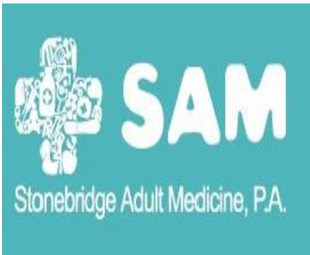


Stonebridge Adult Medicine, P.A.
Registration Form
(Please Print)

PATIENT INFORMATION

Last Name:________________________________ **First Name**:__________________________________

Is this your legal name? □ Yes □ No If not what is your legal name:______________________________

Date of Birth:_____________ **Sex**:□ male □ female **Marital Status**:□ Single □ Married □ Divorced □Widow

Street Address:____ **City:**_____________________________

State:_______________________ **Zip Code:**_______________________ **SS#:**_______________________

Home #:_______________________ **Cel #**:_______________________ **Work #**:______________________

Email Address:____

IN CASE OF EMERGENCY

Name:__________________________________ **Relationship to patient:**_____________________________

Home #:_______________________ **Cel #**:_______________________ **Work #**:______________________

The above information is true to the best of my knowledge. I authorize Stonebridge Adult Medicine, P.A. to apply for benefits on my behalf for covered services rendered by its physicians. I request my insurance benefits be paid directly to the physician or Stonebridge Adult Medicine, P.A. I understand that I am financially responsible for my balance. I also authorize Stonebridge Adult Medicine, P.A. or the insurance company to release any information required to process my claim.

Patient Signature:____ **Date:**__________________________

Stonebridge Adult Medicine, P.A.
3010 Legacy Dr., Suite 210, Frisco, TX 75034
(214)618-9715 phone (214)618-9716 fax

Mission Statement

Stonebridge Adult Medicine, P.A. is committed to providing patients with high quality healthcare. We believe that providing optimal care is not only about the medical advice and treatment we dispense, but more importantly about the relationships we have with our patients. We continue to strive to deliver comprehensive, patient centered, timely, cost efficient care to our patients in order to optimize their quality of life.

Our Physicians

Our physicians are primary care doctors specialized in Internal Medicine. All of our physicians are board certified by the American Board of Internal Medicine. We provide preventative care and management of chronic illnesses such as diabetes, high blood pressure, and cholesterol, as well as acute care to patients 18 years or older.

Office Hours

Four your convenience, our office is open Monday through Friday with morning and afternoon appointments available. In most cases, we have same day appointments available for your urgent care needs. If you are unable to keep an appointment please give us 24 hours notice of your cancellation so we can provide the opportunity for another patient to be seen in your time slot.

Referrals

If a physician refers you to a specialist or schedules additional diagnostic testing we will provide the referral from your insurance company if necessary. We require at least three business days advanced notice to be able to provide quality medical care and referral evaluation. We will also work with the specialist or testing facility to coordinate your medical care. Patients are ultimately responsible for understanding their insurance policy's guidelines for specialty care and any costs associated with care received beyond our practice.

Prescriptions and Refills

We are always happy to provide prescription refill requests to our patients when medically approved. We require at least three business days advanced notice to be able to provide quality medical care and prescription evaluation. You may visit or call your pharmacy to request refills you may need. Unfortunately, refills cannot be called in on the weekends or holidays. We strongly encourage you to notify your pharmacy or our office at least three days before your prescription runs out. Your health is our top priority; therefore, refills will be authorized as needed provided you follow up in the office as recommended by the physician.

In Case of Emergency

We realize that emergency situations arise. If you require urgent medical care, call us anytime at (214)618-9715 and the office will try and arrange for a same day appointment with your physician or the first available physician. If the problem is life threatening, call 911 or proceed to the nearest emergency room for treatment.

In an effort for my physician to provide me with optimal medical care, I understand the above policies and procedures.

Patient Signature:_______________________________________ **Date:**_______________________________

Patient Financial Policies

Thank you for choosing Stonebridge Adult Medicine, P.A. for all of your medical needs. We look forward to providing a complete package of medical treatment and financial services to assist you. We do file your charges with your insurance carrier as a benefit to you. Reimbursement should be received within 45 days in most cases although some exceptions do apply. **It is ultimately the patient's responsibility to know and understand what services are covered under their individual insurance policy. Patients without insurance coverage are required to pay the balance in full at the time of service.** We will not file claims to any Worker's Comp programs or on claims for automobile related accidents.

Common insurance claims denials include, but are not limited to:

- Pre-existing medical condition(s)
- Patient responsible for meeting policy deductible before insurance will pay
- Insurance not in effect at time of service
- Coverage by more then one plan in which coordination of benefits has not been arranged
- Policy maximum has been reached
- No referral for the service (if the policy requires you to list a primary care physician that is not one of our physicians)
- Medical services rendered is not covered by the insurance policy

Professional services are rendered to the patient, not an insurance company. Insurance companies can deny claims for a variety of reasons and the above are only the most common denial reasons. **Any unpaid balance remains the patient's responsibility**.

You can assist in the following ways to expedite your claim and reduce denials:

- You will be asked at every visit to verify your information and make any applicable changes. It is your responsibility to inform us of any demographic and insurance changes. If you have two insurance carriers, please advise the receptionist and provide a copy of both insurance cards
- Medicare patients- If you have switched from traditional Medicare to a Medicare replacement policy (Secure Horizons, Evercare, etc.), please inform the reception staff at the time of service.

If any changes in your insurance information coverage is not provided and/or received within the insurance carrier timely filing period, the patient will become responsible for any balance of the account. **Co-pays are always due at the time of service.**

We accept the following payment types:

- Cash
- Check
- Credit Card (Visa, Mastercard, Discover, and American Express)

No show, cancellation, and late patient policy:

You will receive a phone call reminder a day or two before your scheduled appointment. If you need to cancel an appointment, we ask that you do so within 24 hours of your scheduled appointment time. If you arrive late to your scheduled appointment, we will attempt to see you at the next available time slot if the schedule permits. Any patient that excessively abuses this policy is subject to dismissal from our practice. If you miss your scheduled appointment without canceling the appointment you will be charged a $25 fee.

I have read and understand the above patient policies. I understand that this office will file an insurance claim on my behalf based on the information I provide. Stonebridge Adult Medicine, P.A. and I will receive an Explanation of Benefits (EOB) from my insurance carrier(s) that will detail any payments, deductions, and adjustments per my insurance plan's guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company as applicable by stat and / or federal law.

______________________________ ______________________________

Patient Signature Date

Stonebridge Adult Medicine, P.A.
3010 Legacy Dr., Suite 210, Frisco, TX 75034
(214)618-9715 phone (214)618-9716 fax

Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Receive Information:

Any health information Stonebridge Adult Medicine, P.A. collects or receives about you may be disclosed to the following persons:

____
Name of Person / relation

____
Name of Person / relation

____
Name of Person / relation

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Stonebridge Adult Medicine, P.A.

_____ I do not authorize any information to be disclosed to any other parties except those parties outlined in the Notice of Privacy Practices.

If you have an answering machine or voicemail, may we leave messages regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Stonebridge Adult Medicine, P.A.

_____ Yes _____ No _____N/A

If "No", how may we contact you regarding this information?

Expiration Date of Authorization
This authorization does not expire unless revoked or terminated by the patient or patient's legal representative in writing.

_________________________________ _________________________________
Signature of Patient or Legal Representative Date

_________________________________ _________________________________
Print name of Patient or Legal Representative Print Name of Witness

Consent to Use and Disclose Protected Health Information
Patient Consent Form

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Stonebridge Adult Medicine, P.A. originates and maintains health records describing health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future treatment. This information is utilized to plan your care and treatment, to bill for services provided to you, to communicate with other healthcare providers, and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals. Your protected health information will be used by Stonebridge Adult Medicine, P.A. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to –day healthcare operations of the practice.

THE NOTICE OF PRIVACY PRACTICES

Stonebridge Adult Medicine, P.A. is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. You have been provided a copy of access to the Notice of Privacy Practices and understand that you have the right to review the notice prior to signing this consent. These policies and procedures are defined in the "Privacy Police and Procedure" manual in our office and the "Notice of Privacy Practices" brochure provided to you. Please review it carefully.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, Stonebridge Adult Medicine, P.A. may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or your physician if you would like additional information or clarification.

I request the following restrictions of the use and/or disclosure of my personal health information:

____

____

____

It is a violation of the federal privacy standards if Stonebridge Adult Medicine, P.A. agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Practices brochure, please consult with a practice representative at the location and contact information listed in the Privacy Policy and Procedure manual.

YOU MAY REVOKE THIS CONSENT AT ANY TIME

You may revoke this consent at any time; however, Stonebridge Adult Medicine, P.A. requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

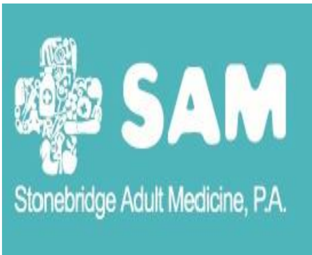
CHANGES TO PRIVACY PRACTICES

Stonebridge Adult Medicine, P.A. reserves the right to change or modify the privacy practices outlined in the Privacy Policy and Procedure manual and the Notice of Privacy Practices brochure. Stonebridge Adult Medicine, P.A. will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that your request.

SIGNATURE

By signing below you indicate you have reviewed this consent form, received the brochure entitled "Notice of Privacy Practices", and given permission to Stonebridge Adult Medicine, P.A. to use and disclose your health information in accordance with this consent and the notice provided.

____________________________	____________________________	____________________
Name of Patient (print or type)	Signature of Patient	Date
____________________________	____________________________	____________________
Patient Legal Representative (if applicable)	Signature of Patient Legal Representative	Date
____________________________	____________________	
Signature of Witness	Date	



Stonebridge Adult Medicine, P.A.
3010 Legacy Dr., Suite 210, Frisco, TX 75034
(214)618-9715 phone
(214)618-9716 fax

Patient Name:____

Date of Request:____________________ **Date of Birth:**____________________

Records requested from the following physician/facility:

Name:____

Phone:____

Fax:____

Please forward the following:

_____ All medical records _____ Test only (specify) ____________________

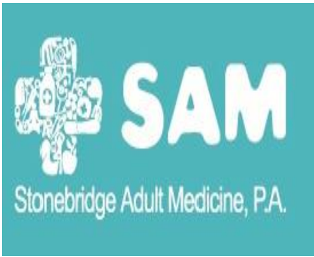
Please fax to the attention of:

Paul Hui Wang, M.D.

By signing below, I am providing written consent for Stonebridge Adult Medicine, P.A. to obtain copies of my medical records. I also agree that photocopied signatures are valid for obtaining medical records.

________________________________ ____________________________

Patient Signature **Witness Signature**



CONSENT FOR TREATMENT

Paul Hui Wang, M.D.
Stonebridge Adult Medicine
3010 Legacy Dr., Suite 210, Frisco, TX 75034

Patient Name:____

I authorize Paul Hui Wang, M.D. to perform any necessary or routine medical or surgical treatments, including examinations, injections, immunizations, and /or diagnostic procedures, including radiologic studies and/or laboratory analysis.

I understand that the practice will share patient health information according to federal and state law for treatment, payment, and operations.

I understand that it is my responsibility for all charges incurred, regardless of my insurance status. If I am under a health insurance plan, I will pay the appropriate copay as described by my plan at the time of service. I authorize insurance payments for services rendered to be paid directly to Paul Hui Wang, M.D.

Scheduling appointments is important and must be cancelled in time for other patients to be able to see the doctor as needed. I agree to pay a $25 fee for canceling less then 24 hours in advance or for not showing up for my scheduled appointment.

Patient Signature________________________________Date__________________

Or

Legal Representative Signature________________________ Relationship_________

Printed Name of Representative____________________________

Stonebridge Adult Medicine
3010 Legacy Dr., Suite 210, Frisco, TX 75034

NEW PATIENT HISTORY

Patient Name____ Date of Birth___________________________
Address____ Email address__________________________
Referring Physician name and number____
I have a: □ Living will □ Durable Power of Attorney for Healthcare
Emergency Contact:____Relationship____________________
Phone:____
Previous Medical History
□ High Cholesterol □ Diabetes □ High Blood Pressure □ COPD
□ CAD □ CVA □ CHF □ GERD
□ Asthma □ other____

Previous Surgical History
Type Date
____
____
____

Family History
Mother □ Diabetes □ Cancer type:____________ □ Heart Disease □Age_____□ Deceased
Father □ Diabetes □ Cancer type:____________ □ Heart Disease □Age_____□ Deceased
Children □ Diabetes □ Cancer type:____________ □ Heart Disease □Age_____□ Deceased Children □
Diabetes □ Cancer type:____________ □ Heart Disease □Age_____□ Deceased

Medications currently taking
____
____
____

Pharmacy Name and Number :____

Allergies Reaction
____
____
____

Social History
Marital Status: □ Single □ Married □ Divorced □ Widowed
Tobacco: □ Yes □ No Type____________________ Amount daily__________________
Alcohol: □ Yes □ No Frequency:_____day _____month
Caffeine: □ Yes □ No Type____________________ Amount Daily_________________
Exercise: □ Yes □ No Type____________________ Frequency______________________