Welcome to Adult Health Services

We are so happy you have chosen AHS to be your primary care provider.

Please fill out the enclosed new patient packet completely and sign.

Scheduling appointments: Call our office at 214-518-5016 to schedule your appointment. At that time, we will verify your insurance and schedule your first appointment.

We normally schedule follow up appointments approximately every four weeks depending on your medical needs. For acute issues, please call our office and we will get you scheduled as soon as possible based on your need. We try to do same day appointments if medical need dictates, so please do not hesitate to call.

Office Hours: Monday through Friday 8:30 am to 5:00 pm and we do offer Saturday hours from 9:00 am to noon for scheduled appointments. If you call during business hours and leave a message our staff will return your call the same day. If a message is left after hours, we will return the call the next business day for non-urgent matters.

X-rays and Labs: Normal lab work and x-rays will be discussed at your next scheduled visit. For abnormal labs or abnormal findings our Provider will contact you directly for medication changes or directions for appropriate action to resolve your issue.

Prescription refills: Please call your pharmacy for prescription refills at least 5 days in advance of when your medication is empty. If there are no refills left, the pharmacy will contact our office to request additional refills.

All medication requests can be faxed to 214-237-1280.

For any questions please call our office at 214-518-5016.

Again, thank you for choosing AHS,

Tracy Cook, NP-C
Mary Sherwood, FNP
AHS Staff

New Patient Data Sheet

Name: _____

Date of Birth: _____

Address: _____ Apt # _____

Sex: M or F

Primary Insurance: _____ Policy #_____ Group #_____

Secondary Insurance: _____ Policy #_____Group #_____

Emergency Contacts:

Name: _____ Email: _____

Address: _____

Phone Number: Home: _____ Cell: _____

Service Providers:

Specialist: Type: _____ Name: _____

Phone Number: _____

Specialist: Type: _____ Name: _____

Phone Number: _____

Pharmacy: _____ Phone Number: _____

Home Care Provider: _____ Phone Number: _____

Hospital of Choice: _____

Resident has Living Will: _____ Medical Power of Attorney: _____

Do Not Resuscitate: _____ Please provide copies of all as applicable.

Consent and Financial Policy

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Thank you for choosing AHS as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you

PLEASE INITIAL IN EACH SPACE BELOW:

_____**AUTHORIZATION TO MAIL, CALL, OR E-MAIL: Name:** _____ **Phone Number:** _____
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize an Argyle Health Services, PLLC dba Adult Health Services representative or my practitioner to mail, call, or e-mail me/ or above name with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the Argyle Health Services, PLLC dba Adult Health Services to that effect in writing.

_____**LAB / X-RAY / DIAGNOSTIC SERVICES:**
I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, X-Ray, EKG, and any other screening service or diagnostic testing ordered by the practitioner or the practitioner's staff. I understand that I may receive a separate bill for these services.

_____**CONSENT TO TREATMENT:**
I hereby consent to evaluation, testing, and treatment as directed by my Argyle Health Services, PLLC dba Adult Health Services or his / her designee.

_____ **FINANCIAL**: I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current. **Person Financially Responsible (Guarantor)** if other than patient: Name: _____ DOB: _____ Relationship to patient: _____

_____ **FINANCIAL**: Adult Health Services will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Adult Health Services if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending practitioner

Signature of Responsible Party: _____ **Date:**_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to practitioner's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Argyle Health Services, PLLC dba Adult Health Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: _____ **Date:** _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your practitioner, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practitioner's practice, and any other use required by law.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR your protected health information may be provided to a practitioner to whom you have been referred to ensure that the practitioner has necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations. We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited to:

- Quality control
- Licensing
- Employee reviews
- Training of medical students

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health Issues, Communicable Disease, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, law Enforcement; Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under Lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your practitioner or the practitioner's practice has taken an action in relation to the use or disclosure indicated in the authorization.

11105 Landmark Ct Denton TX 76207 TEL. 214.518.5016. FAX. 214.237.1920

Your Rights
Following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect and copy your Protected Health Information. Under federal law, however, you may not inspect or copy the following records - psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions, and whom they apply.

Your practitioner is not required to agree to a restriction that you may request. If practitioner believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the right to have your practitioner amend your Protected Health Information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints - You may complain to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 if you believe your privacy rights have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on Feburary 1, 2016.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

11105 Landmark Ct Denton TX 76207 TEL 214.518.5016, FAX 214.237.1820

PATIENT HISTORY FORM PAGE 1

Name:_____ **Date:**

New Patients

Last Doctor:
Address
City, State, Zip
Phone:
Date Last Appointment
Date Last Chest X-ray:

Last EKG date:
Last Physical:

ALLERGIES:

Name of Allergen	Type of Reaction

MEDICATIONS: (List all, including over the counter or others not prescribed for you - you may use back of this form)

Drug Name	Strength/Dose	How Often	Apx Date Started

CURRENT MEDICAL PROBLEMS:

Problem	Doctor	Current Status

PREVIOUS HOSPITALIZATIONS:

Hospital	Doctor	Reason

11105 Landmark Ct Denton TX 76207
TEL: 214.518.5016, FAX 214.237.1280

SURGERIES: (please note approximate date or age)

	Appendectomy		Heart Angioplasty		Hysterectomy		Other:
	Prostate removal		Carotid Artery		Breast Biopsy		
	Cataracts		Stomach Surgery		Mastectomy		
	Hernia Repair		Gall Bladder		Tubal Ligation		
	Vasectomy		Tonsillectomy		C-Section		
	Heart Bypass		Bariatric Surgery		Ovary R / L		

IMMUNIZATIONS: (Indicate approximate date of most recent)

	Flu		Pneumonia		Prevnar 13		Other:
	Shingles		Tetanus/Tdap				

DIABETIC HEALTH: (Please answer yes or no, or provide date for the following)

Y N	Are you Diabetic?
Y N	Do you test your sugar at home with a glucose meter?
Y N	Do you know what to do if your sugar is too high or too low?
	Date of last diabetic foot exam
	Date of Last Diabetic (Retinal) Eye exam - Please provide name of doctor as well
	When did you last attend diabetic education courses?
	Date and reading of last A1c test

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PATIENT HISTORY FORM PAGE 2

Name:_____ **Date:**

FAMILY HISTORY: (Please indicate which relatives have the following health problems (ie: Mother, Father, sister, aunt, etc)

Indicate current age(s) or age at time of death

	Living?		Age	Present Health Problems or Cause of Death
Father	Y	N		
Mother	Y	N		
Brothers	Y	N		
Sisters	Y	N		
Children	Y	N		

ADVANCED DIRECTIVES: (Please answer yes or no, or provide the requested information for the following)

Y N	Do you have a Living will?
Y N	Are you an Organ Donor?
Y N	Do you have a Durable power of attorney for health care?
	Name of Designee:
	Relationship:

Blank forms for advanced directives and medical power of attorney are available upon request. These forms are not intended as legal information, but general information on issues commonly encountered. Argyle Health Services, PLLC dba Adult Health Services is not a law firm and is not a substitute for an attorney.

I certify that the information on this form is complete and correct

Signature: _____ **Date:**

Relationship to patient: _____

11105 Landmark Ct.
Denton, TX 76207
Phone: (214) 518-5016
Fax: (214) 237-1280

Authorization and Request for Release of Medical Information

Patient Name: _____
Last 4 of SSN: _____
Date of Birth: _____

RELEASE RECORDS __ TO __ FROM
Argyle Health Services, PLLC DBA Adult Health Services
11105 Landmark Ct Denton, TX 76207
Phone: (214)518-5016

RELEASE RECORDS __ TO __ FROM
_____
_____
_____

Request is made and permission is granted to release the following:

_____ Admission History and Physical
_____ Alcohol or Substance Abuse Records
_____ Discharge Summary
_____ EKG / Echo / Stress Results
_____ Entire Health Record
_____ Eye Exam Results
_____ Imaging Results
_____ Lab Results
_____ Mammogram Results
_____ Mental Health Records / Notes
_____ Office Visit Notes
_____ Operative / Procedure Reports
_____ Pathology / Biopsy Reports
_____ Treatment of AIDS or HIV records

Dates of service to include date from _____ **to** _____

The purpose of this request is for the following reason(s)
_____ at the request of the individual
_____ for continuity of medical management
_____ transfer of care to another provider or leaving the area.

This authorization shall expire on the earlier of 6 months from the date signed, or on (Date) _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Argyle Health Services, PLLC dba Adult Health Services Attention Medical Release Correspondent, at the above address.

I hereby authorize AHS or Adult Health Services to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

Patient Name: _____
Patient Signature: _____ **Date:** _____
Phone: _____

Legal Representative: _____ Date: _____
Relationship: _____

Witnessed by: _____ Date: _____

Tracy Cook, RN, NP-C