HA GRAND MD PA

3801 Gaston Ave., Suite 315
Dallas, Texas 75246
Phone: (214) 824-2121
Fax: (214) 824-2406

Patient Information

Name: _____ Date of Birth: _____/_____/_____

Street: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____-_____-_____ Driver License Number: _____

Home Phone: _____-_____-_____ Mobile: _____-_____-_____ Work: _____-_____-_____

E-mail Address: _____

Best Contact Method (check one): _____ Phone _____ E-mail _____ Postal Mail

Employer Information: _____

Employer Address: _____

Spouse Name: _____ Date of Birth: _____/_____/_____

Insurance Carrier: _____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Insurance ID: _____ Group: _____

Relationship to Subscriber: _____ Self _____ Spouse _____ Dependent _____ Other

Local Pharmacy: _____ Phone: _____/_____/_____

Mail Order Pharmacy: _____ Phone: _____/_____/_____

Emergency Contact: _____

Relationship: _____ Phone: _____/_____/_____

I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR THE PROFESSIONAL SERVICES RENDERED TO ME. I HAVE READ, COMPLETED, AND UNDERSATND THE INFORMATION ON THIS FORM. I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT. **I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THIS OFFICE OF ANY CHANGES TO THE INFORMATION ABOVE**.

_____ _____/_____/_____

Signature of Patient/ Legal Representative Date

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No Show & Late Cancellation Policy

As a courtesy to our patients, we attempt to call and confirm each appointment at least one day ahead of time. This method allows us to schedule any patients that need immediate attention and to cut loss on any patients that do not show up to their scheduled appointment. However, **it is your responsibility to properly record and maintain all appointments at HA Grand MD PA, or to cancel in accordance with our cancellation policy**.

Please be aware that a fee will be assessed for any appointments missed or cancelled with less than a 24 hour notice. Failure to maintain an appointment or to cancel an appointment within an appropriate time frame denies our practice to serve other patients. We understand that occasions might arise that will prevent you from coming to your appointment; we just ask that you let us know so that we can accommodate other patients.

This fee schedule is based on the amount of time that has been reserved for your care and will be assessed at the rates detailed below:

20 minute appointment slot	$50.00
1 hour physical appointment slot	$100.00

Be certain to reschedule any such appointments as soon as possible to insure appropriate attention for your medical condition(s), current therapies or preventative healthcare.

NOTE: Patients arriving late for a scheduled appointment will be “worked into” our schedule and will be seen as soon as possible, depending on our current patient flow. Patients may be asked to reschedule if we cannot accommodate them the same day and will be subject to the fee mentioned above.

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Health Maintenance Financial Responsibility

Your health is very important to us. We strive to do our best in helping you, as problems or symptoms occur. More importantly, we want to help you avoid these problems before they begin. We refer to this type of care as "Health Maintenance" or "Preventative Medicine" and it consists of inquiries about immunizations, lifestyle practices, cancer screening (such as mammography, colonoscopy, and PAP smears), and annual physicals.

Your annual exam is an evaluation of both your physical and mental health which requires time and effort. It is essential to our providing you with quality medical care. Unfortunately, Medicare and some private insurance carriers (depending on what benefits you or your employer has purchased) will not reimburse us for these services despite the fact that we, your physicians, know these are critical to your health and well-being.

If you know, for a fact, that your medical benefit does not include preventative care, please let us know so that we may avoid any financial burden that comes with providing these services to you. We do provide a discount for patients without insurance or insurance that does not cover routine physical exams or its components.

We hope that you understand the necessity of these services, as well as any fees accompanying them. These services are truly for your benefit. If you have any questions regarding this policy, you may speak with us at any time. We look forward to keeping you happy and healthy for many years.

NOTE: It is your responsibility to know what will or will not be covered through your insurance. As a courtesy to our patients, we will discount any labs or other services performed during your physical to help you financially.

I HAVE READ THE ABOVE PHYSICIAN STATEMENT AND I UNDERSTAND MY FINANCIAL RESPONSIBILITIES. AS EXPLAINED ABOVE, SHOULD MY INSURANCE CARRIER NOT REIMBURSE MY DOCTOR FOR ANY PREVENTATIVE SERVICES ORDERED ON MY BEHALF, I WILL BE FINANCIALLY REPONSIBLE FOR PAYMENT.

_____ _____/_____/_____

Signature of Patient/ Legal Representative Date

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Referral Policy

Different scenarios will generate the need for you to seek additional medical care from a specialist. Many insurance companies require referrals for you to see a specialist.

Obtaining a referral or pre-authorization is a time consuming process for both you and our staff. Understanding your benefits and how they relate to referrals and authorizations is essential.

Please review your health insurance policy to determine if you need a formal authorization (referral) to see a specialist. Normally you can find this information in your policy holder's manual. If you do not have a manual, call your insurance company to obtain one. If your insurance company requires a formal referral to see a specialist, and we have not recently seen you for the problem, **you will need an office visit to obtain that referral**. Your insurance company requires that we establish and document a diagnosis in order to write a referral. Once you have been seen, we will process your referral and fax it to the specialist's office. The specialist's office will contact you to schedule an appointment or consultation.

Please do not make any appointments prior to receiving your referral.

Our office requires **5** business days to complete your referral. **We will not process any referrals for patients that schedule their own appointment and call us from the specialist's office on the day of their appointment.**

Be sure to remember, we cannot backdate referrals.

If you are requesting a referral to a particular doctor of your choice, you must provide our office with the name of the provider, the provider's National Provider Identification (NPI) number, their office phone and fax number, also let us know why you are going to see the doctor. We will need this information when you come in for your appointment in our office.

**** If your insurance company **does not** require a formal, written referral, you may make specialty appointments at your convenience. When making appointments, please verify that the provider participates with your insurance carrier.

_____ _____/_____/_____

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Medical Records Release

Please list any persons that you would like to have access to your medical records.

Spouse:

_____

_____

_____

Parents:

_____

_____

_____

Child(ren):

_____

_____

_____

Other (please include their relations to you):

_____

_____

_____

_____ _____/_____/_____

Patient/ Legal Representative Date

Print Name

_____ _____/_____/_____

Signature of Patient/ Legal Representative Date

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Notice of Privacy Practice For HA Grand MD PA

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how we may use and disclose your protected health information and the rights that you have regarding your health information.

Uses and Disclosures of Protected Health Information

We may use your health information for purposes of providing treatment, payment, and conducting health care operations. Disclosures of your health information for the purposes described in this notice may be made in writing, orally, or by facsimile.

Treatment and Alternatives

We may use and disclose your health information to tell you about possible treatment options or alternatives and other health related benefits that may be of interest to you.

Payment

Your health information will be used to obtain payment for the services that we provide. This may include certain communications to your insurance company to get approval for treatment that we may recommend and to demonstrate the medical necessity of services provided. We may also disclose your health information to another provider so they may obtain payment for services provided with the involvement of your care.

Operations

We may use and disclose your health information for our health care operations, including quality assessment, utilization review, medical review, internal auditing, credentialing, certain medical research, and educational purposes.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Remind you of an appointment

Uses and Disclosures Beyond Treatment, Payment, Health Care Operations Permitted Without Authorization or Opportunity to Object

When legally required we may have to disclose your health information to the public health department, law enforcement, organ procurement organizations, correctional institutions, worker's compensation, health oversight agencies, medical examiner, and funeral directors.

Uses and Disclosures Permitted Without Authorization but With Opportunity to object

Unless you object, we may disclose your health information to family members, other relatives, close personal friends, or any other person (s) who are involved with your medical care or payment.

Uses and Disclosures Which You Authorize

Authorization to disclose your health information will be made only by you in writing, unless we are required by law to do so. You may also revoke this authorization in writing at any time.

Your Rights

Under Federal law you may not inspect or copy psychotherapy notes, information compiled in anticipation for use in a civil, criminal, administrative action or proceeding. Depending on the circumstances, you may have the right to have a decision in denying access reviewed. The following are your rights:

Inspect and obtain a copy your protected health information.

A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. A written request must be submitted to obtain your records and a fee may apply for copying and mailing your records. You may have access to these records for as long as we maintain your health information.

We may deny your request to view or copy your records if upon our professional judgment we determine the request is likely to endanger your life, safety, or to cause harm to another person referenced within the information.

Request a restriction on uses and disclosures of your protected health information.

Your written request must state the specific restriction requested and to whom you want the restriction to apply. Also, we are not required to agree to a restriction but we will notify you of a denial to a restriction. Under certain circumstances we may be required to disclose your information to provide emergency treatment if a restriction is made.

Request to receive confidential communications from us by alternative means or location

Have your physician amend your protected health information

A written request must be provided and a reason to support the requested amendments. In certain cases we may deny your request. All requests must be submitted to our Privacy Officer.

You have the right to receive an accounting of uses and disclosures.

This list will not include disclosures of your health information made for treatment, payment, or health care operations, made to you, or made pursuant to an authorization signed by you.

The request should state the time period for which you wish to receive an accounting and should not exceed a time period of six years or include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. Subsequent accounting requests may be subject to a reasonable fee.

Right to obtain a paper copy of this notice

Our Duties

We are required by law to maintain the privacy of your health information and abide by the terms of this notice. We are also required to provide you with this Notice of our duties and privacy practices.

Complaints and Contact Person

Complaint may be directed to our Privacy Officer and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. Your complaints may be submitted in writing, verbally, or by telephone to the person below. We encourage you to express any concerns you may have regarding the privacy of your information.

HARRELL A. GRAND
3801 GASTON AVE, STE 315
DALLAS, TX 75246
ATTN: PRIVACE OFFICER

Effective Date

This Notice is effective April 14, 2003.

I ACKNOWLEDGE THAT I HAVE RECEIVED AND UNDERSTAND THE ATTACHED NOTICE OF PRIVACY PACTICES.

_____ _____/_____/_____

Signature of Patient/ Legal Representative Date

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Comprehensive Patient History Form

Patient Name: _____ Date: _____

Describe your main problem _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

Most Recent Physical Exam: _____Most Recent EKG: _____

Most Recent Chest X-Ray: _____Most Recent Mammogram: _____

Allergies: _____

Have you ever had the following?

Diabetes.....	yes	no
Hypertension.....	yes	no
Cancer.....	yes	no
Stroke.....	yes	no
Heart trouble.....	yes	no
Arthritis/gout.....	yes	no
Convulsions.....	yes	no
Bleeding tendency.....	yes	no
Acute infections.....	yes	no
Venereal disease.....	yes	no
Hereditary defects.....	yes	no

List previous hospitalizations/Surgeries/Serious Injuries When

_____ _____
_____ _____
_____ _____

List medications you are currently taking:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

Patient Social History

Marital Status: ___Single___Married___Separated___Divorced___Widowed
Sexual Orientation: ___Exclusively Heterosexual____Homosexual____Bisexual
___Will discuss during physician interview
Use of alcohol: ___Never___Rarely___Moderate___Daily
Use of tobacco: ___Never___Previously but quit___Current packs/day_____
Use of Drugs: ___Never___Type/Frequency_____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Paternal Grandparents	_____	_____	_____
	_____	_____	_____
Maternal Grandparents	_____	_____	_____
	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings'	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

PLEASE ANSWER ALL QUESTIONS

Have you experienced any of the following?

CONSTITUTIONAL

Good general health lately.....	No	Yes
Recent weight gain.....	No	Yes
Fever.....	No	Yes
Fatigue.....	No	Yes
Headaches.....	No	Yes

EYES

Eye disease or injury.....	No	Yes
Wear glasses/contact lenses.....	No	Yes
Blurred or double vision.....	No	Yes
Glaucoma.....	No	Yes

ENT

Hearing loss.....	No	Yes
Ringing in the ears.....	No	Yes
Earaches or drainage.....	No	Yes
Sinus problems.....	No	Yes
Nose bleeds.....	No	Yes
Mouth sores.....	No	Yes
Bleeding gums.....	No	Yes
Bad breath or bad taste.....	No	Yes
Sore throat or voice change.....	No	Yes
Swollen glands in neck.....	No	Yes

CARDIOVASCULAR

Heart trouble.....	No	Yes
Chest pain.....	No	Yes
Sudden heart beat changes.....	No	Yes
Swelling of feet, ankles or hands.....	No	Yes

RESPIRATORY

Frequent coughing.....	No	Yes
Spitting up blood.....	No	Yes
Shortness of breath.....	No	Yes
Asthma or wheezing.....	No	Yes

GASTROINTESTINAL

Loss of appetite.....	No	Yes
Change in bowel movements.....	No	Yes
Nausea or vomiting.....	No	Yes
Frequent diarrhea.....	No	Yes
Painful bowel movements or constipation	No	Yes
Blood in stool.....	No	Yes
Stomach pain.....	No	Yes

GENITOURINARY

Frequent urination.....	No	Yes
Burning or painful urination.....	No	Yes
Blood in urine.....	No	Yes
Change of force of strain when urinating.....	No	Yes
Incontinence or dribbling.....	No	Yes
Kidney stones.....	No	Yes
Sexual difficulty.....	No	Yes
Male – testicle pain.....	No	Yes
Female – pain with periods.....	No	Yes
Female – irregular periods.....	No	Yes
Female – vaginal discharge.....	No	Yes

Female - # of pregnancies ____# of miscarriages ____
Female – date of last pap smear_____
Female – findings of last pap smear ___Normal ___Abnormal

MUSCULOSKELETAL

Joint pain.....	No	Yes
Joint stiffness or swelling...	No	Yes
Weakness of muscles or joints.....	No	Yes
Muscle pain or cramps.....	No	Yes
Back pain.....	No	Yes
Cold extremities.....	No	Yes
Difficulty in walking.....	No	Yes

SKIN

Rash or itching.....	No	Yes
Change in skin color.....	No	Yes
Change in hair or nails.....	No	Yes
Varicose veins.....	No	Yes
Breast pain.....	No	Yes
Breast lump.....	No	Yes
Breast discharge.....	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy.....	No	Yes
Convulsions or seizures.....	No	Yes
Numbness or tingling sensations	No	Yes
Tremors.....	No	Yes
Paralysis.....	No	Yes
Stroke.....	No	Yes
Head injury.....	No	Yes

PSYCHIATRIC

Memory loss or confusion.....	No	Yes
Nervousness.....	No	Yes
Depression.....	No	Yes
Sleep problems.....	No	Yes

ENDOCRINE

Glandular or hormone problem.....	No	Yes
Thyroid disease.....	No	Yes
Diabetes.....	No	Yes
Excessive thirst or urination.....	No	Yes
Heat or cold intolerance.....	No	Yes
Dry skin.....	No	Yes
Change in hat or glove size.....	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts.....	No	Yes
Easily bruise or bleed.....	No	Yes
Anemia.....	No	Yes
Phlebitis.....	No	Yes
Past transfusion.....	No	Yes
Enlarged glands.....	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:		
Penicillin or other antibiotics.....	No	Yes
Morphine, Demerol, other narcotics	No	Yes
Novocaine or other anesthetics.....	No	Yes
Tetanus antitoxin or other serums...	No	Yes
Iodine, merthiolate, other antiseptic	No	Yes

Known food allergies: _____

Patient Signature: _____

Physician Signature: _____