PATIENT REGISTRATION INFORMATION

Patient's Name: _____
Last First M.I Preferred Name

Street Address _____ Apt # _____

City: _____ State: _____ Zip: _____

D.O.B _____ DL# _____ ST _____ Exp. Date _____

SSN _____ Email _____ Is patient a Minor? o Yes o No

Home Phone: _____ Cell Phone: _____ Work: _____ Ext: _____

Employer & Occupation _____

Parent/Guardian (if applicable) ———————————— Phone # _____

Spouse/Partner's Name ———————————— Phone # ————————————

Preferred Contact # o Home o Work o Cell

Is your condition the result of a *work-related injury?* o Yes o No *Auto Accident?* o Yes o No

Marital Status o Single o Married o Partnered o Divorced o Widowed Sex: o M o F

****

If the Guarantor is someone other than the patient, fill out this section. Check if SELF D

Guarantor _____ DL# _____ ST _____ Exp. _____

SSN _____ Relationship to patient ————————————

Guarantor's home # _____ Work # ———————— ext. _____

Guarantor's address _____

****

INSURANCE INFORMATION

Circle One: Cash Indemnity HMO PPO POS EPO OTHER

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST UPON ARRIVAL.

Primary Ins: _____ Ins. Phone: ————————————

Name of Insured: _____ Date of Birth: _____ Relationship to pt. _____

ID # _____ Group # _____ Copay $ _____ Deductible $ _____

Employer: _____ Employer Phone: _____

Secondary Ins: ———————— ID# ———————— Group # _____

How did you hear of us? _____

1 hereby authorize payment of any insurance benefits to ABOVE NAMED PHYSICIAN. I understand that I am financially responsible for the charges Incurred whether or not they: are covered by insurance. I hereby authorize ABOVE NAMED PHYSICIAN to release any and all information necessary to secure the payment of benefits. A photocopy of this document shall be as valid as the original. Guarantor files Insurance for reimbur5ement. If additional physician time Is required for formulary changes on your prescription there will be a $10 fee for this service. This will not be covered by insurance and will be the patient's responsibility. Motor Vehicle Accidents are fee for service. You will be supplied with a fee slip to file your auto insurance. NO EXCEPTIONS.

Signature: _____ Date _____

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Kelly L. Wimberly, M.D., P.A., and Medical Staff to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physicians, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, Managed Care Organizations, indemnity Plans, Medicare/Medicaid or other government or third party payers, or and organizations contracting with any of the above entities to perform such functions.

I also give my authorization to have a copy of my medical records delivered to a primary care physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

I also give my authorization for_____to talk to the office staff about my financial data and all medical information.

Patient and/or Guardian Signature:_____ Date_____

**** *THIS AUTHORIZATION WILL REMAIN IN EFFECT PERMANENTLY* ****

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT BETWEEN HOSPITAL AND MEDICAL STAFF

Baylor/Richardson Medical Center, the independent contractor members of its Medical Staff (including your physician), and other health care providers affiliated with the Hospital have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment, or health care operations. This enables us to better address your health care needs. This notice is being provided to you as a supplement to the Notices of Privacy Practices already given to you by the Hospital and by your health care provider.

PATIENT'S RESPONSIBILITY

Signing of this form in no way implies that your insurance company will cover your visits to this office. Kelly L Wimberly, M.D., P.A., the practice PA's and their employees cannot guarantee any information given to us by your insurance carriers regarding your benefits.

1. If you ***are not*** part of an HMO, PPO, Medicare/Medicaid, or Managed Choice Plan that your physician participates in, you will be responsible for your bill at the time of service.
2. If you ***are*** a part of a PPO plan and you have a deductible for services other than you regular co-pay, you will be responsible for payment of said deductible.
3. If you are part of a Managed Choice or HMO Plan, failure to obtain a valid referral form from your Primary Care Physician (PCP) may resulting no benefit its being paid. You will be responsible for any non-payment from your insurance carrier.
4. Medicare may or may not cover the charge from this office. If the charges from this office are not covered/paid by Medicare the amount will be your responsibility.

Patient and/or Guardian Signature _____ Date _____

KELLY L. WIMBERLY M.D, P.A

Diplomate American Board of Family Practice 17101 Preston Road. South Building. Suite 200. Dallas, TX 75248. 972-239-4441

Instructions and Consent form for the Confidential Communication of Protected Health Information

1. Please list the family members or other persons, if any whom we may inform about your general medical condition and your diagnosis *(including: treatment, payment, and health care operations.)*

   _____

   _____

2. Please list the family member or significant other, if any, whom we may call in case of an Emergency:

3. Name:_____Phone #_____

   Name:_____Phone#_____

4. If other than your home address, please provide the address where you would like your billing statement and or correspondence from our office sent to:

   _____

   _____

5. What is the best telephone number we can call and leave a voice message concerning your appointment, test results or other health care information:

   Phone #_____ o Brief o Detailed

   Phone #_____ o Brief o Detailed

Patient Name: _____

Parent/Guardian Signature: _____ Date:_____

YOU MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT YOUR PHYSICIAN OR THE PHYSICIAN'S PRACTICE HAS TAKEN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION.

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MEDICAL HISTORY FORM

Name _____ Date First Seen _____

Date of Birth _____ Place of Birth _____

Family HX	Age	State of Health
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Sisters & Brothers		
_____		
Spouse		
Children		

CB10 Education: HS C PG

Religion:

	Self	
	Yes	No
Operations		
Hospitalizations		
Injuries		
Hepatitis-Jaundice		
Pneumonia		
Tonsillitis		
Measles		
Mumps		
Chicken Pox		
Rubella (3-day measles)		
Scarlet Fever		
Polio		
Tendency to Infection		

Have you or any relative (blood) or husband/wife had:	Self			Relative-Relationship		
	y	N		y	N	
Diabetes						
Cancer						
Anemia						
Gout						
Kidney Disease						
High Blood Pressure						
Heart Trouble						
Bleeding Disorder						
Asthma / Hay Fever						
Seizures						
Mental Retardation						
Malformation						
Neurologic Disease						
Stroke						
Blindness						
Thyroid Problems						
Deafness						
Venereal Disease						
Mental Illness						
Stomach/ Bowel Problems						
Rheumatic Fever						
Tuberculosis						
Glaucoma						
Arthritis						

Menstrual History:

Length _____ Cramps _____

Age menses began Any Clots?

Frequency of Cycle _____

No. of Children

Weight of heaviest child _____

No. of Pregnancies Any Miscarriages? _____

Smoking History:

Do you smoke?_____Age started smoking? _____

Cigarettes _____ Cigars _____ Pipes _____

Quantity_____Packs per day _____

Age stopped _____

Reason for quitting:

KELLY L. WIMBERLY M.D., P.A.
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FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss it with us.

Your Insurance

We have made prior agreements with many insurers and health plans to accept assignment of benefits. We will bill the plans with which we have an agreement and will only require you to pay the contracted co-payment, deductible or co-insurance at the time of service. For your convenience we accept Visa, MasterCard, American express, cash and checks.

If you have insurance with a plan that we do not have an agreement with, payment in full is due at the time of service. You will be given the paperwork necessary to assist you in filing your own claim.

We make every effort to follow the guidelines required by your insurance company, however every contract is unique. There may be times when we perform a test that is not covered on your plan or that is denied, in those instances we have no choice but to bill you directly for those charges.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the custodial parent/guardian for payment.

If your insurance changes, please notify our office 48 hours before your next appointment. Failure to do so may result in a delay in your appointment time and a longer wait to see the doctor.

Insurance referral

Our medical staff will obtain an insurance referral number for you if required by your insurance. If you were given a referral list, please call to make your appointment and then inform our office of the appointment date and the name of the doctor you are seeing. Please notify the office if you need a *referral at least 48-72 hours in advance*. If you have not heard from us regarding your referral please contact the office.

Motor Vehicle Accidents

Motor vehicle accidents are fee for service and due at the time of the visit, you will be supplied with a fee slip to file with your auto insurance. ***NO EXCEPTIONS.***

Missed Appointments

Same day cancellations and/or no shows will incur the following fees: **$35.00 for Physical exams and $25.00 for office visits.** Please contact the office as early as possible to reschedule your appointment.

Reschedule of Appointment

The office retains the right to reschedule your appointment if:

* The patient is late **15** minutes or more for the appointment.
* The patient or responsible party is unable to meet the financial requirement at time of service.
* The patient is unwilling to pay for the visit when insurance is unverifiable.

Form Completion

If you require a form to be filled out by the physician, you will be charged a **$25.00** form fee. Please Leave blank forms with the front desk. Completed forms will be returned to you within 3 business days. Payment is due when the form is returned to you.

Prescription Refills

Please contact your pharmacy FIRST for refills and allow one to two business days to process. Mail order refills may take up to three business days. Please make refill request PRIOR to running out of medication.

_____ _____

Signature of Patient/Responsible Party Date

KELLY L. WIMBERLY M.D, P.A

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CONSENT

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Kelly Wimberly, M.D., P.A. will maintain a record of the care and services you receive at her practice. This consent only covers your protected health information (PHI) created while you are a patient of Kelly Wimberly, M.D., P.A. Your protected health information pertains to your diagnosis and/or treatment at the practice of Kelly Wimberly, M.D., P.A., including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Kelly Wimberly, M.D., P.A use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how Kelly Wimberly, M.D., P.A and her personnel 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 also acknowledge that you have received a copy of Kelly Wimberly, M.D., P.A's Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.

_____ _____

Signature of Patient or Legal Representative Witness

_____

Date

KELLY L. WIMBERLY M.D, P.A

Diplomate American Board of Family Practice

17101 Preston Road. South Building. Suite 200. Dallas, TX 75248. 972239-4441

INFORMED CONSENT TO USE PATIENT PORTAL

Kelly Wimberly, M.D., P.A is offering this secure, HI PPA Compliant communication tool as a courtesy to our patients. It is an optional service, and we reserve the right to suspend or terminate it at any time; we will alert you to any changes as promptly as possible. This form is intended to inform you of the facts and risks surrounding the use of the web portal. By sign i ng bel ow, you confirm that you have read, understand, and agree to com ply with our procedures and gui delines for using the Patient Portal. You also agree not to hold Kelly Wimberly, M.D., P.A or any of her staff liable for network infractions beyond their control.

Privacy and Security

The web portal or web page has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons from being able to access and rea d your health information or your communications to us. To help insure that the tunnel remains secure, we need to have your current (private) email a d dress and be informed if it ever changes. Keep your port a l user ID and password secure so only you, or someone authorized by you, can gain access to patient information. I f you thin k someone h as l earned you r password, immediately go to the porta l site and change it.

Your email address is confidential and protected information. With our best effort, we will protect this information as we do your medical and other persona l information. We will never purposefully share this information with any third party.

All access to our internal network and electronic medical records (EM R) is password protected. Our staff are instructed to logoff their workstations when not physically present. Additionally, in compliance with HI PAA guidelines, our E M R automatically logs the user out after a peri od of inactivity.

Similar to phone communications, messages may be read and addressed by different staff. When your provider is ill or on vacation, your emails will be addressed by a covering provider.

_____ _____

o Sign me up o Not interested

(*please print name)*

Confidential email, please print *CLEARLY:* _____

(Portal *Jog in* information will go to this address, call us with any changes.)

Patient Name: - _____ D.0.B:_____

Signature: - _____ Date:_____

KELLY L WIMBERLY M.D, P.A

17101 Preston Road. South Building, Suite 200, Dallas, TX 75248.

Ph. # 972-239-4441 Fax # 972-239-1597

Please provide us with the following information so that we may be able to send your prescriptions to the pharmacy of your choice:

Local Pharmacy: _____

Pharmacy Address: _____

Pharmacy phone #: _____

Pharmacy fax #: _____

Mail Order Pharmacy: _____

Pharmacy Address: _____

Pharmacy phone #: _____

Pharmacy fax #: _____

Thank you!