Welcome to Doctors of Primary Care at McKinney and your Medical home!

The Patient- Centered Medical Home is a team-based approach to providing comprehensive primary care. The PCMH is a healthcare setting that facilitates a partnership between the patient and their Primary Care Physician, educating and supporting the patient's active participation in the care they receive, helping you make healthy lifestyle choices. Your Care Team includes YOU.

We understand that having a Primary Care Physician that knows you, your history, and family history is important to maintaining your health. The PCP can provide screenings you need to identify and treat minor problems before they become major problems, treating the patient as a whole person. A PCP can provide options for conditions that may not truly require emergency care or recommend a specialists to meet your health care needs. Your PCP will become your central point of contact coordinating information between specialist and other health care providers.

Care coordination and Referrals: As your Medical Home, we coordinate care with your other health care providers. The recommended specialist's office may contact you directly to schedule an appointment. If you have received a referral and have not been contacted or your referral requires a prior- authorization from your insurance carrier, please let us know.

It is important to let us know when you have received care outside of our practice. This allows us to obtain health information from other providers so that your Primary Care Physician has an accurate representation of your health status each time he/she sees you. This information is collected as part of the new patient registration process; however you may have seen another physician since your first visit. A medical release form can be completed at any time. You may choose to fax the request directly to your other physician or complete the form in the office and we can fax it for you. Please include the name of the Physician you have seen and a telephone and fax number. The office fax number is (972) 992-3937. If you have any questions about obtaining copies of medical records from outside our practice, please contact one of our friendly front office staff members at (972) 382-9292.

Messaging: Although we would like to answer each phone call personally, it is sometimes impossible to do so. In order to accommodate all of our patients, we use a voice mail system and by leaving a complete message your concern will be attended to as quickly as possible. When leaving a message, please speak clearly and leave your complete name, date of birth, and telephone number for a return call. Most calls are returned the same day. Messages left after 3:30 pm may be returned the following day. If you have an urgent need, please follow the instructions to speak with the physician on call. Please allow 48 hours for prescription refill requests.

Laboratory and Diagnostic Test Results: After your physician has reviewed your test results, a nurse or medical assistant will contact you to discuss with you the physician comments and recommendations. Results are usually available within 48 hours. If you would like a copy of your results, please let us know. You can print a copy of your results from our Patient Portal.

Patient Portal: Ask about access to through the Patient Portal. Receive past appointment history, notifications of an up-coming appointment, or confirm or cancel an appointment. You can also update your demographic and insurance information and receive laboratory and insurance information. Late arrivals may need to be rescheduled.

Please make every effort to keep your appointments and notify the office as early as possible to cancel or reschedule. Last minute cancellations or failing to show without advanced notice may result in a No-Show charge.

Patient Satisfaction Survey: We are committed to quality. You may receive a survey regarding your visit. We encourage you to complete the survey to help us improve our quality of service to you.

Ladan Bakhtari, M. D.
Thuha Pham, M.D.
Ramita Maharjan, MSN, APRN, FNP-C

240 Adriatic Parkway
McKinney, Texas 75070
Phone: (972) 382-9292

Patient's Name:_____ **SS #:** _____
First Name MI Last Name

Date of Birth:_____ ☐Male ☐Female **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race (Optional):_____ **Ethnicity (Optional):**_____

Street Address :_____

City/State/Zip Code:_____ **Home Phone:**_____

Cell Phone::_____ **Email**:_____

Patient's Employer:_____ **Work Phone:**_____

Responsible Party:_____ **Relationship:** ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

If patient is a Minor, are parents ☐ Married ☐ Divorced Custodial Parent:_____

Custodial Parent's Home Phone:_____ **Work Phone:**_____

Custodial Parent's SS #:_____ **Date of Birth:**_____

Referring Physician's Name & Phone Number:_____

Preferred Pharmacy Name/Address/Phone:_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ **Phone Number:**_____

>>Policy Holders Name:_____ **Date of Birth:**_____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** **SS #:** _____

Policy/Member #:_____ **Group #:**_____

Insurance Company # 2:_____ **Phone Number:**_____

>>Policy Holders Name:_____ **Date of Birth:**_____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** **SS #:** _____

Policy/Member #:_____ **Group #:**_____

- **I hereby authorize Doctors of Primary Care to release any medical information necessary to complete and process my insurance claims.**

>>_____ _____

>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

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I authorize Doctors of Primary Care to treat me and use my personal health information for healthcare operations.

>>_____ _____

>>*Patient's Signature* (OR Parent if patient is a Minor) Date

Name: _____ Date of Birth:_____

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Financial Policy

Payment is required for all services at the time they are rendered. As a courtesy we will file your claim with your insurance carrier. Applicable co-payments, estimated deductibles, coinsurance and non-covered services will be collected. Once our office has received an Explanation of Benefits from your insurance, and the provider adjustments have been applied, you will receive a statement for any outstanding balance, which is due upon receipt. **In the event an overpayment has been made and to ensure the most accurate refund amount, please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.**

If you are a member of a plan in which you must choose a "primary care physician", it is your responsibility to select the physician you are appointed with prior to your first visit with him/her. If you have not done so, your visit may not be covered and you will be responsible for payment in full at the time of service or you may choose to reschedule your appointment.

We accept payment in the form of cash, check, Visa and MasterCard. For appointments which are missed or cancelled with less than 24 hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Doctors of Internal Medicine when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Doctors of Internal Medicine for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature Date

Authorization to Leave a Voicemail

Please provide number(s) **ONLY** IF you approve us to leave **DETAILED** information related to the following, on your voicemail:

- Test results, labs, medical issues
- Billing questions
- Scheduling issues

Primary (_____) _____ ☐ Cell phone ☐ Home Phone

Secondary (_____) _____ ☐ Cell phone ☐ Home Phone

It is our practice policy to confirm all scheduled visits with a phone call or email. This will be done for all patients. Please notify the receptionist if there is an urgent reason not to confirm appointments.

Name: _____ Date of Birth:_____

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Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent. I authorize this facility to speak to the following family members or my personal representative regarding:

• All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.

The above medical information shall only be released to the following person(s):

1._____Relationship: _____Phone number: _____

2._____ Relationship: _____Phone number: _____

☐ Do not disclose any information on file other than to patient on record.

In case of an emergency please contact:

_____Relationship: _____ Phone number: _____

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA). This information must be updated on an annual basis.

_____ _____
Signature Date

Name: _____ Date of Birth:_____

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Notice of Privacy Practices

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, 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 and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your protected health information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications, and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication, and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other than expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information, for which we would receive compensation, would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes".

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions on disclosures that are otherwise allowed. However, in certain instances, if you make a request for restrictions on disclosures, we will be obligated to abide by them. Specifically, if you pay for an item or service in full, out of pocket, and request that we not disclose the information relating to that service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

To the extent that this office maintains your Protected Health Information (PHI) in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three (3) years prior to such request, as required by HIPAA.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined in HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of September 23, 2013.

Patient's Name:_____ **SS #:** _____
First Name MI Last Name

Name: _____ Date of Birth:_____