G. DeAn Strobel, MD, PA

Hormonal Balance & Wellness

G. DeAn Strobel, MD * Susan Lee Fisher, PA-C * Brooke Lipscomb, PA-C * Angelica Ortiz, NP * Jessica Morton, NP
230 East Evergreen Street * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279

NEW PATIENT INFORMATION

Name ____ Birthdate ________________Today's date: ______________________
Address: ____City: ________________________State: __________
Primary Care Physician: _________________________ Marital status: Married Single Divorced Widowed Separated
How did you hear about us? Doctor? _________________ Friend? __________________ Patient here? ___________________
Internet? ____________________ Facebook? ___________ Newspaper? ______________ Other? ______________________

Provide the following if person responsible for payment is different than patient:

Insured's name/Name of Person Responsible for Payment: ____
Their Address: ____City ___________________________State__________
Zip Code: ____________________________SSN:______________________________DOB: _________________________

Provide insurance information if you have not already provided this information to the office OR if the information has changed.

Primary Insurance: (please circle one) PPO HMO Other Unsure
Name of Insured: ____ Group Number: _______________________
Policy Number: ______________________________ Patient's relationship to insured: ______________________________
Insurance address:____

Secondary Insurance: (please circle one) PPO HMO Other Unsure
Name of Insured: ____ Group Number: _______________________
Policy Number: ______________________________ Patient's relationship to insured: ______________________________
Insurance address:____

I plan to make payment of my medical expenses as follows (please check one or more):

CASH CHECK MasterCard VISA AMER EXPRESS DISCOVER CARE CREDIT

I authorize G. DeAn Strobel, MD, PA to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand that I am responsible for all medical fees during my treatment at G. DeAn Strobel, MD, PA.

If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to G. DeAn Strobel, MD, PA. I also certify that the above information is correct to the best of my knowledge.

____

Patient/Guardian Signature Date

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MEDICAL & FAMILY HISTORY FORM

Do you: Smoke? YES or NO If yes, how many packs per day __________ # Years smoked ____________
Drink Alcohol? YES or NO If yes, how many drinks per day? __________
Drink soda/coffee/tea? _____________ How many per day? _______________________
Use artificial sweeteners? __________ How much per day? _____________________
Do you have problems with milk or dairy products? YES or NO Other foods? _________________________

List the prescription and over-the-counter medications you are now taking:

__________________________________ ____________________________________ ___________________________________
__________________________________ ____________________________________ ___________________________________

List any supplements, herbs or vitamins that you are taking:

__________________________________ ____________________________________ ___________________________________
__________________________________ ____________________________________ ___________________________________

Are you interested in weight loss? If so, please list all medications, products that you have tried in the past and how they worked for you. Also, list any special diets or meal plans that you have tried in the past.

__________________________________ ____________________________________ ___________________________________
__________________________________ ____________________________________ ___________________________________

List any allergies you have to drugs, food or other items:

__________________________________ ____________________________________ ___________________________________
__________________________________ ____________________________________ ___________________________________

Are you currently under medical care for any reasons? If yes, please explain: ____
____

WOMEN ONLY:

Age when menstrual periods began ____________________
Are your periods regular? ____________________ How Often? ____________
How many days do your periods last? ____________________
How many times have you been pregnant? ____________________
How many children born alive? ____________________
Are you menopausal? YES or NO If yes, did this occur NATURALLY or SURGICALLY? And at what age? ___________

Past Psychiatric/Mental Health Care: YES or NO

Therapist's Name: _________________________________ For How Long and When: _______________

List All Operations:

Operation Performed	Year	Hospital	Doctor

List all times you have been admitted to a hospital overnight (except for childbirth)

Reason Hospitalized	Year	Hospital	Doctor

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Have you had any of the following illnesses or conditions: (Please check all that apply)

☐ Measles	☐ Diabetes	☐ Typhoid	☐ Chronic constipation/diarrhea
☐ Rubella (German measles)	☐ Goiter/thyroid disease	☐ Malaria	☐ Ulcerative colitis or Crohn's
☐ Chickenpox	☐ Hives	☐ Other tropical diseases	☐ Rheumatoid arthritis
☐ Mumps	☐ Allergies	☐ Hepatitis	☐ Hashimoto's
☐ Whooping cough	☐ Eczema/psoriasis	☐ Venereal disease or sexually transmitted infection	☐ Osteopenia or osteoporosis
☐ Scarlet fever	☐ Mononucleosis	☐ Seizures	☐ Stroke or TIA
☐ Tonsillitis	☐ Rheumatic fever	☐ Meningitis	☐ Blood clots/DVT or pulmonary embolism
☐ Diphtheria	☐ Poliomyelitis	☐ Ear infections	☐ Glaucoma
☐ Asthma	☐ Pleurisy	☐ Heart murmur	☐ Bronchitis
☐ High blood pressure	☐ Low blood pressure	☐ Migraine headaches	☐ Angina or chest pain
☐ Tuberculosis	☐ Heart attack	☐ Infertility	☐ Ulcer
☐ Phlebitis	☐ Kidney stones	☐ Low hormones or low testosterone	☐ Bladder or kidney infection
☐ Depression or anxiety	☐ Heart stent	☐ Heart arrthymia	☐ Cancer

WOMEN ONLY:

☐ Endometriosis	☐ Breast cancer	☐ Uterine cancer	☐ Ovarian cancer
☐ Uterine fibroids	☐ Uterine polyps	☐ Abnormal pap smear	☐ Menstrual migraines
☐ Fibrocystic breast disease	☐ Breast pain	☐ Prior breast biopsy	

MEN ONLY:

☐ Enlarged prostate	☐ Difficulty urinating or emptying bladder completely	☐ Erectile problems	☐ Prostate cancer

Other serious illnesses: (Please Explain) ____
____
____

Please list the date and results (if known and if applicable) of your last:

Bone Density Scan: ______________________ Date: ______________
Mammogram: ______________________ Date: ______________
X-ray: ______________________ Date: ______________
EKG: ______________________ Date: ______________
Blood Count: ______________________ Date: ______________
Cholesterol: ______________________ Date: ______________
Blood chemistry: ______________________ Date: ______________

Date of last examination by a doctor: ___________ Doctor _______________ Results: ______________________
____

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PERTINENT SEXUAL HISTORY

Concerns about sexuality are sometimes difficult for many patients to discuss. These issues are important to discuss to evaluate risks AND to help with any concerns. In order to better address your needs, please answer the following questions.

Are you currently sexually active? YES or NO Sexual preference: MALES FEMALES BOTH

If over the age of 18 and you are not sexually active, is there a medical condition present in you or your partner that is causing this? YES or NO; If YES, please explain: ____

____

____

PERTINENT FAMILY HISTORY

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: ☐	Kidney Disease: ☐	Asthma: ☐	Mental Illness: ☐
Stroke: ☐	Bleeding Tendencies: ☐	Tuberculosis: ☐	Blood clots: ☐
Cancer: ☐	Seizures: ☐	Colitis: ☐	Other: ☐
Emphysema: ☐	Heart Disease: ☐	Anemia: ☐	
Ulcers: ☐	Sugar Diabetes: ☐	Gout: ☐	

Do you have several members of the family with an inherited disease OR several members in the family with cancer? YES or NO
If YES, please explain: ____

____

____

We like to communicate with your other doctor(s) from time to time to keep them abreast of any changing medical conditions and medications as well as to send them various test and lab results. Please list all your current doctors, as appropriate.

Primary care provider (PCP): ____________________ Gastroenterologist (GI): ____________________

Cardiologist (heart): ____________________ Pulmonologist (lung): ____________________

Surgeon: ____________________ Podiatrist: ____________________

Dentist: ____________________ Rheumatologist: ____________________

Some of our patients come to our clinic for specific concerns while others prefer most of their medical needs be performed here.

Will you be having your routine wellness exams with another provider? YES or NO? If so, who? ______________

Do you currently keep up to date on your vaccinations? If not, why not? ____________________

If so, please list the date of your most recent: Tetanus __________ Flu __________ Pneumonia __________ Shingles __________

If you are under the age of 26, have you received the Gardasil or HPV vaccine series? YES or NO?

It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.

____

Patient Signature Date

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Privacy Practice Notification

The Health Insurance Portability & Accountability of 1996 (HIPAA) is a federal program that requires all medical records and other identifiable health information used or disclosed by G. DeAn Strobel, MD, PA, in any form, whether electronically, on paper, or oral are kept properly confidential. This ACT gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services including medical laboratories by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Heath care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related issues and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorizations. You may revoke such authorization in writing, and we are required to honor and abide by your written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you may exercise by presenting a written request to our "Privacy Officer."

- ❖ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or another person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- ❖ The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.

- ❖ The right to inspect and copy your protected health information. There is a charge of $35 for the first 20 pages and the $.25 per page thereafter for copies.

- ❖ The right to amend your protected health information. You must make your request in writing to the privacy manager.

- ❖ The right to receive an accounting of disclosure of protected health information. You may request once annually with no charge. There is a $25 charge for all subsequent requests.

- ❖ The right to receive a paper copy of this notice upon request.

To file a complaint please notify: "The Department of Health & Human Services Office of Civil Rights", 200 Independence Ave. S.W., Washington, D.C. 20201 or call 1-877-696-6775.

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HIPPA Consent Form

PLEASE READ AND INITIAL ALL NINE (9) STATEMENTS BELOW

1. I understand that under the Health Insurance Portability and Accountability Act I have certain rights to privacy regarding health information. I have read the Privacy Practice notification provided. **Initials**: _______________

2. I authorize G. DeAn Strobel, M.D., P.A. office to leave messages via my answering machine or voicemail for appointments, reminders, general medical information, test results, billing, and/or referral information. **Initials:** _____________

3. I authorize G. DeAn Strobel, M.D., P.A. to communicate verbally with the following family member or friend: ____ regarding my appointments, test results, general medical information, or referral information. *(Verification to release any information will be by the patient's date of birth.)* If no name is written on the above line, then that means I do not want anyone at all to be able to speak with the clinic about my medical information. (This does not apply to minors.) **Initials**: ______________

4. I authorize G. DeAn Strobel, M.D., P.A. to release any medical information needed to determine payment for my services. **Initials:** _______________

5. I authorize G. DeAn Strobel, M.D., P.A. to release protected health information to only HIPAA covered entities (health plans, providers, medical laboratories and healthcare clearinghouses) on my behalf. **Initials:** ___________

6. I authorize my insurance carrier to make direct payments on my behalf to G. DeAn Strobel, M.D., P.A. for medical services furnished. **Initials:** ______________

7. I am aware I am responsible for co-payments, co-insurance, or any deductible at the time of services. **Initials**: _________________

8. Authorization is valid until rescinded by me in writing. **Initials**: ______________

9. I authorize G. DeAn Strobel, M.D., P.A. to evaluate and treat: ______________________________________.
   Initials: _______________ **(Patient Name)**

Patient/Guardian Name: _______________________________________ Date of Birth: ______________________

Signature: ____Today's Date: _______________________

Relationship to patient (if patient is a minor or unable to sign):____

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Financial Policy

TO OUR VALUED PATIENTS:

Thank you for choosing *G. DeAn Strobel, M.D., P.A.* We are committed to providing you with the best medical care possible. Please review a brief explanation of our policies & procedures below. If you have any questions, please ask one of our staff to assist you with an explanation. If you require further explanation, the billing administrator may be contacted. After you have read this document in its entirety, please sign below. Your signature constitutes an agreement to the procedures and policies of our practice.

Thank you,

Providers and Staff of *G. DeAn Strobel, M.D., P.A.*

OFFICE HOURS

We are open Mondays through Thursdays 8:30 A.M. to 4:30 P.M and Fridays 8:30 A.M. to 12:00 P.M. We are closed Memorial Day, Labor Day, Good Friday, Thanksgiving Day, Christmas Day and New Year's Day.

DEFINITIONS

<u>IN NETWORK:</u> We refer to "in network" as the insurance companies with whom we have a contractual agreement. If we are in network, we have agreed upon a pay scale with the insurance company. In other words, we have agreed to a discounted rate for members of the insurance carrier with whom we are contracted.

<u>OUT OF NETWORK/ NON-PARTICIPATING INSURANCE:</u> If we are not in network with your insurance carrier, we will bill your carrier as a courtesy. If payment is not received within 60 days, the balance becomes your responsibility. You, the patient, will have to contact your insurance company to determine why payment has not been made. Please be aware, you may incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check with your insurance company for benefits.

<u>ACCEPT ASSIGNMENT DEFINITION:</u> Accept assignment means that we agree to accept check payment from the insurance company for services rendered.

FINANCIAL POLICIES AND PROCEDURES

At *G. DeAn Strobel, M.D., P.A.*, we believe that all patients who come to this office deserve the best medical care that can be provided. For us to provide you with the highest quality medical care and current technology, we must ensure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

<u>PAYMENT AT TIME OF SERVICE</u>

As a courtesy, we will bill your insurance for all office visits. However, we ask that you pay any portion not covered by your insurance due to deductibles or co-payments on the day of service, unless otherwise specified in specific policies of *G. DeAn Strobel, M.D., P.A.*

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SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

BALANCES DUE AFTER INSURANCE PAYS

If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. Payment arrangements can be made for special circumstances by contacting the billing administrator within 30 days of the receipt of the invoice. It is your responsibility to contact our billing office to make special arrangements.

OUTSTANDING BALANCES

We urge you to keep your account current to avoid any misunderstandings with our office. All account balances past due over 90 days will be sent to an outside agency for collections. At that point, the account is out of our hands. If you need to make special arrangements, it is your responsibility to contact the billing administrator at our office before your account is sent to an outside agency.

PAYMENT ARRANGEMENTS

Under special circumstances, payment arrangements can be made. These arrangements are made with the "check out" receptionist or with the billing administrator. Our office can set this up for you as a courtesy. You will be sent a monthly statement. However, it is your responsibility to know your monthly due date, which will be determined at the time your payment arrangement is set up. After one missed payment, the account will be due immediately in its entirety or will be sent to an outside agency for collections.

PAYMENT OPTIONS

Our office accepts Visa, MasterCard, American Express, Care Credit and Discover. Our office also accepts money orders, checks or cash. There will be a $30 fee for all returned checks.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the 20 percent at the time of service. Payment plans can be set up for special circumstances.

CASH PAYMENT

If you pay cash, please ask for a receipt so that you will have a record of your payment.

BILLING PROCEDURE

You will receive a statement with your remainder balance once a reply is received from your insurance company. If you are self-pay or have not met your insurance plan's deductible, you should be prepared to pay for your visit before leaving the office. If you have an outstanding bill, you will be required to pay your account in full before being seen for subsequent appointments. If necessary, our billing office personnel will help you set up a budget plan. This will allow you to remain in good standing while you pay off your balance over a period of time.

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SURGERY

We require 100% prepayment prior to the scheduling of any elective surgery. If you wish, our office will be glad to process your insurance claim for surgical procedures. Please be sure that we have your correct insurance information.

SPECIAL FORMS

Any disability, insurance, or other forms will have a $20.00 processing fee.

TELEPHONE VISITS

A telephone visit is a visit between a provider OR nursing staff which reviews results and plan(s) of care. Most insurance carriers do not cover telephone visits.

TELEVISITS

A televisit is a virtual one-on-one office visit which is performed via a real-time 2-way audiovisual portal or app. This means that it takes place over an internet connection through a computer or cell phone. 'Visit' means that you will see a provider in real-time to discuss your health. The provider will be able to assess your symptoms and issues and make the necessary recommendations, including prescribing medications and scheduling follow up appointments. Most commercial insurance companies are covering televisits now, but some carriers have special requirements. It is your responsibility to know your coverage prior to having a televisit. We will require a payment or copayment PRIOR to the televisit. Your insurance will be billed as a courtesy in the same manner as an in-person office visit.

We are not able to offer televisits currently to patients who are not located in Texas.

NO SHOW FEE

We understand that an emergency may arise, and you may miss an appointment without notice. FOR AN ESTABLISHED PATIENT: With the first missed appointment with no notice, a letter will be sent to remind you to call to reschedule your appointment. With the second missed appointment without notice, there is a charge of **$50.00** which must be paid prior to future appointments or prescription refills. FOR A NEW PATIENT: We allot additional time for new patient's appointments. Therefore, a new patient missed appointment with no notice will result in a charge of **$50.00.** This charge must be paid prior to any future appointments. Established patients may be dismissed from the practice if there are three (3) no-shows.

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Financial Policy Signature Form

I, ____(name) verify by signing this document that I have received, read and understand *G. DeAn Strobel, M.D., P.A.* Financial Policy. I understand that payment is due in full at time of service. If my insurance changes or is no longer in effect, I understand that I am responsible for my balance in full.

____

Signature Date