PARK LANE MEDICAL GROUP, P.A.
Grant P. Beckham, M.D.

PATIENT INFORMATION

____/________/___________
Last Name First Name Middle Initial Social Security #

____
Street Address City State Zip

Date of Birth: ______________________ Age: ________ Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ D ☐ S ☐ W

Home Phone Number: __________________ Cell Phone Number: ___________________ Work Phone Number: _____________________

Email Address: ____

Responsible Party: ☐ Self ☐ Other: Name: ____ Relationship to patient: ___________________

Home Phone Number: __________________ Cell Phone Number: ___________________ Work Phone Number: ______________________

Address: ____
Street # City State Zip

Emergency Contact Name: ________________________ **Phone #:** ________________________ **Relationship to patient:** _________________

Whom may we thank for your referral to us? ____

Insurance Information

Primary Carrier:

Insurance Company Name: _______________________________________

Insurance Company Address: ____

Insurance Company Phone #:_____________________ Employer, If Group Coverage: ____

Policy ID #: _____________________________ Group Name and / or #: ___________________ Subscriber's SS #: ___________________

Subscriber Name: ____ Subscriber Date of Birth: _______________ ☐ Male ☐ Female

Patient's Relationship to Subscriber: (Please Circle One) Self Spouse Child Other: ___________________

Secondary Carrier: ____ **N/A**

Insurance Company Name: _______________________________________

Insurance Company Address: ____

Insurance Company Phone #:_____________________ Employer, If Group Coverage: ____

Policy ID #: _____________________________ Group Name and / or #: ___________________ Subscriber's SS #: ___________________

Subscriber Name: ____ Subscriber Date of Birth: _______________ ☐ Male ☐ Female

Patient's Relationship to Subscriber: (Please Circle One) Self Spouse Child Other: ___________________

ASSIGNMENT OF BENEFIT & AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to my primary care physician located at 8140 Walnut Hill Lane, Suite #650, Dallas, TX 75231. 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 whether or not paid by said insurance. I hereby authorize said assignee to release all medical information including hospital records in the assignee's possession to my insurance company, attorney or employer, who may have a responsibility towards securing payment of my account including Medicare, where applicable.

PATIENT (or LEGAL GUARDIAN) SIGNATURE_______________________________________ DATE________________

Park Lane Medical Group, P.A.
Phone 214-361-7000
Fax 214-361-7675

8140 Walnut Hill Lane
Suite 650
Dallas, TX 75231

AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Date________________________

Re: ____ ______________________
(Name of Patient) (Date of Birth)

____
Address Line 1

____
Address Line 2

New federal privacy guidelines, HIPAA, prevent this office from disclosing protected health information ("PHI") to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial record with this facility.

I, the undersigned, hereby authorize Park Lane Medical Group, P.A. to disclose PHI from my medical or financial record to the following person/people:

Name:____

Relationship:____

Type of Information: (Circle One) Medical Financial Both

Name:____

Relationship:____

Type of Information: (Circle One) Medical Financial Both

Name:____

Relationship:____

Type of Information: (Circle One) Medical Financial Both

ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY

This authorization is given freely with the understanding that:

1. I may revoke this authorization in writing at any time, but not retroactively.
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

____
Patient's printed name

____
Patient's signature

____
Date

PARK LANE MEDICAL GROUP, P.A.

AUTHORIZATION OF USE/DISCLOSURE OF PROTECTED INFORMATION

How may we contact you regarding appointments, lab results, treatment and/or other information pertinent to your healthcare and/or payment for services provided by Park Lane Medical Group, P.A.? (Check all that apply)

Mail _______ Phone _______ Fax _______

Preferred mailing address: ____

____

Preferred phone: Home #__________________ Cell #__________________

Work #__________________ Fax #___________________

OK TO LEAVE VOICE MESSAGE (CIRCLE ONE) YES NO

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent will require your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke will not affect or undo any disclosure prior to your notification date. You have the right to request restrictions on use and disclosure of your health information.

Please list any restrictions below: _______________________________

____

____

____

____

______________________________ _______________

Patient Signature Date

Park Lane Medical Group, P.A.
Grant P. Beckham, M.D.

Payment Policy

Please read the policy, ask us any questions you may have and sign in the space provided.

1. Self-pay means that payment is due at the time of service. This also means that we will not file a claim to an insurance company for you. We offer a 30% discount in fees for self-pay patients paying in full at the time of the visit.
2. Insurance: We participate in many major insurance plans, including traditional Medicare. If you ***are not*** insured by a plan we do business with, payment in full is expected at each visit. If you ***are*** insured by a plan we do business with, but you cannot provide us with an up-to-date insurance card, payment in full for each visit is required at the time of service. ***Knowing your insurance benefits is your responsibility.*** Please contact your insurance company with any questions you may have regarding your coverage.
3. Co-payments, co-insurance and deductibles: All co-payments, co-insurance amounts and deductibles must be paid at the time of service. Co-payments are a part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment each visit.
4. Non-covered services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. For example, some insurance plans do not cover for annual physical exams or pap tests. Again, knowing your insurance benefits is your responsibility. You must pay for these services in full at the time of the visit. If you are a Medicare recipient, you will be required to sign a form called an Advanced Beneficiary Notice or "ABN" prior to services being rendered.
5. Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must have a copy of your driver's license and current insurance card to verify proof of insurance. If you fail to provide us with the correct insurance information you will be responsible for payment in full of services rendered at the time of service.
6. Claims submission: After your appointment, we will submit a claim to your insurance company. We will help you in any way we reasonably can to get your claims paid by the insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to call the insurance company upon request. Please be aware that any remaining balance of your claim not paid by insurance is your responsibility. Once a claim is filed, if your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Settling any grievances you have with your insurance company regarding unpaid portions of claims is solely your responsibility unless failure to pay is due to error on our behalf during claims submission. If we identify errors on our behalf, we will correct them and re-submit the claim for you.
7. Coverage changes: If your insurance changes, you must notify us before your next visit so we can update our records to help you receive your maximum benefits. Failure to notify us of a change in coverage will make you responsible for payment in full at the time of the visit if we are unable to verify benefits for any reason.
8. Non-payment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
9. Missed appointments: We reserve the right to charge for missed appointments not canceled within 24 hours. First time: warning, second time: $25.00, third time: $50.00, fourth time: discharged. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping regularly scheduled appointments.
10. Billing: Our Practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges in the area.
11. Accepted forms of payment: For your convenience, we accept payment by cash, personal check with valid driver's license, Visa, MasterCard, Discover and American Express.

Thank you for understanding our Payment Policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to follow these guidelines and payment requirements.

______________________________	____	_________________
Name of Patient (PRINTED)	Signature of Patient or Responsible Party	Date

GRANT P. BECKHAM, M.D.
PARK LANE MEDICAL GROUP, P.A.

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 REVIEW IT CAREFULLY.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof. We may use or disclose your protected health information in an emergency treatment situation.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization, unless permitted or required by law. You may revoke your authorization at any time. Our office is collectively the sole owner and user if the information collected from the patient's.

You may request restrictions on certain uses and disclosure in writing. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to a copy of your medical information to inspect and request in writing an amendment of your protected health information. You may also request an accounting of disclosures of your protected health information from this office. Requests to review medical and billing records must be in writing.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information at any time. The new notice will be effective for all protected health information that we maintain at that time.

You may register a complaint with the office manager if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. This Notice of Privacy Practices is effective as of April 14, 2003.

I have read and understood my rights. I have received a copy of the Notice of Privacy.

Patient Signature:_______________________Date:_______________

This Notice of Privacy will remain in effect forever.