PMC

PHAM MEDICAL CLINIC, P.A.

FAMILY MEDICINE

BAO THANG "TOMMY" PHAM, MD
12545 Briar Forest Dr. Ste A
Houston, TX 77077
P: (281) 531-5293
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PATIENT REGISTRATION FORMS

FULL LEGAL NAME: _____ **DATE OF BIRTH:** _____
First Middle Last

ADDRESS: _____ **CITY:** _____ **STATE:**_____ **ZIP:**_____

EMAIL: _____ **SOCIAL SECURITY #:** _____ **SEX:** ☐Male ☐Female

HOME #: _____ **CELL #:** _____ **WORK #:** _____

ETHNICITY: _____ **PRIMARY LANGUAGE:** _____

CHECK APPROPRIATE BOX: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

IF MARRIED: NAME OF SPOUSE: _____ **PHONE:** _____

IF THE PATIENT IS A MINOR: NAME OF PARENT/GUARDIAN AND RELATIONSHIP: _____

NAME OF SCHOOL OR EMPLOYER: _____

EMERGENCY CONTACT PERSON: _____
Full Name Relationship to you Phone #

INSURANCE POLICYHOLDER:

IF YOU ARE NOT THE INSURANCE POLICYHOLDER, PLEASE COMPLETE THE FOLLOWING:

POLICYHOLDER'S FULL LEGAL NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **CITY:** _____ **STATE:**_____ **ZIP:**_____

PHONE #: _____

RELATIONSHIP TO PATIENT: ☐ Parent ☐Step Parent ☐Spouse ☐Other _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF INSURANCE BENEFITS:

I authorize the release of any medical information necessary to process my medical claims. I permit a copy of this authorization to be used in place of the original. I have authorized Dr. Bao Thang Pham to apply for insurance benefits on my behalf for any services rendered by his order. I request that payment from my insurance company be made directly to Dr. Bao Thang Pham. **I certify that the information I have reported in regards to my insurance coverage is correct.** I am aware of my responsibility as a patient to keep my account up-to-date in regards to address, phone numbers, and insurance information for as long as I continue my care at this office. I understand that I am ultimately responsible for any balance on my account for services that have been rendered to me. This authorization is to remain in effect unless revoked in writing by me.

_____ _____
Signature of Patient or Legal Guardian **Today's Date**

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION (HIPAA FORM)

PATIENT'S FULL NAME (PRINTED): _____ **DATE OF BIRTH:** _____

Under the Healthcare Insurance Portability and Accountability Act (HIPAA), Pham Medical Clinic, P.A. must have your written and signed consent to disclose your health information for the following purposes:

FOR TREATMENT: We may use health information about you to provide with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, and personnel who are taking care of you and your health.

FOR PAYMENT: We may use and disclose health information so that treatment and services you receive at this office may be billed to and payment may be collected from you or your insurance company.

FOR HEALTHCARE OPERATIONS (doctor to doctor): We may use and disclose health information about you in order to run the office and make sure that you receive quality care.

FOR LABORATORY: REGARDING LABS (QUEST, LABCORP, ETC) AND OUTSIDE BILLING, YOU ARE ULTIMATELY RESPONSIBLE FOR ENSURING THAT YOUR SPECIMENS GO TO YOUR INSURANCE PLAN'S PREFERRED LAB. IF YOU ARE UNSURE, CALL YOUR INSURANCE FOR CONFIRMATION. PLEASE SPECIFY YOUR PREFERRED LAB.

Preferred laboratory: ☐ **BIOREFERENCE** ☐ **QUEST** ☐ **LABCORP** ☐**OTHER**_____

Comments: _____

FOR FAMILY AND FRIENDS: We may use and disclose health information about you to your family members or friends as directed by you. **PLEASE COMPLETE THE FOLLOWING:**

1. Please list the person(s) to whom we may disclose/discuss your health, treatment information, and/or payment arrangements. You have the right to limit the disclosure of any information.

Name: _____**Relationship**:_____ **Phone:**_____

Name: _____**Relationship**:_____ **Phone:**_____

FOR TEST RESULTS: If you consent to have your test results, correspondence, and/or billing statements to be mailed, faxed, or emailed at YOUR REQUEST, please select accordingly:

☐ **MAILED** ☐ **FAXED** ☐ **EMAILED**

***Do we have permission to leave a phone message on preferred contact number? Yes_____ No _____

Comments: _____

I understand that I may request a copy of the "Notice of Privacy Practices," which will describe more completely the above information. I also understand that I may list in the comment section any limitations regarding the disclosure of my protected health information. My signature is valid from this date unless I revoke this permission in writing.

_____ _____

Signature of Patient or Legal Guardian **Today's Date**

Pham Medical Clinic, P.A.

Bao Thang "Tommy" Pham, MD
12545 Briar Forest Dr. Ste A
Houston, TX 7707
Tel: (281) 531-5293
Fax: (281) 759-9175

FINANCIAL POLICY

Thank you for choosing us as your family physician. Our goal is to provide you with highest quality medical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS, AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON A CASE-TO-CASE BASIS.
- WE ACCEPT THE FOLLOWING METHODS OF PAYMENT: CASH/ VISA/ MASTERCARD/ DISCOVER/ AMERICAN EXPRESS/ APPLE PAY.
- WE ACCEPT ALL HEALTH SAVINGS ACCOUNT (HSA) PAYMENT.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- NO CHECKS ARE ACCEPTED.

*****There are additional fees that can apply to your account and will not be covered by your insurance plan, which are as follows:**

- A $25.00 MISSED APPOINTMENT fee applies to missed regular office visits, if you fail to cancel/reschedule before your scheduled appointment time.
- A $50.00 MISSED APPOINTMENT fee applies to missed Annual Wellness Exams and/or Well Woman Exams, if you fail to cancel/reschedule at least 24hrs before your scheduled appointment time due to the extra time allocated for these types of visits and the demand of these appointments.
- A $25.00 WALK-IN fee if you DO NOT have an appointment and want to be seen by a provider.

Please make note of these additional fees as they are non-negotiable and will be collected before ANY future services (such as office visits, medication refills, referrals, prior authorizations, etc.) are rendered. By signing this financial policy, I have read, fully understand, and accept these terms.

X

Patient's Full Name (PRINTED)	Signature of Patient or Legal Guardian	Date

Regarding the Utilization of Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this physician's office. However, you will be personally responsible for your account balances regardless of whether your insurance pays for the total balance of your claims unless you're eligible for discounts under our indigency policy predetermined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. We require that you make payment at time services are rendered if your insurance company/employee benefits plan has determined your claims to be the patient's responsibility for the reasons of annual deductible, copayment, coinsurance, and/or noncovered or not medically necessary services.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as a self-pay.

Regarding Affordable Care Act (ACA) Discount

We may offer Affordable Care Act (ACA) Discounts to uninsured (Self Pay) and under-insured patients. We may also waive or reduce your cost-sharing amounts, such as deductibles, co-insurance, and co-payments based on the individual medical needs and ability to pay, on a case-by-case, non-routine, unadvertised basis for under-insured patients, and after determining in good faith that you are in financial need or after reasonable collection efforts failed. Unless expressly prohibited by any specific terms of the health plan, we are fully in compliance with the terms of health plan, applicable federal and state laws under our Corporate Indigency Policy.

Once indigency is determined, collection is no longer undertaken with regards to the patient for the forgiven amount without waiving any patient financial and legal obligation or responsibility to the provider's actual total charges AND patient's right and eligibility, assigned to the provider, to claim for the reimbursement, under the health plan coverage. Our patient advocate collection efforts are proactive with indigency determination and subsequent claim submissions and/or appeals. Any patient balance billing is only consequential to administrative and/or judicial appeal outcomes and subject to proactive patient indigency agreement. You may apply for financial indigency ACA Discount assistance by asking our staff to determine if you are eligible.

Regarding Provider and Facility Charges

We will disclose to every patient our physician charges as clearly as practically possible before completing your medical or surgical procedures, but only if it is known to us beforehand. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you may be aware, your insurance company requires your physicians to charge and bill the services separately from other facilities or LABORATORIES. You shall not be surprised that you will receive separate billing in addition to this facility. If you have any questions about your diagnostic testing or other invoices, please direct your questions to your insurance provider.

While we do not anticipate any unforeseeable circumstances, we have no control over any such events that may arise. Should you require additional medical care in any event of complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital or urgent care. The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

Regarding PPO and HMO Network Participation

As you may know, you may have choice to choose a physician with or without PPO or HMO participation under different insurance coverage and benefits levels. We provide the highest quality of care to every patient; however, we have no power to change your insurance coverage or network limitations. Most health care plan or insurance policies may provide medical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose our current participation status of your insurance plan to you. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperation with your insurance company or health plan during claim processing such as responding to insurance inquiries, requests for additional information, and co-ordination of benefits verification or any other inquiries for the purpose of the finalization during claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your services rendered by this doctor, you agree to submit such insurance reimbursement checks to our office within fifteen (15) business days after your receipt of insurance checks owed to us. In a failure or refusal to forward us the insurance reimbursement checks for the medical services rendered by our providers, all of your discount arrangements will be voided. At that time, the total outstanding balance will be due immediately. You further agree to compensate us for any legal fees if we must retain any legal services to collect past due balances.

We are committed to serving you with highest quality care possible at affordable cost. Every staff at our office is ready to help you at all time. If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation.

****We will verify your insurance coverage for all anticipated services as a courtesy to you before every visit. However, please understand that insurance verification is not a guarantee of insurance payment and claims are processed at the time they are received. ****

I have read, fully understand, and agree to this Financial Policy.

X

Patient's Full Name (PRINTED)	Signature of Patient or Legal Guardian	Today's Date

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Disclosure and Authorization Form for Patient Referral to Other Physicians or Facility
"Advocacy for Patient's Freedom of Choice for Providers"

Dear _____ [Patient's Full Name (PRINTED)]:

In order to better serve you with the highest quality of care and safety at the most affordable costs, sometimes it is necessary and important to have other providers or entities to join our team to complete or continue your medical procedures or treatment in order to ensure a speedy recovery for you. We would like to keep you informed of your choice and our recommendation of these other providers or entities and obtain your informed authorization before our referral and scheduling of possible future procedures or treatment begins. While no provider or entity can be participating in every managed care network, such as the one your health plan has contracted with, these other providers or entities may or may not be in your health plan's network. As a courtesy to you, we will verify your insurance coverage for participating and non-participating providers and/or entities and will obtain any necessary referral authorizations, if applicable, on your behalf. However, please understand that both the insurance verification and referral authorization process is not a guarantee of insurance payment according to your health plan's disclosure. If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider, please call the member services number on your Insurance Identification Card.

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctors and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and/or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred to; and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, as protected by all applicable federal and state laws, including Medicare, ERISA, PPACA, and the Section 102.006 of Texas Occupations Code.

Facilities with affiliation and remuneration: BioReference Laboratory; Cigna Healthspring; Vicare IPA; Verda Health Insurance; USPCP

I certify that the Advocacy for Patient Freedom of Choice for Provider(s) with the above specific disclosure from my provider(s) is in full compliance with the Section 102.006 of Texas Occupations Code, in a manner otherwise permitted under Section 102.001, in accepting remuneration to advocate, protect, secure, or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency. I certify that I was informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I have read, fully understand, and agree to this Disclosure and Authorization Form.

X

Patient's Full Name (PRINTED)	Signature of Patient or Legal Guardian	Today's Date

PATIENT'S MEDICAL HISTORY

The answers on this form will help your healthcare provider get an accurate history of your medical concerns and conditions.

MAIN REASON FOR TODAY'S VISIT: _____

Current Symptoms: _____

PAST MEDICAL HISTORY (Do you currently have or have had in the past any of the following conditions):

□ Allergy □ Anemia □ Anxiety □ Arthritis □ Asthma □ Blood Clot

□ Cataracts □ Colon Polyp □ Depression □ Diabetes □ Glaucoma □ Gout

□ Heart Attack □ Hepatitis □ High blood pressure □ High Cholesterol

□ Osteoporosis □ Pneumonia □ Seizure □ Stroke □ Thyroid

□ Cancer _____

□ Surgeries _____

Additional Comments: _____

SOCIAL HISTORY:

[Tobacco Use] Do you smoke cigarettes: □ Never □ No (# of years quit: ____) □ Yes (# of years: ____)

Other tobacco products: □ Electronic Cigarette/Vape □ Pipe □ Cigar

□ Snuff □ Chewing Tobacco

[Alcohol Use] Do you drink alcohol? □ No □ Yes # of drinks per week: _____

Type: □ Beer □ Wine □ Liquor

[Drug Use] Do you use marijuana or recreational drugs? □ No □ Yes

HEALTH MAINTENANCE SCREENING TESTS:

Your Last Complete Physical Exam (annual wellness exam): Date: _____

Sigmoidoscopy or Colonoscopy (circle one): Date: _____ Polyps? □ No □ Yes

Bone Density Test: Date: _____ Normal? □ No □ Yes

WOMEN'S HEALTH HISTORY: *(If you are male, please skip to the next page)*

Total number of pregnancies: _____ Number of live births: _____

Date (month/day if known) of your last menstrual period (if you are still menstruating): _____

Menopausal? □ No □ Yes (If yes, please list your age when menopause began: _____)

Last Mammogram Date: _____ Normal? □ No □ Yes

Last Pap Smear Date: _____ Normal? □ No □ Yes

FAMILY HISTORY (List any immediate family members' serious health problems and/or cause of death):

Mother:

Father:

Siblings:

Others:

ALLERGIES OR INTOLERANCE TO MEDICATIONS (include type of reaction): □ **NONE**

List: _____

PHARMACY INFORMATION:

Pharmacy's Name: _____ Phone: _____

Address or Street Intersection: _____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc.

□ **TAKE NO MEDICATIONS**

Medication Name/ Dosage/ How many times per day?

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

****PLEASE USE THE BACK OF THIS PAGE IF YOU NEED TO LIST MORE MEDICATIONS****

Patients are responsible for any updates on medical history, medications, and/or changes in pharmacies.

PATIENT'S FULL NAME (PRINTED): _____ TODAY'S DATE:_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____