

(Please Print Clearly)

			PATII	ENT	INFORMA	TION					
Patient's last name:	Patient's last name: First:			Middle:				Marital status (circle one) Single / Mar / Div / Sep / Wid			
Is this your legal name ☐ Yes ☐ No	? If not, v	ot, what is your legal name?			Maiden name:		E			Age:	Sex:
Street address:			Social Security no.:		Phone no.:						
City:			State:				() Zip Code:				
Email:											
Occupation:			Employer:			Employer phone no.:					
Preferred Pharmacy:								()			
•			D4DENIZ/01								
			PARENT/GI			DRMATION					
Name: Birth date:			Address (if different):				Phone no.:				
Occupation:	Employer:	/ / Empl	over address.					()		
Occupation.	Employer.	ЕШрі	oyer address:					Empl	loyer ph)	one no.:	
			INSURA	NCE	INFORM	ATION					
Is this patient covered	by insurance	e? 🗆 Yes	□ No								
Please indicate primary	y insurance										
Subscriber's name:	iber's name: Subscriber		's S.S. #: Birt		th date:	Group no.:		Policy no.:			Co-payment:
Patient's relationship to	subscriber:	□ Self	☐ Spot	use	☐ Child	□ Other					
Name of secondary insurance (if applicable):		Subscriber's name:				Group no.:		Polic	cy no.:		
Patient's relationship to	subscriber:	□ Self	☐ Spot	use	□ Child	□ Other					
			IN CAS	SE O	F EMERG	ENCY					
Name of friend or relative:					Relationship to patient: Phone ()			
The above information that I am financially res required to process my prescriptions electronic	ponsible for claims. I au	any balance. I thorized Your I	also authorize Y lealthcare to co	′H Anı ntact r	na PLLC / You ne by phone.	ır Healthcare or email and/or tex	insurance	compa	ny to re	lease an	v information
				SIG	NATURE						
Name:							Date:				



PATIENT INFORMATION SHEET

NAME:			GENDER:	DOB:	DATE:		
DRUG ALLERGIES:							
List ALL MEDICATION and when taken. If yo					ns and vitamins. Include specific doses		
				-			
PERSONAL MEDICAL	HISTORY: (Ple	ease circle all th	nat apply)				
Up to date on Immuniza		0)					
(adult) Date of last tetar				10003			
ADHD	Allergies, Se	asonal	Diabetes: 1		GERD (Acid Reflux)		
Anxiety	Asthma		High Blood F		Hiatal Hernia		
Depression	COPD/Emphysema		High Cholesterol		Irritable Bowel Syndrome		
Bipolar Dementia	Sleep Apnea		Heart Attack		Gastric Ulcer		
	Osteoporosis		Heart Disease		Crohn's Disease		
Migraines Headaches	Osteoarthritis		Bleeding Problems		Ulcerative Colitis		
	Rheumatoid Arthritis		Anemia		Diverticulitis		
Neuropathy Stroke	Gout		DVT (blood o	clot)	Liver Disease		
	Thyroid Disc		idney Disease		Hepatitis		
Seizure Disorder Psoria		Kidney Sto		HIV			
Bladder Problems / Inco Cancer:	ntinence An	nytnmia (irregui	ar heart beat) Per	ipherai vasc	ular Disease		
Colonoscopy	Yes/No	Date:	Normal	Abnormal			
Colonoscopy	165/110	Date	Normal /	Apnormai			
Other medical problems	s not listed abo	ove:					
Women:							
Last Menstrual Period		Date:	Normal /	Ahnormal			
Pap Smear	Yes/No		Normal /				
Mammogram	Yes/No		Normal /				
Form of Birthcontrol:			The state of the s				
Surgical History: Pleas	se list all prior	surgeries and	approximate date	s performe	d.		
Date			urgery	o p	. .		
			8 1				

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2100 W White St, Ste 150 Anna, TX 75409 972-587-6080



Education Completed:		I □ Vocational □ 2yr College	☐ 4vr University or higher			
Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No Nicotine Use: ☐ Current ☐ Past ☐ Never Type: Amount/day: # of Years total:						
Alcohol: Number of dr	rinks per week:	Amount/u	ay # Of rears total			
		Туре:				
Are you sexually active						
Are there any persona	I problems or concerns at ho	me, work, or school you would	d like to discuss? □Yes □ No			
		re related to our delivery of ca				
			Jsually □ Sometimes □ Rarely □ Neve			
	16 0					
Comments (Please fee	el free to comment on any ans	wers marked "yes" above):				
FAMILY HISTORY:						
	Deceased: Age					
Alcoholism	Bipolar Disorder	Depression	High Cholesterol			
Osteoporosis High Blood Pressure	Anemia	Cancer:	_ Diabetes 1 or 2			
DVT (Blood Clot)	Stroke Kidney Disease	Asthma	COPD/Emphysema			
Dementia	Kidney Disease Heart Disease	Thyroid Disorder	Arthritis			
Other:		Migraines				
MOTHER: Living: Age	Deceased: Age					
Alcoholism	Bipolar Disorder	Depression	High Cholesterol			
Osteoporosis	Anemia	Cancer:	Diabetes 1 or 2			
High Blood Pressure	Stroke	Asthma	COPD/Emphysema			
DVT (Blood Clot)	Kidney Disease	Thyroid Disorder	Arthritis			
Dementia	Heart Disease	Migraines				
Other:						
Link address on a discussion	and a second					
Dentist, etc.)	viders you see on a regular b	asis (i.e. Cardiologist, Mental	Health Provider, Kidney Doctor,			
Dentist, etc.,						
Patient Signature:			Date			
	f pt is a minor)		Date:			



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND AUTHORIZATIONS

Privacy Practices:

I have reviewed Y.H. Anna, PLLC / Your Healthcare's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Authorizations:

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

I authorize Y.H. Anna, PLLC / Your Healthcare, to release to my insurance provider any information required, including the diagnosis and recommended course of my examination or treatment.

I understand it is the patient's responsibility to let Y.H. Anna, PLLC / Your Healthcare, to know if Pre-Certification is required for any office visit, Radiological procedures, specialty referrals and any surgeries.

I understand that failure to notify this office may cause me increased out-of-pocket expenses such as denies claims and reduced benefits.

I authorize payment directly to Y.H. Anna, PLLC / Your Healthcare, for the medical and/or surgical benefits otherwise payable to me, for services to me. I understand that I am financially responsible for the charges not covered by my insurance.

CONSENT FOR TREATMENT: I voluntarily consent to evaluation, treatment, diagnostic testing, medication, nursing care and/or therapy which my healthcare provider or his/her designees, determines to be necessary.							
Patient Name (Print)	Patient Signature	Date					
If completed by a patient's Parent / Legal Guardian, please print and sign your name in the space below.							
Parent / Guardian (Print)	Parent / Guardian Signature						



GENERAL INFORMATION-PLEASE READ

In an effort to avoid any confusion, we would like to provide the following information. It is our hope that this will answer most of the questions or concerns you may have regarding our financial policies. If you have additional questions, please do not hesitate to ask. If you would like a copy of this form, please ask at the front desk.

Payment *IS DUE ON THE DAY OF SERVICE.* Please be prepared to pay on the day of service. We accept cash, check, Visa, MasterCard, Discover, and American Express.

CREDIT CARD ON FILE. To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills we will require all patients keep an active credit card on file with us. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of patient responsibility. Circumstances when your card would be charged include but are not limited to: missed or canceled appointments without 24-hour notice, missed co-payments, deductible and co-insurance, any non-covered services and/or denial of services.

INSURANCE: We will file insurance as a courtesy to our patients. We make no guarantee of coverage by insurance but will verify insurance benefits. The portion of the treatment not estimated to be covered by the primary insurance is due on the day of service. If insurance has not paid after 60 days from the date of service, the balance becomes the responsibility of the patient. If you have any questions or concerns regarding your coverage please contact your insurance carrier directly. If you need to know what your insurance will cover for a specific procedure, we can file a pre-treatment estimate. *ANY PORTION NOT COVERED BY INSURANCE IS THE RESPONSIBILITY OF THE PATIENT*.

If you are a new patient and you do not have your insurance information with you, payment will be due in full.

Medicaid/Medicare: WE DO NOT FILE WITH MEDICAID OR MEDICARE. IF YOU CHOOSE TO BE TREATED, YOU CAN NOT SUBMIT CLAIMS FOR REIMBURSMENT TO MEDICARE.

RETURNED CHECKS: THERE IS A \$30.00 FEE FOR A RETURNED CHECK. If a person has two returned checks, we will no longer accept personal checks. Payment must be made by cash, credit card or certified funds.

BROKEN/MISSED APPOINTMENTS: In order to provide the best possible service and availability to all our patients, we reserve the right to charge for missed/cancelled appointments (less than 24-hour notice). Monday appointments must be cancelled by close of business on the prior Friday to avoid being subject to the fee. Please call us as early as possible to reschedule your appointment. If a patient has two or more broken appointments in a six-month period, we will not be able to schedule any further appointments. The fee for missing or canceling an appointment with less 24-hour notice is 20% of the scheduled procedure(s) fee. If you arrive more than 10 minutes late, your appointment may have to be rescheduled. We will make every attempt to keep your appointment, but feel we must be fair to the next person scheduled.

PAST DUE ACCOUNTS: When an account is over 90 days past due, it will be turned over to a collection agency. The patient will be placed in a "dismissed" status until the balance, including any fees, is paid in full. Once the balance is paid, payment will be due in full on the day of service for all future appointments and we will no longer accept insurance assignment.

THIRD PARTY ACTION: If third party action becomes necessary, the financially responsible party agrees to pay for all collection fees to include: 30% collection agency fee, court costs, and attorney fees.

SIGN BELOW INDICATING YOU HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENTS

Signature	Date