Kelly L. Wimberly, M.D., P.A.
Family Medicine
17101 Preston Rd. #200 | Dallas, TX 75248
972.239.4441 (phone) | 972.239.1597 (fax)

New Patient Registration

Name (First, Middle, Last) _____

DOB (mm/dd/yyyy) _____ **Social Security Number** _____

Street Address _____ **Apt #:** _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Alternate Phone** _____

Employer Name _____ **Work Phone** _____

Email _____ **Sex: Male** ☐ **Female** ☐ **Minor: Yes** ☐ **No** ☐

If yes, Parent/Guardian Name _____ Phone _____

Address _____

How did you hear about us? ☐ Friend/Family ☐ Internet ☐ Insurance Provider ☐ Mailer ☐ Other

Preferred Pharmacy _____ Phone _____

Address _____

Marital Status (optional)

Married Single Divorced Widowed Separated

Languages

☐ English ☐ Other

If other, please specify _____

Ethnicity (Optional)

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other race

Primary Insurance Information

Insurance Carrier _____
ID/Member No. _____
Group/Policy No. _____
Policy Holder (if other than patient)
Name _____
DOB ____/____/____ Phone _____
Address _____
City _____ State _____
Zip _____ Sex M ☐ F ☐

Secondary Insurance Information

Insurance Carrier _____
ID/Member No. _____
Group/Policy No. _____
Policy Holder (if other than patient)
Name _____
DOB ____/____/____ Phone _____
Address _____
City _____ State _____
Zip _____ Sex M ☐ F ☐

ASSIGNMENT AND RELEASE:
I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurances. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process medical claims.

_____ _____
Patient Signature (Parent or Guardian if minor) Date

HEALTH HISTORY

Please note, this information is for clinic use only and will not be shared unless agreed to by you.

MEDICAL HISTORY

Have you ever had any of the following?

Heart Disease	O	Sickle Cell Disease	O	Mononucleosis	O
Heart Murmur	O	Blood Transfusion	O	Gall Bladder Disease	O
Rheumatic Fever	O	High Cholesterol	O	Kidney Problems	O
Asthma	O	Diabetes	O	Mood Disorders	O
COPD	O	Cancer	O	Depression	O
Pneumonia	O	If yes, what kind_____		Anxiety	O
High Blood Pressure	O	Migraine	O	Chronic Pain	O
Stroke	O	Congenital Disease	O	Arthritis	O
Blood Clots	O	Seizures	O	Osteoporosis	O
Rheumatological Disease (e.g. Lupus)	O	Epilepsy	O	Insomnia	O
		Liver Disease	O	Anemia	O
Mumps	O	Measles	O	Chicken Pox	O
Sleep Apnea	O	Hepatitis	O	Other_____	

Have you ever had any surgeries? Yes O No O If yes, please list _____

_____

Do you experience any of the following symptoms regularly?

Chest Pain O Shortness of breath O Vision Problems O Dizziness O

Headaches O Sensory Difficulties O Pain O (location of pain_____)

Hospitalizations? Yes O No O If yes, please complete below:

Date most recent _____Hospital Name/Location_____

Reason for admission_____ No of days_____

FAMILY HISTORY

Do any of the following conditions run in your Family (blood relatives only)?

Stroke	O	Diabetes	O
Heart attack/disease	O	Genetic Condition	O
High Cholesterol	O	Breast Disease	O
High Blood Pressure	O	Other_____	
Cancer O If yes, list type_____			

SOCIAL HISTORY

Do you smoke? Yes O No O

If yes, number smoked daily _____

Do you drink alcohol? Yes O No O

If yes, number of drinks weekly_____

Have you ever used illegal drugs? Yes O No O

If yes, which ones? _____

MEDICATION/ALLERGY HISTORY

List your current medications below:

Name	Dose	Frequency

List your allergies below:

Food/Drug Name	Reaction

I certify that this information is correct and up-to-date to the best of my knowledge.

Name_____ **Signature** _____**Date:**_____

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INSTRUCTIONS AND CONSENT FORM FOR THE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including: treatment, payment, and healthcare operations)

Name	Phone	Relationship

Please list the family members or other persons, if any, whom we may call in the case of an emergency:

Name	Phone	Relationship

If other than you home address, please provide the address where you would like your billing statements and/or correspondence from our office sent:

_____

What is the best telephone number we can call and leave a voice message concerning your appointments, test results, and other health care information:

Phone Number_____ O Brief O Detailed

Patient Name (please print)_____ **DOB**_____/_____/_____

Patient/Guardian Signature_____ **Date**_____

YOU MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT YOUR PHYSICIAN OR THE PHYSICIANS'S PRACTICE HAS TAKEN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION.

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PATIENT PORTAL INFORMED CONSENT

Kelly L. Wimberly, M.D., P.A. is offering access to a secure, HIPPA Compliant communication tool as a courtesy to our patients. This is an optional service that we reserve the right to suspend or terminate at any time. We will alert you to any changes as promptly as possible. This consent is intended to inform you of the facts and risks surrounding the use of the web portal. By signing below, you confirm that you have read, and understood and agreed to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Kelly L. Wimberly, M.D., P.A. or any of her staff members liable for a network infraction beyond their control.

PRIVACY AND SECURITY

The web portal or web page has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information or your communications to us. To help insure that the tunnel remains secure, we need to have your current (private) email address and to be kept informed if your email address changes. Your portal user ID and password must remain secure so only you, or someone authorized by you, can gain access to your patient information. If you believe an unauthorized person has obtained your password, immediately go to the portal site and change your password. As an added convenience, your medical records can also be accessed via your smart phone through the Healo App that can be downloaded for both Android and IPhones.

Your email address is confidential and protected information. To the best of our ability, we will protect this information as we do your medical and other personal information. We will never purposefully share this information with any third party.

All access to our internal network and electronic medical records (EMR) is password protected. Our staff is instructed to logoff their workstations when not physically present. Additionally, in compliance with HIPPA guidelines, our EMR automatically logs the user out after a period of inactivity.

Similar to phone communications, messages may be read and addressed by different staff members. When your provider is ill, on vacation, or out of the office for any reason, your emails will be addressed by a covering provider.

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○ Yes, please sign me up to use patient portal **○ No, I do not wish to utilize the patient portal**

If yes, please print confidential email address CLEARLY_____

Patient Name (please print)_____ **Date of Birth** ____/____/____

Patient/Guardian Signature_____ **Date**_____

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PROTECTED HEALTH INFORMATION PRACTICES CONSENT

Name of Patient_____ **Date of Birth**_____/_____/_____

Name of person giving consent if other than patient:

Name_____ **Relationship to Patient**_____

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATION, AND AS OTHERWISE ALLOWED BY LAW

Kelly L. Wimberly, M.D., P.A. will maintain a record of the care and services you receive at her practice. This consent only covers your protected health information (PHI) created while you are a patient of Kelly L. Wimberly, M.D., P.A. Your protected health information pertains to your diagnosis and/or treatment received at the practice of Kelly L. Wimberly, M.D., P.A., including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress, or any other such related information.

By signing this form, I consent to Kelly L. Wimberly, M.D., P.A.'s use and/or disclosure of my protected health information for treatment, payment, health care operations, and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how Kelly L. Wimberly, M.D., P.A. and her personnel may use and/or disclose my protected health information for treatment, payment, health care operations, and as otherwise allowed by law. A copy of Kelly L. Wimberly, M.D., P.A.'s *Notice of Protected Health Information Practices* will be provided for your review upon request. By signing this form, I also acknowledge that I have had an opportunity to review a copy of Kelly L. Wimberly, M.D., P.A.'s *Notice of Protected Health Information Practices* before signing this consent.

I authorize Kelly L. Wimberly, M.D., P.A. and her personnel to release and furnish on a confidential and a strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by the Physician and Medical Staff, or to assist with, aid in, or facilitate the collection of data for the purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, Managed Care Organizations, Indemnity Plans, Medicare/Medicaid or other government or third-party payers, and/or organizations contracting with any of the above entities to perform such functions.

I understand and acknowledge that Kelly L. Wimberly, M.D., P.A. participates in an electronic medical record exchange program with other health care facilities and providers ("Exchange Participants"). I understand that when I seek treatment from Kelly L. Wimberly, M.D., P.A. or Exchange Participants, my health information may be shared electronically between Kelly L. Wimberly, M.D., P.A. and Exchange Participants in order to provide care and services to me, and I do hereby authorize Kelly L. Wimberly, M.D., P.A. to share my health information in this manner with Exchange Participants. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses or treatments for substance abuse, mental illness (excluding psychotherapy notes) or communicable diseases (including HIV or AIDS), and that some Sensitive Information cannot be disclosed through the medical record exchange program without a separate authorization by me.

Signature/Patient or Legal Guardian_____ **Date**_____

Name of Witness_____ **Initials** _____

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FINANCIAL POLICY AND PRACTICE PROCEDURES

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss these with us.

Your Insurance

We have agreements with many insurers and health plans to accept assignment of benefits. We will bill the plans with which we have an agreement and will only require you to pay the contracted co-payment, deductible, or co-insurance at the time of service. For your convenience, we accept Visa, MasterCard, American Express, and Discover credit cards as well as cash and checks. **There is a $25.00 fee for any returned checks. Any unpaid balances that are turned over to collections will be assessed an $18 collections processing fee.**

If you have an insurance plan with which we currently do not have an agreement, payment in full is due at the time of service. We will be happy to provide you with the paperwork necessary to assist you in filing a claim with your insurance provider.

We make every effort to follow the guidelines required by your insurance company, however every contract is unique. There may be times when we perform a test that is not covered on your plan or that is denied. In those instances we have no choice but to bill you directly for those charges. If your insurance denies a claim, you will be billed for all services not covered in accordance with our insurance contracts. This may include but is not limited to denials due to eligibility, out of network services, non-covered services, and maximum benefits reached. For all services rendered to minor patients, the adult accompanying the patient or the custodial parent/guardian will be responsible for payment at the time of service.

It is your responsibility to inform us if your insurance has changed. Please notify our office with the new insurance information prior to your next appointment. Failure to do so may result in a delay in your appointment time and a longer wait to see the doctor.

Cash Pay Patients

In the event that you do not have insurance, payment is due in full at the time of service. Cash pay estimated pricing will be provided upon request prior to the appointment, but this is only an estimate and the final price due at checkout may vary from the estimated quote based on the services rendered during the appointment.

Insurance Referrals

Our medical staff will obtain an insurance referral if one is required by your insurance. If you are part of an HMO or Managed Choice plan, failure to obtain a valid referral from your Primary Care Physician (PCP) may result in denial of your claim by your insurance. You will be responsible for any non-payment from your insurance company. ***Referrals require a minimum of 48-72 hours to be processed. Please allow sufficient time prior to your appointment to complete the referral process. Failure to do so may result in your having to reschedule your appointment with the physician/facility where you are being referred.***

Motor Vehicle Accidents

Motor vehicle accidents are a fee for service and due at the time of service. We will provide you with a fee slip to file with your auto insurance. ***NO EXCEPTIONS!***

Missed Appointments

Same-day cancellations and/or no shows will incur the following fees: $35.00 for Physical exams and $25.00 for office visits. Please contact the office at least 24 hours prior to your appointment to reschedule or cancel.

Rescheduling of Appointments

The office retains the right to reschedule your appointment if:

- The patient is **15** minutes or more late for an appointment.
- The patient or responsible party is unable to meet the financial requirement at time of service.
- The patient is unwilling to pay for the visit when insurance is unverifiable.
- The physician with whom patient is scheduled is going to be out of office requiring appointment to be rescheduled to a later date or with a different provider.

Form Completion

There is a **$25.00** processing fee for any forms, such as FMLA paperwork, that must be filled out by the physician. Please leave blank forms at the front desk. Completed forms will be returned to you within 3 business days. Payment is due when the completed form is returned to you.

Medical Record Requests

Medical records are available upon request. There is a **$25.00** processing fee assessed when requesting a copy of your complete medical record either for your personal use or to be forwarded to another physician. **Please allow 7-10 business days for your request to be processed.**

Prescriptions Refills

Please contact your pharmacy FIRST for prescription refills and allow one to two business days for your request to be processed. Mail-order refills and prior authorizations may take from 3 to 5 business days to be processed. Prescription requests may be denied if an appointment is required before refills will be authorized. Please make refill requests **PRIOR** to running out of medication.

I understand and agree to the financial policy and practice procedures as outlined above:

Patient Name (please print) _____ **Date**_____

Patient/Guardian Signature_____

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MID-LEVEL PRACTITIONER CONSENT FOR TREATMENT

Kelly L. Wimberly, M.D., P.A., has on staff mid-level practitioners, for example physician assistants and/or nurse practitioners, to assist in the delivery of medical care.

A mid-level practitioner is not a doctor. A nurse practitioner is a registered professional nurse who has received advanced graduate education and clinical training. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, mid-level practitioners can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

Mid-level practitioners may provide such medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

A mid-level practitioner can serve as a patient's primary health care provider and is able to provide the coordination and management of care required in various health care delivery models, such as medical home, accountable care organizations, transitional care, etc.

I have read the above and hereby consent to the services of a mid-level practitioner for my health care needs.

I understand that at any time I can refuse to see the mid-level practitioner and make an appointment to see a physician.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Patient/Guardian Signature Date

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YOUR PATIENT CENTERED MEDICAL HOME

Patient-centered

Patient-centered means you will be surrounded by a dedicated team of health professionals working together to meet all of your individual health care needs. As your primary care provider, I'm the most familiar with your health as a whole and will lead your team. The rest of the team includes other health care providers you already see of may need to see to maintain your optimal health.

Medical Home

Your team will be able to keep up with your health status at all times and will use technology like electronic medical records to communicate with each other and coordinate your care. When you get a lab test, for instance, everyone on the team will have access to the results. Instead of finding out what's going on with your health when you come in for an appointment, all of your team members will be on the same page all the time.

Join the Team

Dr. Kelly Wimberly and her mid-level providers want to help you take responsibility for your health. As the patient, you are the most important part of your health care team. We can only make recommendations; the power to decide if you will follow them is yours. So, as part of your health care team, we hope you will share the team's goal: to give yourself the best care possible. It's not difficult, but it's important.

Here are some thing you can do:

- Communicate with all the members of your care team about your health needs. You can contact the office for clinical advice by phone or web portal during office hours. The office has an answering service for emergencies when we are closed and non-urgent messages may be sent through your patient portal.
- Share any updates on medications, dietary supplements, or remedies you're using, and ask any questions you may have about them when you come for a visit.
- Provide the office with a complete medical history and inform us when you see another health care provider so we can add them to your team and help coordinate your care.
- Do your best to keep scheduled appointments or, if you can't, call to reschedule or cancel as early as possible.
- Feel free to ask questions about your care, tell us then you don't understand something, and ask for information about how to stay as health as possible.
- Let us know if you do not receive your test results within two week.

- Feel comfortable working with members of your extended health care team who I have asked to contact you for health and wellness coaching, education, and advice.
- Offer any feedback you might have to help us improve our care.

Here are the things we will do:

- We will ask you what your health care goal is or what you want to do to improve your health.
- We will ask you to help plan your care and let us know if you think you can follow the plan.
- We will give you a written copy of the care plan.
- We will have team care members managing more and/or different parts of your care.
- We will remind you when tests are due so you can receive the best quality care.
- We will use current, best evidence in decision making about your care and offer support for self-management of your health and healthcare.
- We may ask you to have blood tests done before your visits so the doctor has the results at your visit.
- We will continue to increase the use of technology as we manage your healthcare in ways such as e-prescriptions and self-management support materials.

As part of our Patient Centered Medical Home orientation, we are asking you to acknowledge your agreement to the above, and we acknowledge our agreement to you. Either you or your doctor may end this partnership at any time. If you choose to end the partnership, please notify us as tell us why. If your doctor decides to stop seeing you, we will notify you with an explanation as to why. With your written permission, we will then forward a copy of your information to your next doctor.

Thank you for choosing Dr. Kelly L. Wimberly, M.D., P.A., as your primary care physician.

Please circle the name(s) of your preferred provider(s). The office will strive to schedule you with your preferred provider(s) whenever possible, but some situations may arise when the provider you prefer is not available. We will be glad to schedule you with another provider of your choosing at that time.

Dr. Kelly L Wimberly, M.D.	Gina Quon, PA-C	Jill Weinger, PA-C
Carolyn Martin, ANP	Breshena Marshall, PA-C	No Preference

Patient Name (please print)_____ **DOB** _____/_____/_____

Patient/Guardian Signature_____ Date_____