G. DeAn Strobel, MD, PA

Hormonal Balance & Wellness

G. DeAn Strobel, MD * Karissa L. Cryer, DO * Angelica Ortiz, FNP * Katie Green, FNP * Daniela Castillo, FNP
230 East Sycamore Street * Suite 200 * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279
Save this on your computer then email to: info@drdeanstrobel.com

Patient Name _____ Birthdate _____Today's date: _____

NEW PATIENT INFORMATION

Address: _____City: _____State: _____ Zip code: _____
Home Phone: _____ Cell Phone: _____ Email: _____
SSN: _____ Pharmacy: _____City/State: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Marital status: Married Single Divorced Widowed Separated

Primary Care Physician: _____ City/State: _____
Local pharmacy & address: _____
Mail-order pharmacy & address (if applicable): _____

How did you hear about us? Doctor? _____ Friend? _____ Patient? _____
Internet? _____Facebook? _____ Newspaper? _____ Other? _____

Reason for Visit: (circle all that apply)
Yearly exam Hormones Bleeding Pain Bladder/Incontinence 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) 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

G. DeAn Strobel, MD, PA

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CREDIT CARD ON FILE

Is patient <18 or does patient have a legal representative/guardian? If not, skip to next section. If so, please complete the following:

Name of legal representative/guardian: _____
Parent/Guardian Cell Phone: _____Email: _____

DEFINITIONS

CREDIT CARD ON FILE is a way to store credit card information for current and/or future payments in a secure way. Our staff is not able to access your credit card information after it is stored in the system as this is stored securely within our HIPAA-secure electronic medical records. This may be done for several reasons:

1. For convenience
2. Payment plans
3. Pre-payment of scheduled services
4. Prior collections status
5. And more.

NO-SHOWS & SAME-DAY RESCHEDULING. A no-show is not showing up for visit (OR canceling/rescheduling without 24 hours' notice) OR not showing up within 15 minutes of scheduled time.

OUTSTANDING PATIENT BALANCE

Balance remaining after insurance pays claim which is not paid by patient (or guarantor) within 30 days.

PATIENT PAYMENT PLAN For patients with an outstanding balance, we offer patient payment plans. A patient payment plan lets you pay your medical bills in smaller, easy monthly payments instead of all at once, making it more affordable. These are automated monthly payments of an agreed upon amount (recurring charge).

> **RECURRING CHARGE** – You authorize regularly-scheduled charges to your Credit Card or Bank Account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your Credit Card or Bank Account Statement. You agree that no prior notification will be provided unless the date or amount changes.

FEES

MISSED APPOINTMENT FEES

New patients and established patients scheduled for a procedure will be charged $75 if the appointment is missed (no-show) OR if the appointment is CANCELLED OR RESCHEDULED on the same day. Established patients scheduled for a routine visit will be subject to a $50 charge for no-show OR for an appointment CANCELLED or RESCHEDULED on the same day.

MISCELLANEOUS FEES Completion of forms will result in a fee of $25 charged to your account.

CREDIT CARD

Written revocation should be submitted within 2 weeks of the next scheduled payment date. I understand, however, that the total outstanding balance will be due in full at the time of credit card authorization revocation.

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AUTHORIZED CREDIT/DEBIT CARD CHARGES (please initial in front of each statement)

1. **_____Missed Appointment Fees**
   a. I have been informed that G DeAn Strobel, MD, PA and/or GDS Wellness requires a 24-hour advance notice to cancel or reschedule my scheduled appointment. In the event 24 hours advanced notice is not provided, I authorize G DeAn Strobel, MD, PA and/or GDS Wellness to charge the appropriate Missed Appointment Fee to my credit (or debit) card on file. Missed Appointment Fees are $75 for a new patient visit or for an established patient who is scheduled to have a procedure in the office AND $50 for a routine or follow-up visit. Fees are subject to change. Should fees increase, I authorize G DeAn Strobel, MD, PA and/or GDS Wellness to charge the current fee to my credit (or debit) card.
2. **_____Outstanding Patient Balance**
   a. I understand that I will receive a monthly billing statement that outlines the balance owed by me (my Outstanding Balance). I authorize G DeAn Strobel, MD, PA and/or GDS Wellness to make charges to my credit (or debit) card on file for my Outstanding Balance without any additional notification. These charges may include copayments, coinsurance, deductible and/or insurance retraction amounts.
3. **_____Patient Payment Plan**
   a. I authorize G DeAn Strobel, MD, PA and/or GDS Wellness to charge my credit (or debit) card on file each month in accordance with the term of my Patient Payment Plan. My Patient Payment Plan outlines the full balance due, monthly payment amount, and day of the month on which the payment will be charged to my credit (or debit) card.
4. **_____Outstanding Balance & Payment Plan**
   a. I acknowledge that my monthly Outstanding Balance will be charged to my credit (or debit) card in addition to the charges associated with my Patient Payment Plan. This may result in multiple charges to my credit (or debit) card within one calendar month.

I authorize G DeAn Strobel, MD, PA to charge my Credit Card or Debit Card above for the payment plan and/or balance agreed upon on the date of signing this form. I authorize G DeAn Strobel, MD, PA to charge my credit (or debit) card on file, as indicated in this authorization form and according to the terms outlined herein. I acknowledge that the origination of credit card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card and will not dispute these approved transactions; so long as the transactions correspond to the terms indicated in this authorization form.

Credit Card Payment Authorization

Date of CC Authorization: _____ Card number:_____
Cardholder First Name: _____ Last Name: _____
Expiration Date: _____**Security code: CVV:** _____ Zip Code _____

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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 reason(s)? 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 procedures, operations, or surgeries:

Operation/procedure performed	Year	Hospital	Doctor

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

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 arrythmia	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	Chronic constipation/diarrhea
Rubella (German measles)	Goiter/thyroid disease	Malaria	Ulcerative colitis or Crohn's

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: MALE(S) FEMALE(S) 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.

Cardiologist: _____Gastroenterologist (GI): _____

Other specialist(s): _____ Pulmonologist (lung): _____

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

1. Will you be having your routine wellness exams with another provider? YES or NO? If so, who? _____
2. Do you currently keep up to date on your vaccinations? YES or NO If not, why not? _____
3. If so, please list the date of your most recent:
   a. Tetanus _____ Flu _____ Pneumonia _____ Shingles _____
4. If you are under the age of 26, have you received the Gardasil or HPV vaccine series? YES or NO?
5. 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 our policies & procedures below. If you have any questions, please ask one of our staff to assist you. 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. We also are closed between Christmas and New Year's for several days, but the exact dates vary from year to year.

DEFINITIONS

IN NETWORK: 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.

OUT OF NETWORK/ NON-PARTICIPATING INSURANCE: 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.

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

FINANCIAL POLICIES AND PROCEDURES

PAYMENT AT TIME OF SERVICE

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.*

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.

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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. Any outstanding balance must be paid before refills can be sent OR scheduling future appointments. Also, a credit card may be required to keep on file for all future outstanding balances or charges incurred.

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.

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.

SURGERY

We require 100% prepayment (of the surgeon fee) 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 $25 (twenty-five dollars) processing fee. Our office only completes these forms for condition(s) that we are treating, however.

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TELEPHONE VISITS

A telephone visit is a visit between a provider OR nursing staff which reviews results and plan(s) of care. This is a phone only visit WITHOUT video. Most insurance carriers do not cover telephone visits. This is NOT the same as a telemedicine visit. There could be an additional charge depending on the length and complexity of the call

TELEVISITS (or TELEMEDICINE VISIT)

A televisit is a virtual one-on-one office visit which is performed via a real-time 2-way audiovisual portal, healow app, or a video link. 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, but some carriers have special requirements. It is your responsibility to know your coverage prior to having a televisit. Your insurance will be billed as a courtesy in the same manner as an in-person office visit. **Televisits are billed at the same rates as office visits because the same things are covered as in an in-person visit** (except for weigh-in, vitals, and physical exam), and the same amount of work is required by the nurse or medical assistant as well as the provider.

NO SHOW and SAME DAY CANCELLATION FEES

We request at least 24 hours' notice be given for canceling or rescheduling appointments, including televisits. Because a significant amount of work is done BEFORE the appointment, there are other patients waiting on appointments, and because we are unable to fill vacant spots at the last minute, we do charge no-show or rescheduling fees as outlined below if appropriate notice is not given. However, we do understand that medical emergencies may arise and reserve the right to waive fees when deemed necessary or appropriate. Patients may be dismissed from the practice if there are three (3) no-show or last-minute cancellations.

> FOR AN ESTABLISHED PATIENT: There is a charge of **$50.00** for no shows or same day cancellations for regular AND telemedicine appointments as well as wellness exams. There is a **$75.00 fee** for no shows and same day cancellations for procedure, ultrasound, and pellet appointments. Any fee(s) and outstanding balances must be paid prior to future appointments or prescription refills.
>
> FOR A NEW PATIENT: We allot additional time for new patient appointments. Therefore, a new patient missed appointment OR same day cancellation will result in a charge of **$75.00.** This charge must be paid prior to any future appointments.

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

G. DeAn Strobel, MD, PA
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PATIENT JOINT HEALTHCARE AGREEMENT

Thank you for choosing **G. DeAn Strobel, MD, PA**. We are committed to providing you with the best medical care possible. We believe that healthcare is best obtained through teamwork which means that the healthcare provider AND the patient work together toward a common goal.

Please review a brief explanation of our policies & procedures regarding the shared responsibilities in managing your healthcare. 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, MD, PA**

INSURANCE COVERAGE: Your insurance is a contract between you, the patient, and your insurer. Therefore,

- It is the patient's responsibility to know your insurance coverage and whether our office is IN NETWORK or OUT OF NETWORK with your carrier.
- It is the patient's responsibility to know your coverage for laboratory or pathology tests and whether there is a preferred lab company required by your carrier.
- Any blood work or pathology specimens ordered through our clinic will be filed to your insurance by the lab company. You may receive a bill from a separate lab or pathology company.
- As a courtesy, we will bill your insurance for all office visits, televisits, and phone visits, but any portion not paid by your insurance is the patient's responsibility. You will be required to pay a copay OR your office visit may go to your deductible. This is determined by your individual policy.

PRIVATE PAY PATIENTS: At **G. DeAn Strobel, MD, PA,** we believe that all patients who come to this office deserve the best medical care that can be provided. Therefore, for patients who are private pay, we do offer private pay rates. The rates vary according to the type of visit and complexity. Any labs, pap smears, or other procedures will be charged in addition to the office visit charge. Payment for all private pay services is due at the time of service.

LAB, IMAGING AND OTHER TEST RESULTS: It is the policy of **G. DeAn Strobel, MD, PA** to contact a patient regarding laboratory, radiology tests, vaginal cultures and bone density scan results within seven (7) business days. Because of new healthcare regulations, both normal and abnormal lab and test results are available and visible to our patients immediately in the patient portal. Abnormal results often require a follow-up visit or televisit to review the results in detail and formulate and plan of care. You will be contacted once your provider has had time to review the labs. This may occur AFTER you see your results. Please give our providers at least 48 hours to review your test results before contacting the office.

We do not contact patients in most cases with normal mammogram or pap smear results. Mammogram results are sent directly to the patient by the imaging facility. Pap smear results are available in the patient portal within seven (7) days, or you may call for the results. Biopsy and bone density scan results done in our office are also usually back within seven (7) days. If you have not seen your results on the patient portal within 7 – 10 business days, you should contact our office.

G. DeAn Strobel, MD, PA

Hormonal Balance & Wellness

G. DeAn Strobel, MD * Karissa L. Cryer, DO * Angelica Ortiz, FNP * Katie Green, FNP * Daniela Castillo, FNP
230 East Sycamore Street * Suite 200 * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279
Save this on your computer then email to: info@drdeanstrobel.com

Patient Name _____ Birthdate _____Today's date: _____

Through our electronic medical records, you have a patient portal available to view results of your visits and tests ordered. If you choose not to participate in using your patient portal, you may contact our office for results. Phone calls and messages are returned within 24-48 hours period unless it is over the weekend or a holiday.

MEDICAL FOLLOW UP: It is the responsibility of the patient to contact our office if the medical condition being treated does not improve, worsens, or if there are any questions regarding a medication or its side effects. Phone calls and messages are returned within 24-48 hours period unless it is over the weekend or a holiday.

ACCESSING YOUR PATIENT PORTAL: The Patient Portal is a secure, HIPAA-compliant messaging system that allows you to communicate safely with our office. Through the portal, you can send and receive messages, view lab and imaging results, update demographic information, see upcoming appointments, and pay balances. We encourage all patients of **G. DeAn Strobel, MD, PA** to use this convenient communication tool. Please indicate below whether you would like to set up a patient portal account. Select one option only.

☐ Yes, I **HAVE** access to my patient portal or ☐ Yes, I wish to have access to my patient portal

☐ No, I decline to set up a patient portal.

HEALOW CHECK-IN: We offer secure, touchless check-in and payment via your mobile phone. Patients can complete forms, sign consents, pay balances, and check in electronically to reduce wait times.

SECURE TWO (2)-WAY TEXTING: Patients now can text our main number directly at 903-957-0275 for real-time assistance from our staff. G. DeAn Strobel, MD, PA has contracted with OHMD for secure two-way texting.

ARTIFICIAL INTELLIGENCE (or AI): Our practice uses AI-assisted scribe technology to support accurate and efficient documentation of your visit. In addition, on occasion, clinicians may use AI-supported tools (without patient identifiers) to assist with extensive medical record review, clinical research on health conditions or medications, or drug-interaction and safety checks. These tools are used to support—not replace—clinical judgment. All documentation, diagnoses, and treatment decisions are reviewed and made by licensed medical professionals.

I verify by signing this document that I have received, read and understand *G. DeAn Strobel, MD, PA* **Patient Joint Healthcare Agreement.**

Name (please print) Signature Date

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PRESCRIPTION HISTORY CONSENT & REFILL POLICY

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. This includes over-the-counter drugs, supplements, or herbal remedies that you take on your own.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

I give my permission to G. DeAn Strobel, MD, PA to obtain my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years. This also may include any prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

I acknowledge that G. DeAn Strobel, MD, PA may use health information exchange systems to electronically transmit, receive and/or access my prescription history. I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from G. DeAn Strobel, MD, PA, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

MEDICATION REFILL POLICY

It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

Medication refills will only be addressed during regular office hours (Monday-Thursday 8A-5P and Friday 8A-12P). **The providers and staff will not return any phone calls regarding refills after hours or on weekends or holidays.** Please notify the office the next business day if you find yourself out of medication after hours.

Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers or for conditions for which we have not evaluated you recently.

Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

Long-term medications such as sleep and anxiety medications, thyroid, cholesterol, blood pressure, and others will require at least one additional appointment per year. New prescriptions for blood pressure, anxiety, sleep, depression or weight loss medications will require more frequent visits until desired results achieved. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills.

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All prescriptions require a follow up appointment at least every 6 to 12 months. Controlled substances, including testosterone, may require more frequent evaluations (every 3 to 6 months).

If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.

New conditions, symptoms, or events require an appointment. Your provider cannot and will not diagnose or treat over the phone.

I certify that I have read this **Prescription History Consent & Refill Policy** form, or it has been read to me.

_____

Name (please print) Signature Date

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TELEMEDICINE CONSENT FORM

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her provider's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

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By signing this telemedicine consent form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

8. I understand that this is billed the same as an office visit and that my insurance (if applicable) will be billed and that a copay (or full payment) is required.

9. I understand that my insurance (if applicable) may decide not to cover telemedicine visits and that it is my responsible to be aware of that prior to the appointment. Any charges incurred are my responsibility.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

_____

Name (please print) Signature Date

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Patient Name _____ Birthdate _____Today's date: _____

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record(s) of:

Patient Name: _____ DOB: _____

Social Security No.: _____Phone: _____

Information Release TO: G. DeAn Strobel, MD, PA
230 E. Sycamore Street, Suite 200
Sherman, TX 75090
Phone: (903) 957-0275 Fax: (903) 957-0279

Information Release FROM:

_____

_____

_____

Please release the following:

____All records ____Problem List ____X-ray/CT/MRI rep ____Progress Notes ____X-ray/CT/MRI

____EKG Reports ____Lab Reports ____Bone density ____Immunizations ____Pap smears

____Pathology report f ____Operative Reports ____Other _____

Please include information (if applicable) pertaining to: mental health, drug/alcohol use, HIV/AIDS, and communicable disease treatment.

Purpose or need for disclosure of medical information: ____Continued patient care ____Personal use

____Transfer of care ____Other_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____

Signature of Patient or Legal Representative Date