Dr. Keith Rigsby, MDPA
Jareka Anderson. Nurse Practitioner
Courtney McKey, Practice Manager
601 South Clay Street, Suite 104
Ennis, TX 75119
(972) 875-6600

VIP HEALTHCARE

New Patient Registration

Please complete these forms before arriving for your appointment

FINANCIAL POLICY

VIP Healthcare wants to provide our community with healthcare services. To do this, we need your help. We ask you to read and agree to our payment policy below:

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between you and the insurance company.
- You need to contact your insurance company with any questions about what services are covered.
- We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at VIP Healthcare will help to arrange a budget plan.
- Any bill not paid by the date it is due will be sent to a collection agency.

If you DO NOT have health insurance

Your Responsibility

- You must pay your entire bill at the time of service or inform us of your inability to pay.

Our Responsibility

- VIP Healthcare will provide the services you need, even if you cannot pay at the time of service but will require you to meet with a Patient Financial Representative to discuss payment options.

If you HAVE health insurance

We participate with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your health benefits.
If we DO participate with Your insurance plan:

Your Responsibility

- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance company. Payment is due upon receipt of the statement, except for those from whom VIP Healthcare can not collect by law or agreement. If you do not pay we will begin collection efforts.

Our Responsibility

- We will send a bill to your insurance company for all services perform at our office.

If we DO NOT participate with your insurance plan:

Your Responsibility

I. You must pay for the service at the time it is given

To make it simple, our office accepts cash, checks, VISA, MasterCard, Discover, MAC (debit), and bank drafts.

We will charge you a $25.00 fee for any returned checks.

Our Responsibility

II. After you have paid us, we will send your bill to your insurance company. Your insurance will then pay you.

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient who receives care and treatment from VIP Healthcare must pay any charges that are not paid by insurance or any other party.

Other providers, such as specialist and outpatient facilities, will bill the patient separately.

The patient must pay any amount not paid by insurance upon receipt of the statement.

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601 South Clay ST. Suite 104 | Ennis , Texas 75119 Phone: 972-875-66001 Fax:817 -391·3 252 | viphealthcare.ennis@gmail.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____
Last Name First Name

Previous Name:_____ Social Security #:_____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____

Facility Address:_____ Facility Fax:_____

City, ST, Zip: _____

The purpose of disclosure is:

_____ Change of Insurance or Physician _____ Referral _____ Other

This request and authorization applies to:

Dates and Type of information to disclose:
_____ 2 years prior from last date seen
_____ Dates Other: _____
_____ Specific Information Requested: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:
Release To: _____
Address: _____
City, State, Zip: _____ Phone: _____

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization

_____ _____
Patient Signature /Parent/Guardian or Authorized Representative Date

VIP HEALTHCARE

PATIENT INFORMATION

Last Name: First Name: MI:

Address: Mailing Address:

City: State: Zip:

Date of Birth: Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Responsible Party (if under 18): Phone:

PATIENT CONTACT

Home Phone Cell Phone

Appointment Reminder Preference: (Please choose one) ☐ Home or ☐ Cell If Cell: ☐ Voice or ☐ Text

Email Address for Patient Portal Use: Drivers License & State Issued:

Emergency Contact Name: Emergency Contact Phone:

Emergency Contact Address: Relation to You:

EMPLOYMENT

Employer Name: Retired ☐ Unemployed ☐ Disable ☐

INSURANCE

Primary: Policy/Group: Effective Date:

Secondary : Policy/Group: Effective Date:

Please bring your Insurance Card to each visit

Supplemental Data Collection:

Race:

☐ White ☐ Hispanic ☐ Black-African American
☐ Asian ☐ American Indian ☐ Native Hawaiian
☐ Other Pacific Islander ☐ Unreported/Refused to Report ☐ Other Race

Ethnicity:

☐ Hispanic ☐ Non-Hispanic ☐ Refused to Report

Preferred Language:

☐ English ☐ Spanish ☐ Other:_____

PATIENT PHYSICAN LIST

VIP HEALTHCARE

Patient Name

Date of Birth

I give VIP Healthcare permission to contact past and current physicians for diagnostic test results, and discuss protected health information with, the following Physician(s):

Doctor Name	Specialty
Address:	Telephone:
Doctor Name	Specialty
Address:	Telephone:
Doctor Name	Specialty
Address:	Telephone:
Doctor Name	Specialty
Address:	Telephone:
Doctor Name	Specialty
Address:	Telephone:

By signing this form I give VIP Healthcare permission to receive patient correspondence to the address provided.

Indicate your relationship to the patient: ☐ Patient ☐ Patient Representative

Print Name (if other than patient)

Patient Signature

Date

This form is valid for one year from effective date.

PATIENT QUESTIONNAIRE

VIP HEALTHCARE®

Patient Name | Date of Birth | Date of Visit

Do you have an Advanced Directive? Yes ☐ No ☐

Would you like to make or revise your Advanced Directive? Yes ☐ No ☐

Please list any surgery /operations you have had:

Date of Surgery:	Procedure	Surgeon's Name
Date of Surgery:	Procedure	Surgeon's Name
Date of Surgery:	Procedure	Surgeon's Name
Date of Surgery:	Procedure	Surgeon's Name
Date of Surgery:	Procedure	Surgeon's Name

Are you allergic to latex? Yes ☐ No ☐

Allergies: _____

PAST MEDICAL HISTORY

Do you have or have you every had any of the following

Cholesterol	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Thyroid Disease	Yes ☐	No ☐	Heart Disease	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Gallbladder	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Depression	Yes ☐	No ☐
	Yes ☐	No ☐	Sleep Apnea	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
HIV/AIDS					

Other: _____

FAMILY/SOCIAL HISTORY

Do you have a family history of:	**Relationship**
Heart Disease	
High Blood Pressure	
Diabetes	
Stroke	
Cancer	
Thyroid Disease	
Depression	
Dementia	

Your personal Habits:	**Do you?**
Exercise regularly	Yes ☐ No ☐
Smoke or use tobacco?	Yes ☐ No ☐
How Much?	
Use tobacco in the past?	Yes ☐ No ☐
Drink Alcohol	Yes ☐ No ☐
How Much?	
Have you ever had a blackout?	Yes ☐ No ☐
Recreational Drugs?	Yes ☐ No ☐

Patient Name _____ DOB

VIP HEALTHCARE

PAST /PRESENT

GENERAL HEALTH PROBLEMS
Fever or chills Yes ☐ No ☐

EARS, NOSE THROAT
Ear problems Yes ☐ No ☐
Nose problems Yes ☐ No ☐
Throat problems Yes ☐ No ☐

STOMACH
Nausea or vomiting Yes ☐ No ☐
Bowel problems Yes ☐ No ☐
Blood in stool or vomit Yes ☐ No ☐

LUNG OR BREATHING PROBLEMS
Coughing Yes ☐ No ☐
Wheezing Yes ☐ No ☐

BRAIN OR NERVES
Headaches Yes ☐ No ☐
Numbness or tingling Yes ☐ No ☐
Weakness Yes ☐ No ☐

GLANDS/HORMONES
Always thirsty Yes ☐ No ☐
Always feeling cold or hot Yes ☐ No ☐

ALLERGIES
Seasonal Allergies Yes ☐ No ☐
Food Allergies Yes ☐ No ☐
Medication Allergies Yes ☐ No ☐

EMOTIONAL
Over the last 2 weeks, how often have you?

1. Little or no interest or pleasure in doing things?
☐ Not at all ☐ Several days
☐ Half the days ☐ Nearly everyday

2. Felt down, depressed or hopeless
☐ Not at all ☐ Several days
☐ Half the days ☐ Nearly everyday

MEDICAL DEVICES/IMPLANTS
☐ None
☐ Hepatic Infusion Pump
☐ Dialysis access
☐ Insulin Pump
☐ Orthopedic implants

Patient Signature Date

Patient Name DOB

Current Medications: *Please include prescription medications, over-the-counter drugs, vitamins and supplements*

Name / Dose	# Tabs / Frequency	Name / Dose	# Tabs / Frequency
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Pharmacy: **Pharmacy Phone:**

Immunization Record:

Date/Year Last Dose Given

Tetanus
Pneumonia Vaccine
Flu Vaccine
Hepatitis Vaccine
Other

VIP HEALTHCARE

HIPAA Medical Information Release Form

Patient Name **Date of Birth**

Release of Information

I authorize the release of all medical information including the diagnosis (including HIV testing), records; examination rendered to me and claims information. This information may be released to the following persons: *Please check the appropriate box below*

☐ Spouse Name

☐ Child(ren)

☐ Other Relationship

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by the patient or patient representative in writing.

Phone messages

I authorize the release of all medical information to be left in voice messages on;

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Other number

I do **NOT** authorize the release of any medical information to be left in a voice message

☐

The best time to reach me is (*day*) between (*time*)

Patient Signature Date

Witness Date

Patient Consent Agreement for Chronic Care Management Services

Dr. Rigsby has recommended that I receive Chronic Care Management (CCM) services because I have been diagnosed with two or more chronic conditions, which are expected to last at least twelve months, and place my health at risk of decline.

I understand that CCM services include: 24/7 access to a member of my care team via phone or other non-face-face means; a designated practitioner or care team member with whom I am able to get successive routine appointments; systematic assessment of my health care needs; processes to ensure timely receipt of preventative care services; oversight of my medication regimen; a jointly created and comprehensive care plan that is congruent with my choices and values; management of care transitions across all of my providers and settings; coordination with home and community based clinical service providers.

By signing this agreement, I consent to receive these services and agree to the following:

- A representative of VIP Healthcare has explained the availability and the elements of the CCM services that are relevant for my condition(s).
- I consent to receive CCM services from the provider listed above and/or any associates he/she may designate to assist in providing me with CCM services.
- I understand that I have the right to stop CCM services at any time (effective at the end of a calendar month) with VIP Healthcare and the effect of a revocation of this agreement. I may revoke this agreement verbally by calling (972) 875-6600 or in writing to 601 South Clay Street, Suite 104 Ennis, Texas 75119. After revocation of this agreement, I may opt to receive CCM services from another healthcare provider in the month following revocation of this agreement.
- I understand that Medicare permits only one practitioner to furnish and be paid for these services during a calendar month.
- I understand that I will receive a written or electronic copy of my comprehensive care plan.
- I authorize electronic communication of my medical information with other treating providers.
- A representative of VIP Healthcare has explained potential cost-sharing obligations that may apply when receiving CCM services.

Patient Name Date of Birth

Patient Signature Date

New Patient Checklist

Thank you for choosing VIP Healthcare for your healthcare. VIP Healthcare would like to receive your medical records prior to your first appointment. Please, send copies to *601 South Clay Street, Suite 104, Ennis Texas 75119.*

The following is a list of items you need to bring with you for your first appointment;

Insurance card
Driver's license or alternate photo ID
Medication list: Please include all prescription and over-the-counter medications you are currenty taking , X-ray films, CT, PET, and/or MRI scans (only if available).

In addition to the above required items, we also suggest you bring the following with you to your appointment;
Friend or family member: Your first appointment may be a little overwhelming. A friend or family member can help in asking your doctor all the right questions and in remembering all that is discussed during your appointment.

Questions for your Doctor: Consider bringing your questions in a written form. This will help remember what questions you want answered. Bring a pen and notebook so you have a place to write the answer to your questions.

As a new patient to VIP Healthcare, please be on time for your scheduled appointment. Arrive 15 minutes prior to your appointment, you will be asked to pay copayments during each visit. These payments can be made by cash, check, or credit card.

Thank you for choosing VIP Healthcare !