? How Often?

MEDICAL HISTORY

Are there any changes to your medical history? Y ☐ N☐ Have you ever had, or do you now have, any of the following conditions? Please check YES or NO. If yes, indicate the age when the condition occurred.

Condition	N	Y	Age	Condition	N	Y	Age	Condition	N	Y	Age
Broken Bones	☐	☐		Dislocated Joints	☐	☐		Painful/Stiff Joints	☐	☐	
Knee Conditions	☐	☐		Foot Trouble	☐	☐		Head/Spinal Injury	☐	☐	
Hives/Eczema	☐	☐		Asthma/Wheezing	☐	☐		Pneumonia/Pleurisy	☐	☐	
Chronic Cough	☐	☐		Excess Phlem	☐	☐		Shortness of Breath	☐	☐	
Chest Pain	☐	☐		Rheumatic Fever	☐	☐		Dizziness/Fainting	☐	☐	
Blood Disease	☐	☐		Anemia	☐	☐		Allergy/Hay Fever	☐	☐	
Arthritis	☐	☐		Cancer/Tumor	☐	☐		Liver Conditions	☐	☐	
Hepatitis	☐	☐		Kidney/Bladder	☐	☐		Nervous/Mental	☐	☐	
Sinus Trouble	☐	☐		Tuberculosis	☐	☐		Varicose Veins	☐	☐	
Industrial Disease	☐	☐		Epilepsy	☐	☐		Eye Conditions	☐	☐	
Genital Disease	☐	☐		Gout	☐	☐		Low Blood Pressure	☐	☐	
Hernia	☐	☐		High Blood Pressure	☐	☐		Back Trouble	☐	☐	
Lung Problems	☐	☐		Meningitis	☐	☐		Mononucleosis	☐	☐	
Diabetes	☐	☐		Emphysema	☐	☐		Venereal Disease	☐	☐	
Thyroid Disease	☐	☐		Ulcers	☐	☐		Tobacco Addiction	☐	☐	
Alcohol Addiction	☐	☐		Drug Addiction	☐	☐					

REVIEW OF SYSYEMS

Do you currently have any of the following conditions or symptoms? Please check YES or NO.

General	N	Y
Fever	☐	☐
Chills	☐	☐
Sweats	☐	☐
Anorexia	☐	☐
Fatigue	☐	☐
Weakness	☐	☐
Malaise	☐	☐
Weight Loss	☐	☐
Sleep Disorder	☐	☐

Eye	N	Y
Vision Loss - 1 Eye	☐	☐
Double Vision	☐	☐
Eye Irritation	☐	☐
Vision Loss - Both Eyes	☐	☐
Blurring	☐	☐
Eye Pain	☐	☐
Halos	☐	☐
Discharge	☐	☐
Light Sensitivity	☐	☐

ENT	N	Y
Ringing In Ears	☐	☐
Ear Discharge	☐	☐
Ear Ache	☐	☐
Decreased Hearing	☐	☐
Nasal Congestion	☐	☐
Nosebleeds	☐	☐
Difficulty Swallowing	☐	☐
Hoarseness	☐	☐
Sore Throat	☐	☐

Cardiovascular	N	Y
Difficulty Breathing at Night	☐	☐
Near Fainting	☐	☐
Chest Pain or Discomfort	☐	☐
Racing/Skipping Heart Beats	☐	☐
Fatigue	☐	☐
Lightheadedness	☐	☐
Shortness of Breath	☐	☐
Palpitations	☐	☐
Swelling of Hands or Feet	☐	☐
Difficulty Breathing While Lying Down	☐	☐
Fainting	☐	☐
Leg Cramps with Exertion	☐	☐
Bluish Discoloration of Lips or Nails	☐	☐
Weight Gain	☐	☐

Respiratory	N	Y
Sleep Disturbances Due to Snoring	☐	☐
Cough	☐	☐
Shortness of Breath	☐	☐
Coughing Up Blood	☐	☐
Chest Discomfort	☐	☐
Wheezing	☐	☐
Excessive Sputum/Plem	☐	☐
Excessive Snoring	☐	☐

GI	N	Y
Excessive Appetite	☐	☐
Loss of Appetite	☐	☐
Indigestion	☐	☐
Vomiting Blood	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Yellowish Skin Color	☐	☐
Gas	☐	☐
Abdominal Pain	☐	☐
Abdominal Bloating	☐	☐
Hemorrhoids	☐	☐
Diarrhea	☐	☐
Change in Bowel Habits	☐	☐
Constipation	☐	☐
Dark Tarry Stools	☐	☐
Bloody Stools	☐	☐

Genital / Urinary	N	Y
Foul Urinary Discharge	☐	☐
Blood in Urine	☐	☐
Urinary Frequency	☐	☐
Inability to Empty Bladder	☐	☐
Urinary Urgency	☐	☐
Kidney Pain	☐	☐
Trouble Starting Urinary Stream	☐	☐
Painful Urination	☐	☐
Night Time Urination	☐	☐
Inability to Control Bladder	☐	☐
Genital Sores	☐	☐
Lack of Sexual Drive	☐	☐
Excessive Heavy Periods	☐	☐
Missed Periods	☐	☐
Unusual Urinary Color	☐	☐
Abnormal Vaginal Bleeding	☐	☐
Pelvic Pain	☐	☐

Musculoskeletal	N	Y
Joint Swelling	☐	☐
Muscle Cramps	☐	☐
Joint Pain	☐	☐
Presence of Joint Fluid	☐	☐
Back Pain	☐	☐
Stiffness	☐	☐
Muscle Weakness	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Loss of Strength	☐	☐
Muscle AchesAches	☐	☐

Neuro	N	Y
Difficulty with Concentration	☐	☐
Poor Balance	☐	☐
Headaches	☐	☐
Disturbances in Coordination	☐	☐
Numbness	☐	☐
Inability to Speak	☐	☐
Falling Down	☐	☐
Tingling	☐	☐
Brief Paralysis	☐	☐
Visual Disturbances	☐	☐
Seizures	☐	☐
Weakness	☐	☐
Sensation of Room Spinning	☐	☐
Tremors	☐	☐
Fainting	☐	☐
Excessive Daytime Sleeping	☐	☐
Memory Loss	☐	☐

Psych	N	Y
Sense of Great Danger	☐	☐
Anxiety	☐	☐
Thoughts of Suicide	☐	☐
Mental Problems	☐	☐
Depression	☐	☐
Thoughts of Violence	☐	☐
Frightening Visions or Sounds	☐	☐

Endocrine	N	Y
Excessive Hunger	☐	☐
Cold Intolerance	☐	☐
Heat Intolerance	☐	☐
Excessive Urination	☐	☐
Excessive Thirst	☐	☐
Unexpected Weight Fluctuation	☐	☐

Heme	N	Y
Enlarged Lymph Nodes	☐	☐
Easy Bleeding	☐	☐
Skin Discoloration	☐	☐
Easy Bruising	☐	☐
Fevers	☐	☐

Allergy	N	Y
Persistent Infections	☐	☐
Hives or Rash	☐	☐
Seasonal Allergies	☐	☐

CURRENT MEDICATIONS

Preferred Pharmacy

Are there any changes to your medications since you've seen Dr. Yates? Y ☐ N ☐

Names	Dosage	Frequency

HOSPTIAL ADMISSIONS

Have there been any changes to your hospital admissions? Y ☐ N ☐

Condition	Hospital	Year

FAMILY MEDICAL HISTORY

Are there any changes to family medical history? Y ☐ N ☐

	Mother	Father	Maternal Family	Paternal Family
Diabetes	☐	☐	☐	☐
Cancer (if so, what type?)	☐	☐	☐	☐
Heart Disease (Men <55) (Women <65)	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐

PHYSICIAN INFORMATION

Are there any changes to physician information? Y ☐ N ☐

Who is your regular physician? Last time you saw her/him?

Have you seen any specialists in the last 5 years? ☐ ☐ If yes please detail below:

Specialist 1 Condition
Specialist 2 Condition
Specialist 3 Condition

Are you currently under a physician's restrictions? ☐ ☐

If yes, please explain

Are you interested in hearing more about medical our weight loss program? ☐ ☐