Texas Inpatient Consultants

16701 Creek Bend Dr # 500
Sugar Land, TX 77478
Tel: 281-265-0409; Fax: 281-265-0402

Date : _____ **Account/Chart #** _____

Name(Last): _____ **(First):** _____ **(Middle):** _____

Address : _____ **Apt #** _____

City : _____ **State :** _____ **Zip Code :** _____

Home Tel # _____ **Cell #** _____

Work Tel # _____ **E-mail address :** _____

SS # _____ **Date of Birth** _____ **Age :** _____

Employer : _____ **Occupation :** _____

Address : _____

Marital Status : _____ **Male :** _____ **Female :** _____

Spouse's Name : _____ **SS#** _____ **DOB :** _____

Spouse's Employer : _____ **Address :** _____

Emergency Name : _____ **Phone # :** _____

Referred by : _____ **Phone # :** _____

Pharmacy Name _____ **Pharmacy Number:** _____

****

Primary Insurance Name : _____ **Tel Number :** _____

Insurance ID : _____ **Group Number :** _____

Insured's Name : _____ **Employer :** _____

Insurance Address : _____

Secondary Insurance Name : _____ **Tel Number :** _____

Insurance ID : _____ **Group Number :** _____

Insured's Name : _____ **Employer :** _____

Insurance Address : _____

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO TEXAS INPATIENT CONSULTANTS FOR SERVICES RENDERED.I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY.I ALSO AUTHORIZE A RELEASE OF MY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT.I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT.I AUTHORIZE RELEASE OF REPORTS ON REQUEST.I REQUEST THAT PAYMENT OF AUTHORIZED BENEFIT BE MADE ON MY BEHALF.A PHOTOCOPY OF THESE ASSIGNMENTS,SHALL BE VALID AS THE ORIGINAL.

Patient's Signature : _____ **Date :** _____

Parent/Guardian Signature : _____ **Date :** _____

(Legal Guardian does not include step-parents unless authorized by the Court)

General Patient Information

Name : _____ **Date of Birth :** _____

Occupation : _____ **Sex (circle one) : Male Female**

Education (check all) : ☐ Elementary ☐ High-school ☐ College ☐ Post-grad

Religion : _____ **Marital Status :** S☐ M☐ D☐ W☐

Current Medications :

_____
_____
_____
_____

Allergies : _____
_____

Surgeries :

_____
_____

Medical Problems :

_____
_____
_____
_____

Family Medical Problems :

Mother : _____
Father : _____
Brother : _____
Sister : _____

Do you use :

Tobacco/Smoke : _____ **Amount Daily ?** _____ **How many years ?** _____
Alcohol ? _____ **Quantity per week ?** _____
Nutritional supplements : _____ **Type :** _____
Recreational drugs : _____ **Type :** _____
Have you had a recent ? (year) DT _____ **Flu Vac** _____ **Pneumo Vac** _____
Females : LMP : _____ **Number of Pregnancies :** _____ **Miscarriages :** _____

Circle/Check all that apply :

- ☐ Headaches
- ☐ Chest Pains
- ☐ Stomach Pains
- ☐ Anemia
- ☐ Fainting Spells
- ☐ Hypertension
- ☐ Heartburn
- ☐ Arthritis
- ☐ Dizziness
- ☐ Stroke
- ☐ Nausea/Vomiting
- ☐ Gout
- ☐ Blurred Vision
- ☐ Heart murmur
- ☐ Diarrhea
- ☐ Fracture
- ☐ Double vision
- ☐ Shortness of breath
- ☐ Blood in BM
- ☐ Eye pain Glaucoma
- ☐ Tuberculosis
- ☐ Cataracts
- ☐ Ear ache
- ☐ Change of stool size
- ☐ Pneumonia
- ☐ Painful urination
- ☐ Asthma
- ☐ Hearing loss
- ☐ Hay Fever
- ☐ Blood in urine
- ☐ Cancer
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Cough
- ☐ Seizures
- ☐ Palpitations
- ☐ Nosebleeds
- ☐ Bleeding Gums
- ☐ Bypass
- ☐ Swollen Feet
- ☐ Enlarged veins
- ☐ Skin Changes
- ☐ Colitis
- ☐ Loss of Urine/Feces
- ☐ Vaginal Discharge
- ☐ Penile Discharge

Reason for your visit : _____

Signature : _____

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

PATIENT NAME: _____

DOB : _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices in accordance with current laws, and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

_____ _____
Signature of Patient Date

_____
Relationship to patient (if signed by other than patient)

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FINANCIAL POLICY

Thank you for choosing TIC as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. Our fees are based on treatment received, regardless of the outcome. All patients must complete our Information and Insurance forms before seeing the doctor.
Full payment is expected at the time services are rendered. We accept cash, credit cards, and checks. We offer extended payment options with prior approval.

REGARDING INSURANCES:
Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. As a courtesy, we will attempt to bill your primary insurance company. However, due to rising costs of medical practice, we are unable to bill to your secondary insurance plan. You can, however, coordinate benefits with your individual policies and they will forward your claims. The balance is your responsibility whether your insurance pays or not. **Also, we cannot bill your insurance unless you give us your updated insurance information and sign a claim form**. Please be advised that if after 45 days your insurance claim has not been paid, you will receive a bill for the entire balance due upon receipt. Balances over 90 days will be turned over to a collection agency. Please be aware that some and perhaps all services provided may not be covered, reasonable and customary, and/or necessary under your individual insurance plan even though your doctor believes they are. It is each individual's responsibility to determine your individual benefits.

USUAL AND CUSTOMARY RATES:
Our practice is committed to providing the best treatment for our patients and will charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PRE-EXISTING CONDITIONS:
We will contact your insurance company and attempt to get verification of coverage and a summary of your benefits. If your insurance carrier tells us of a pre-existing clause, you will be required to post a deposit for all services rendered until your insurance plan has paid all your claims.

OUT-OF-NETWORK OR COBRA POLICIES:
If you elect to go out-of-network, you will be required to pay for your services in full at the time of service. We can give you a receipt and we can send a copy of the claim to your insurance carrier if you want us to do so.

REQUEST FOR MEDICAL RECORDS:
If requests for medical records come from a physician/medical practice, there will be no charge for the records. There will be charges incurred for requests from all others, including but not limited to insurance companies, attorneys, and patients/clients. Charges for medical records will be based on individual cases.

MISSED APPOINTMENTS:
It is our policy to charge **$60.00** for each missed appointment, unless notified 24 hours prior to your scheduled time. Please help us serve you better by keeping your scheduled appointments.

RETURNED CHECKS:
For all returned checks there will be a non-sufficient fund fee of **$35.00** added to your balance. Thereafter, there will be a cash only payment policy.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Responsible Party	Date

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to **Texas Inpatient Consultants**. When you schedule an appointment with Texas Inpatient Consultants we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a **$60.00 fee.**
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a third time may be dismissed from the Practice.
- Any new patient who fails to show for their initial visit will be attempted to reschedule for a second time. Any no-shows, after that. will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- At initial registration, every patient must provide the practice with an email address and a cell phone number.As backup,other additional numbers,including an emergency contact must also be provided.It is the patient's responsibility to update us with any new/changed information, including phone numbers.
- Per protocol,all patients will receive automatic appointment reminders to their emails a week in advance, and a text reminder to the cell phones, 3-days in advance. It is the responsibility of the patient and/or the caregiver to confirm this appointment in a timely manner.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Practice Administrator, who may be able to waive the No Show fee. You may contact Texas Inpatient Consultants 24 hours a day, 7 days a week at 281-265-0409.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its term.

Signature of Patient

Date

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Paticnt Name: _____ Date: _____

Address: _____ SS# _____

_____ DOB: _____

Records Released From: Records Released To:

_____ _____

_____ _____

_____ _____

Please send a copy of my records as indicated for date(s) of treatment: _____

• Operative Records • Lab Reports • H & P • X-ray Reports

• Prenatal Records • Discharge Summary • Other: _____

Purpose for releasing medical information: _____

_____ _____

Signature of Patient, Parent or Legal Guardian **Date**

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F. R. Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____ _____

Signature of Patient **Date**

Permission to fax records for medical emergencies? • Yes • No

This authorization expires ninety (365) days from the date of this signature.

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Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting **[Texas Inpatient Consultants]** at **[281-265-0409]**.
5. I understand that the laws that protect privacy and the confidentiality of healthcare information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurance that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
Witness Signature	Date

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Nondiscrimination in provider care

Patient agrees that there is no discrimination in care by providers at Texas Inpatient Consultants. Patients will be comfortable with being seen by any provider at the practice such as Dr. Sreshta, MD, Dr. Opara, MD and Aimee Plattsmier, PA. If a patient is not in agreement with this nondiscrimination in care, then the patient may look for a new provider within 30 days. If a patient is in agreement with this non discrimination of care policy, please sign below.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness/TIC Employee (Name & Signature): _____