ADVANTAGE IR IN TEXAS

AIR Texas, PLLC

New Patient Welcome Packet

Last Update: 12/17/2019

Welcome to Advantage IR in Texas!

Our goal is to provide world class treatment and care for you. It all starts with getting to know you better, to make sure we provide the best possible care. We know it's a lot, but please fill out the information below as completely as possible.

I. Demographic Information

Patient Information			
Name:		SSN:	
Date of Birth / Age:		Marital Status:	# of Children:
Employer:		Occupation:	
Sex: ☐ Male ☐ Female		Height:	Weight:
Home Address:			
	City:	State:	Zip:
Phones	Home:	Mobile:	Work:
Contact Permissions:	☐ Home ☐ Mobile ☐ Work I grant permission to have voice messages which may contain personal health information left on the phones selected above.		
Email Address:			
	By providing an email address, you allow Advantage IR in Texas (AIR Texas, PLLC) to contact you about your medical condition and potential future treatment advice via HIPAA compliant secure email.		

Emergency Contact	
Contact Name:	Relation:
Phone:	

II. Reason for Visit

Please describe the major problem that brings you in today

III. Care Information

Primary Care Physician (PCP)			
Physician Name:			
Address:			
	City:	State:	Zip:
Phones:	Office:	Fax:	
Email Address:			

Referring Physician (If Different from PCP)		
Physician Name:		Specialty:
Phones:	Office:	Fax:

Additional Physicians	
Physician Name (1):	Specialty:
Physician Name (2):	Specialty:
Physician Name (3):	Specialty:

Pharmacy			
Pharmacy Name:			
Address:			
	City:	State:	Zip:
Contact Phones	Main:	Fax:	

IV. Surgical History

Please list all operations you have had:

	Date:
	Date:
	Date:
	Date:
	Date:
	Date:
	Date:
	Date:

V. Medical History

Please list all active medical conditions:	
	Duration:
	Duration:
	Duration:
	Duration:
	Duration:
	Duration:

Please list all MEDICATIONS you take routinely *(including current and previous chemotherapy)*:		
Name of Medication	*Dosage*	*Frequency of Use*

Medical Allergies
Are you ALLERGIC to any medicines, latex, X-Ray Dye or Iodine? Yes ☐ No ☐
If yes, please list allergies and reactions:

Females Only	Yes	No	
Are you, or could be pregnant?	☐	☐	
How many times have you been pregnant?	☐	☐	How many children do you have?
Are you still having menstrual periods?	☐	☐	How many days do they last?
If you have heavy bleeding, what is the most Number of pads per day?			For how many days?
Do you have any constipation?	☐	☐	
Ever used birth control pills?	☐	☐	
Do you have any urinary urgency of frequency?	☐	☐	
Have you had a recent Pap smear or Endometrial biopsy?	☐	☐	
Do you have varicose veins?	☐	☐	
Do you have pelvic pain	☐	☐	

	Yes	No
Constitutional (Health in General)		
Good general health lately	☐	☐
Recent weight loss	☐	☐
Recent weight gain	☐	☐
Fever	☐	☐
Other constitutional concerns	☐	☐
Eyes		
Wear glasses/contact lenses	☐	☐
Blurred or double vision	☐	☐
Eye disease, discharge, or injury	☐	☐
Other eye or vision concerns	☐	☐
ENMT (Ears, Nose, Mouth & Throat)		
Hearing loss or ringing	☐	☐
Ear pain, infections or discharge	☐	☐
Use of hearing device	☐	☐
Problem snoring, apnea	☐	☐
Difficulty swallowing or speaking	☐	☐
Ulcers or bleeding in mouth	☐	☐
Other ENMT concerns	☐	☐
Cardiovascular (Heart)		
Chest pain or angina	☐	☐
Palpitations	☐	☐
High cholesterol	☐	☐
Blood clots	☐	☐
Fainting	☐	☐
Other cardiovascular concerns	☐	☐
Peripheral Vascular		
Leg pain	☐	☐
Cramping leg pain with activity	☐	☐
Swelling of feet, ankles, or hands	☐	☐
Skin changes on feet or legs	☐	☐
Varicose veins	☐	☐
Other peripheral vascular concerns	☐	☐
Respiratory (Breathing)		
Shortness of breath	☐	☐
Difficulty breathing with activity	☐	☐
Chronic coughs or congestion	☐	☐
Asthma or wheezing	☐	☐
Other respiratory concerns	☐	☐
GI (Stomach & Intestines)		
Loss of appetite	☐	☐
Abdominal pain	☐	☐
Nausea or vomiting	☐	☐
Change in bowel movements	☐	☐
Frequent diarrhea	☐	☐
Other GI concerns	☐	☐

Yes	No	
		Urinary and Reproductive
☐	☐	Painful or difficult urination
☐	☐	Frequent Urination
☐	☐	Hormone replacement or birth control
☐	☐	Female : # of pregnancies
		Musculoskeletal (Muscles, Bones, Joints)
☐	☐	Muscles weakness, pain/stiffness
☐	☐	Joint pain/stiffness
☐	☐	Neck or back pain
☐	☐	Cold extremities
☐	☐	Difficulty in walking
☐	☐	Use of cane, walker, or wheelchair
☐	☐	Other musculoskeletal concerns
		Skin
☐	☐	Rash or itching
☐	☐	Sores or lesions
☐	☐	Areas of hardened skin
☐	☐	Other skin concerns
		Neurological
☐	☐	Light-headed or dizzy
☐	☐	Weakness on one side
☐	☐	Numbness/ tingling on one side
☐	☐	Frequent headaches
☐	☐	Seizures
☐	☐	Difficulty controlling muscles
☐	☐	Other neurological concerns
		Psychiatric
☐	☐	Depression
☐	☐	Anxiety or nervousness
☐	☐	Other psychiatric concerns
		Endocrine
☐	☐	Significant weight loss or gain
☐	☐	Heat or cold intolerance
☐	☐	Excessive thirst, hunger, or urination
☐	☐	Other endocrine concerns
		Hematologic/ Lymphatic (Blood and Lymph)
☐	☐	Bleeding or bruising tendency
☐	☐	Slow to heal after cuts
☐	☐	Enlarged glands
☐	☐	Blood clots
☐	☐	Anemia
☐	☐	Other blood/ lymph concerns
		Allergic/ Immunologic
☐	☐	Allergic reaction to the environment
☐	☐	Frequent infections
☐	☐	Other allergic/ immunologic concerns

VI. Social History

Social Use	Yes	No	
Do you smoke cigarettes or e-cigarettes ("vape")?	☐	☐	If so, how many packs/times a day?
At what age did you start?			If applicable, at what age did you stop?
Do you drink alcohol?	☐	☐	If yes, how frequently daily/weekly?
At what age did you start?			If applicable, at what age did you stop?
Do you use recreational drugs?	☐	☐	
If yes, types:			

Nutrition Assessment	Yes	No	
Have you experienced daily vomiting/diarrhea for more than two days?	☐	☐	
If yes, please explain:			
Have you experienced nausea or poor appetite for more than five days?	☐	☐	
If yes, please explain:			
Have you lost weight without wanting to?	☐	☐	If so, how many pounds?

Energy Level	Yes	No
Are you able to do physically strenuous activities?	☐	☐
Do you have enough energy to do all the things that you want to?	☐	☐
How many hours do you sleep at night?		
Do you take naps during the day?	☐	☐
Is this more than ½ the time you are awake?	☐	☐

VII. Power of Attorney

Do you have a Healthcare Medical Power of Attorney	Yes ☐	No ☐
If yes, please provide details:		

VIII. Advanced Medical Directive

Do you have an Advance Medical Directive?	Yes ☐	No ☐
If yes, please provide details:		

IX. Additional Information

Is there any other information you think we need to know?

By signing below, I voluntarily consent to all medical and surgical treatment performed by Advantage IR in Texas (AIR Texas, PLLC). I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure or treatment, and to discuss it with my health care provider. I understand that if an employee or any individual associated with Advantage IR is exposed to my blood or bodily fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV).

The information on this form is accurate to the best of my knowledge.

Signature of Patient/Legally Authorized Representative _____ Date _____

Printed Name of Patient/Legally Authorized Representative _____ Relationship to Patient _____

Note: If you are a Legally Authorized Representative, you must complete a responsible party form to store on file.

Notifications and Financial Policy

You are financially responsible for the medical services you receive at Advantage IR in Texas (AIR Texas, PLLC, hereafter referred to as the "Practice"). Please carefully review this Financial Policy, initial each section and sign the agreement to indicate your acceptance of its terms.

Appointments

1. Copayments and Deductibles. Copayments and deductibles for clinic visits are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your copayment at the time of service, the Practice reserves the right to reschedule your appointment until such time that you are able to make your copayment.
2. Procedure Prepayment. The Practice may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim. In the event of overpayment, you may request a refund.
3. Self-Pay. If you do not have health insurance, or if your health insurance will not pay for services rendered by the Practice or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.
4. Missed Appointments and Late Arrivals. You may be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier.

Initial:

Insurance Payments

1. Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.
2. Coverage Changes and Timely Submission. It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which the Practice can submit a claim on your behalf. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

Initial:

Benefits and Authorization

1. Insurance Plan Participation. The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.
2. Referrals. Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, it is your responsibility to obtain this referral prior to your appointment. Although, your referring health care provider, and the Practice, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, the Practice is not required to agree with you.

As a matter of course, the Practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice.

3. Prior Authorization and Non-Covered Services. The Practice may provide services that your insurance carrier's plan excludes or require prior authorization. The Practice, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.
4. Out-of-Network Payments and Direct Insurer Payments. You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately.

Initial:

Account Balances and Payments

1. Reassignment of Balances. If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving an initial statement.
2. Collection of Unpaid Accounts. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.
3. Returned Checks. You may be charged for returned checks according to the Public Fee Schedule.
4. Refunds. Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: airtexas@advantage-ir.com
5. Statements. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the receipt.

Initial:

Additional Fees

1. Medication Refill Requests. All medication refill requests are to be approved by your provider. A fee may be charged according to the Public Fee Schedule for any of the following requests: lost prescriptions; urgent refill/office visit requests (same or next business day); and refills processed after a missed appointment.
2. Medical Records Requests. The Privacy Rule allows you to receive a copy of your personal medical records, billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. However, if you are unable to come into one of the Practice's clinics, the Practice will make every accommodation to fulfill your request. A fee may be charged for medical records requests according to the Public Fee Schedule. There is no charge to transfer a copy of your medical records to a new Provider
3. Other Forms. The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. Other forms not listed may be considered for completion by the Practice. In these cases, the fee will be determined by the Practice manager. All requests require an office visit.

Initial:

Additional Notifications

Notice of Privacy Practice. By initialing this section, I acknowledge that I have received a copy of the Practice's Notice of Privacy Practice which includes a Statement of Patient's Rights to review.	Initial:
Advanced Directive. By initialing this section, I acknowledge that I have received a copy of the Practice's Advanced Directive Statement to review.	Initial:
Code of Conduct. By initialing this section, I acknowledge that I have received a copy of the Practice's Code of Conduct Statement to review.	Initial:
Use of Media. By initialing this section, I acknowledge that I have received a copy of the Practice's Use of Media statement to review	Initial:

I have read and understand the Financial and Responsibility Policy of Advantage IR in Texas (AIR Texas, PLLC) and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I receive from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Signature of Patient/Legally Authorized Representative

Date

Printed Name of Patient/Legally Authorized Representative

Relationship to Patient

Note: If you are a Legally Authorized Representative, you must complete a responsible party form to store on file.

Authorization for Release of Medical Records to Your Physicians

I hereby authorize Advantage IR in Texas (AIR Texas, PLLC) to disclose my entire medical record including information regarding my condition, treatment, imaging and diagnosis to my Physicians as listed below as of the date signed below.

Physicians Allowed *(Physicians Must be listed in Section III Care Information)*	
Physicians: *(Select One or More)*	☐ Primary Care Physician ☐ Referring Physician ☐ Additional Physician (1) Listed in Section III: Care Information ☐ Additional Physician (2) Listed in Section III: Care Information ☐ Additional Physician (3) Listed in Section III: Care Information OR: ☐ Do Not Release my Medical Records to Any of my Physicians Listed

Disclosure Type and Method	
Type of Disclosure:	All Patient Medical Records
Method(s) of Disclosure:	We will contact your Physician to Determine the method of Delivery

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may revoke this authorization at any time by giving oral or written notice to Advantage IR in Texas (AIR Texas, PLLC). A photocopy of this authorization shall constitute a valid authorization. I realize once my medical records have been released, Advantage IR in Texas (AIR Texas, PLLC) cannot retrieve them and has no control over the use of the already released copies. I understand that the health information I am authorizing may disclose additional information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

I hereby release Advantage IR in Texas (AIR Texas, PLLC) from any and all liability which may arise as a result of my authorized release of records. I understand that my treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on whether I choose to release my records. I have read this authorization and acknowledge the terms and conditions.

Signature of Patient/Legally Authorized Representative _____ Date _____

Printed Name of Patient/Legally Authorized Representative _____ Relationship to Patient _____

Note: If you are a Legally Authorized Representative, you must complete a responsible party form to store on file.

Notice to Recipient(s) Receiving Medical Records:
The attached medical information pertaining to the patient listed above is confidential and legally privileged. Advantage IR in Texas (AIR Texas, PLLC) has provided it to you as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law.

Authorization for Release of Medical Records to Personal Representatives (OPTIONAL)

I hereby authorize Advantage IR in Texas (AIR Texas, PLLC) to disclose my medical record to my personal representative(s) as listed below as of the date signed below. This disclosure shall be limited based on the selections below:

Personal Representative Information		
Representative Name:		Relation:
Address:		
	Phone:	Fax:
Email Address:		

Disclosure Type and Method	
Type of Disclosure:	All Patient Medical Records
Method(s) of Disclosure:	We will contact your Representative to Determine the method of Delivery

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may revoke this authorization at any time by giving oral or written notice to Advantage IR in Texas (AIR Texas, PLLC). A photocopy of this authorization shall constitute a valid authorization. I

of the already released copies. I understand that the health information I am authorizing may disclose additional information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

I hereby release Advantage IR in Texas (AIR Texas, PLLC) from any and all liability which may arise as a result of my authorized release of records. I understand that my treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on whether I sign this authorization. I have read this authorization and acknowledge the terms and conditions.

Signature of Patient/Legally Authorized Representative

Date

Printed Name of Patient/Legally Authorized Representative

Relationship to Patient

Note: If you are a Legally Authorized Representative, you must complete a responsible party form to store on file.

Notice to Recipient(s) Receiving Medical Records:
The attached medical information pertaining to the patient listed above is confidential and legally privileged. Advantage IR in Texas (AIR Texas, PLLC) has provided it to you as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law