

Acknowledgment Regarding Insurance Coverage

Insurances do not always cover all costs including but not limited to office visits, labs, ultra sounds/imaging, or procedures.

You could receive a bill for the following, including but not limited to:

1. Your plan does not cover/has exclusions labs such as genetic testing.
2. Procedures, test, etc. not deemed "Medically Necessary" by your plan.
3. You have not met your plan Deductible or Out of Pocket.
4. Insurance information on file in our office is not Up-to-Date.

*IT IS YOUR RESPONSIBILITY AS A POLICY HOLDER TO UNDERSTAND WHAT YOUR PLAN COVERS OR EXCLUDES.

*IT IS YOUR RESPONSIBILITY TO ENSURE OUR OFFICE HAS UP-TO-DATE AND ACCURATE INSURANCE POLICY INFORMATION, INCLUDING MULTIPLE POLICIES (PRIVATE AND MEDICAID). PLEASE INFORM OUR OFFICE OF ALL ACTIVE INSURANCE POLICIES AS WELL AS ANY CHANGES TO YOUR INSURANCE COVERAGE. FAILURE TO DO SO MAY RESULT IN CLAIM DENIAL LEAVING YOUR CHARGES UNPAID BY YOUR INSURANCE, WHICH YOU WILL THEN BE RESPONSIBLE FOR PAYING.

This form serves as an acknowledgment that you have read and understand the above stated information.

Signature of Patient

Date

DR. TRACY PIPKIN MD, PA
2870 LEWIS LANE, SUITE 229
PARIS, TX 75460
(903)739-9006
FAX: (903)737-4577

PATIENT HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____

A) Name: _____ **Age:** _____ **DOB:** _____

1. Marital Status: Single Married Long-Term Relationship Divorced Widowed
2. Reason for Visit: _____
3. Referring Physician or PCP: _____
4. Occupation: _____
5. Preferred Phone Number: _____

B) Menstrual History (Please complete even if post-menopausal or no longer having periods)

1. Age of first period. : _____
2. My menstrual periods are regular and start every _____ days
3. My menstrual periods are irregular and start every _____ to _____ days (12-45)
4. Duration of bleeding: _____ days
5. Does bleeding or spotting occur between periods: YES NO
6. Does bleeding or spotting occur after intercourse: YES NO
7. First day of last Menstrual period: _____
8. Is pain associated with periods: YES NO
9. IF yes, is it: Before periods During periods Both

C) PREGNANCY HISTORY (ALL PREGNANCIES) HAVE NEVER BEEN PREGNANT
OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

YEAR	PLACE OF DELIVERY OR TERMINATION	DURATION PREGNANCY	HOURS IN LABOR	TYPE OF DELIVERY	COMPLICATIONS -PRECLAMPSIA -GEST. DIABETES -PREMATURE LABOR	CHILD SEX	CHILD BIRTH WEIGHT	CHILD PRESENT HEALTH

D) BIRTH CONTROL HISTORY

What birth control method(s) do you currently use: _____

E) SEXUAL HISTORY

1. Do you have a sexual partner? YES NO MALE FEMALE
2. Are there concerns about your sexual activity which you may want to discuss with your doctor?
 YES NO

F) PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES: CHECK ALL THAT APPLY OR NONE

SURGERY	YEAR	SURGERY	YEAR
<input type="checkbox"/> D&C	_____	<input type="checkbox"/> Ovarian Surgery	_____
<input type="checkbox"/> Hysteroscopy	_____	<input type="checkbox"/> L cyst(s) removed ovarian	_____
<input type="checkbox"/> Infertility Surgery	_____	<input type="checkbox"/> R cyst(s) removed ovarian	_____
<input type="checkbox"/> Tuboplasty	_____	<input type="checkbox"/> L ovary removed	_____
<input type="checkbox"/> Tubal Ligation	_____	<input type="checkbox"/> R ovary removed	_____
<input type="checkbox"/> Laparoscopy	_____	<input type="checkbox"/> Vaginal or Bladder repair for prolapsed or incontinence	_____
<input type="checkbox"/> Hysterectomy(vaginal)	_____	<input type="checkbox"/> Other (Specify)_____	_____
<input type="checkbox"/> Hysterectomy (adominal)	_____		
<input type="checkbox"/> Myomectomy	_____		

G) PAST SURGICAL HISTORY (NOT OB/GYN): LIST ALL SURGERIES AND THEIR YEAR OR NONE

SURGERY	MONTH/YEAR	COMPLICATIONS

H) PAP SMEAR/MAMMOGRAM HISTORY

1. Date of lat pap smear: _____ Normal Abnormal
2. Have you had abnormal pap smears? YES NO
3. Have you had treatment for abnormal smear? YES NO
4. If yes, what type(s) of treatment have you had?

Treatment	Year	Treatment	Year
<input type="checkbox"/> Cryotherapy	_____	<input type="checkbox"/> Cone Biopsy	_____
<input type="checkbox"/> Laser	_____	<input type="checkbox"/> Loop excision (LEEP)	_____
5. Date of last mammogram: _____
6. Have you had abnormal mammogram: YES NO

OTHER PAST GYNECOLOGICAL HISTORY: CHECK ALL THAT APPLY OR NONE

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Venereal Warts | <input type="checkbox"/> Herpes-genital | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> HPV | <input type="checkbox"/> Other (Specify) _____ | | |

I) PAST MEDICAL HISTORY: CHECK ALL THAT APPLY OR NONE

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Diabetes: | <input type="checkbox"/> Liver Disease, includes hepatitis | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Diet Controlled | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV + |
| <input type="checkbox"/> Pill Controlled | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Insulin Controlled | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Gestational | <input type="checkbox"/> Blood Clots Leg/Thigh | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Cancer (Specify) | _____ |
| <input type="checkbox"/> Kidney Disease | _____ | _____ |

J) CURRENT MEDICATIONS (INCLUDE DOSE/AMOUNT PER DAY)

MEDICATION	DOSE	FREQUENCY

K) DO YOU CURRENTLY:

- Smoking: Never Yes, Packs/Day: _____ Cigarettes
 Former Years Smoked: _____ VAP HOOKA
- Alcohol: Never Former Yes, Drinks/Week: _____ Type: _____
 Illicit Drugs: Never Former Yes Type: _____
 Caffeine Intake YES NO
 Coffee Tea Soda Energy Drink Chocolate Daily Intake: _____
- Lifestyle: Are you on a specific diet? YES NO If yes, which type of diet: _____
 Do you exercise regularly? YES NO If yes, which type of exercise: _____

L) DRUG ALLERGIES NO YES, LIST:

M) FAMILY HISTORY OR NONE

	DECEASED (Note age & cause)	AFFECTED RELATIVES (Father, Mother, Brother, Sister, Son, or Daughter)
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Ovarian Cancer	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Endometrial Cancer	_____	_____
<input type="checkbox"/> Breast Cancer	_____	_____
<input type="checkbox"/> Colon Cancer	_____	_____
<input type="checkbox"/> Other (Specify)	_____	_____

N) OTHER SYMPTOMS OR PROBLEMS: CHECK ALL THAT APPLY OR NONE

- | | | |
|---|---|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Hair Growth | <input type="checkbox"/> Change in Energy |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Change in Exercise Tolerance |
| <input type="checkbox"/> Breast Discharge | <input type="checkbox"/> Hot Flushing/Flashing | <input type="checkbox"/> Change in Urinary Function |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Physical Abuse/Domestic Violence | <input type="checkbox"/> Other (Specify): _____ |

0) COMPLETE ONLY IF YOU ARE PREGNANT OR PLANNING TO BE PREGNANT IN THE NEAR FUTURE

Have you or the baby's father or anyone in immediate families ever had the following :

AFFECTED RELATIVES
(Father, Mother, Brother, Sister, Son, or Daughter)

- Down Syndrome (monogolism) _____
- Other Chromosomal abnormality _____
- Neural Tube Defect (spina bifida, anecephaly) _____
- Hemophilia or orhter coagulation abnormality _____
- Muscular Dystrophy _____
- Cystic Fibrosis _____

If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs Disease?

Father Result: _____

Mother Result: _____

If you or the baby's biological father are of African ancestry, have either of you been tested for Sickle Cell Trait?

Father Result: _____

Mother Result: _____

If you or the baby's biological father are of Italian, Greek, or Mediterranean ancestry, have either of you been tested for B-thalessemia?

Father Result: _____

Mother Result: _____

If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalessemia?

Father Result: _____

Mother Result: _____

IN CASE OF EMERGENCY, WOULD YOU CONSENT TO TRANSFUSION OF BLOOD PRODUCTS? _____

Patient Signature

Date

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CONSENT FORM FOR THE HIV ANTIBODY BLOOD TEST

I have been informed that my blood will be tested in order to detect whether or not I have antibodies in my blood to the HIV virus, which is probably the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood and using a substance to test the blood.

I have been informed that the test is new and it's accuracy and reliability is still uncertain and that the test results in some cases may indicate that a person has antibodies to the virus when the person does not (false positive) or fail to detect that a person had antibodies (false negative). I also have been informed that a positive blood test results does not mean that I have AIDS and that in order to diagnose AIDS, other means must be used in conjunction with the blood test.

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks and alternative tests, I may ask questions before I decide to consent to the blood test.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood test and release of results and have had all my questions answered. Further, I acknowledge that I have given consent for the performance of a blood test to detect antibodies of HIV virus.

_____ I HEREBY **CONSENT** TO BE TESTED FOR HIV ANTIBODY

_____ I HEREBY **REFUSE** TO BE TESTED FOR HIV ANTIBODY

Patient Name: _____ (Please Print) Date of Birth: _____

Signature of Patient or Guardian

Date

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Request for Release of Protected Health Information (PHI)

Patient's Name (Please Print) _____ Date of Birth _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____

Do hereby authorize the use and/or disclosure of my protected health information (PHI)

AUTHORIZED ENTITY

I request to have information released **from** or **to** the following entity: (check one)

Name _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

AUTHORIZED PROTECTED HEALTH INFORMATION

- Complete Record
- Records of care from _____ to _____
- Records of care regarding condition(s): _____
- Confer with designated person(s) orally about information in my medical record
- Other/Specify: _____

I understand that the release of medical records may involve making available to myself or to the other information of a personal nature. Issues with regard to personal use of cigarettes, alcohol, and other drugs, as well as possible exposure to infections disease may be part of the medical record.

HIV/AIDS: I Consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records YES NO Initials: _____

Purpose of Disclosure: Medical Care Employer Attorney Insurance Other: _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA Privacy regulations. I hereby acknowledge that this consent is truly voluntary and valid until revoked, and that I may revoke this consent at any time; In writing, except to the extent that action based on this consent has been taken. I further understand that this authorization will expire in 180 days from the signature date unless specified otherwise. _____(expiration date).

Signature of Patient or Legal Guardian _____ Date _____

Signature of Witness _____ Date _____

**DR. TRACY PIPKIN MD, PA
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**ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES, HIPAA**

I authorize payment of medical benefits to Dr. Tracy Pipkin MD, PA for any services rendered to me or to the minor child. I authorize any holder of medical information about me, or the minor, to release to my insurance company, or any third party payers and their agents, any information needed. I understand that Medicare and some other insurance policies do not cover some items(s) or service(s). The fact that Medicare or some insurances may not pay for certain things does not mean I should not receive them. I understand that I am responsible for all charges (including any account collection charges incurred) not paid by Insurance.

I understand and have been offered a HIPAA Notice of Privacy Practices, which provides a more complete description of information uses and disclosures. I understand that I am entitled to receive a copy of this document.

I understand that I have the right to revoke anyone listed on the authorization and must fill out a form before the revocation can be complete. All revocations must be sent to Dr. Tracy Pipkin, attention of Privacy Officer and are not effective until received by the Privacy Officer. I further understand that Dr. Pipkin reserves the right to change their notice and practices and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should a change be made, a copy of the revised notice will be provided to the address on file.

I understand that as part of this organizations treatment and payment of healthcare operations, It may be necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this authorization.

Signature of Patient or Personal Representative

Date

Please **DO NOT** contact me in the following manner:

(Check all that apply)

Do NOT call my:

Do NOT leave a message at my:

Do NOT mail information to:

Home Phone

Home Phone

Home

Cell Phone

Cell Phone

Work Address

Work Phone

Work Phone

Name(s) of Person(s) who may receive my information

Please Print Legibly

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Name

Relationship

Phone Number

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REGISTRATION FORM

TODAY'S DATE:		PCP:	
PATIENT INFORMATION			
PATIENT LAST NAME:	FIRST:	MIDDLE:	<input type="checkbox"/> MR <input type="checkbox"/> MISS <input type="checkbox"/> MRS <input type="checkbox"/> MS
			MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOWED
IS THIS YOUR LEGAL NAME IF NOT WHAT IS YOUR LEGAL NAME:		FORMER NAME:	BIRTH DATE: AGE: SEX:
<input type="checkbox"/> YES <input type="checkbox"/> NO			/ / <input type="checkbox"/> M <input type="checkbox"/> F
STREET ADDRESS:		SOCIAL SECURITY NUMBER:	HOME PHONE NUMBER: ()
PO BOX:	CITY:	STATE:	ZIP CODE:
OCCUPATION:		EMPLOYER:	WORK PHONE NUMBER:
REFERRED BY:	<input type="checkbox"/> DR	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> HOSPITAL
	<input type="checkbox"/> FAMILY	<input type="checkbox"/> OTHER:	
OTHER FAMILY MEMBERS SEEN HERE:			
RACE:		ETHNICITY: <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON HISPANIC	LANGUAGE SPOKEN:
PRIMARY CARE PHYSICIAN:		PHONE NUMBER:	
PHARMACY:		PHONE NUMBER:	
MAIL ORDER:			
IN CASE OF EMERGENCY			
NAME OF LOCAL FRIEND OR RELATIVE (Not living with you):		RELATIONSHIP TO PATIENT:	HOME PHONE NUMBER: OTHER PHONE NUMBER:
The above information is true to the best of my knowledge. I authorize my Insurance benefits be paid directly to this physician. I understand that I am financially responsible for any balance. I also authorize Tracy Pipkin MD, PA or Insurance company to release any information required to process my claims.			
Patient/Guardian signature: _____		Date: _____	
INSURANCE			
INSURANCE NAME:		POLICY/SUBSCRIBER NUMBER:	GROUP NUMBER:
WHO IS POLICY HOLDER (PLEASE CIRCLE ONE): PATIENT PARENT SPOUSE OTHER: _____			
IF POLICY HOLDER IS NOT PATIENT PLEASE LIST:			
NAME: _____		DATE OF BIRTH: _____	
SOCIAL SECURITY NUMBER: _____		EMPLOYER: _____	

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PARIS, TX 75460**

Dr. Tracy Pipkin MD, PA
2870 Lewis Lane, Suite 229
Paris, Texas 75460
(903) 739-9006
Fax: (903) 737-4577

Telehealth/Virtual Insurance Disclaimer

A quote of benefits and/or authorization does not guarantee payment. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies

Patient's Name / Date

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Patient Forms

It is the goal for Dr. Pipkin and staff to accommodate as many requests as possible to the furthest reasonable extent in an accurate and timely manner. Due to the increasing amount of request, we are instituting a fee for all patient forms.

FORMS AND LETTERS

1. Blank forms will not be accepted. Personal information must be completed.
2. Turnaround time is usually 7 business days.
3. Many forms require a current examination prior to being completed; if so, we will make an appointment as soon as one is available.
4. The charge for review and completion of medical forms is \$15.00. It is due at the time of drop off of forms.
5. There will be a \$10.00 fee for letters written by physician.

FMLA/Disability Forms

1. Blank forms will not be accepted. Personal information must be completed.
2. Turnaround time is usually 7 business days.
3. A request form must be completely filled out prior to your forms being filled out.
4. There is a \$15.00 fee due when forms are completed.

INCOMING/OUTGOING MEDICAL RECORDS

1. If you are requesting a copy of your medical records, there is a \$25.00 fee and a turnaround time of usually 7 business days.
2. If you are transferring care to another provider, we will send those records to the new physician once a released is signed.

Patient Signature

Date

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AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR THE SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE TRACY PIPKIN MD, PA TO FURNISH THE INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO TRACY PIPKIN MD, PA LLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HER/HIS ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, E-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENT'S) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

PATIENT INFORMATION CONSENT:

I UNDERSTAND THAT TRACY PIPKIN MD, PA MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT OF SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES TRACY PIPKIN MD, PA TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS.)

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW TRACY PIPKIN MD, PA PRIVACY NOTICE TO REQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND REVOKE MY CONSENT AT A LATER DATE.

I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, TRACY PIPKIN MD, PA MAY REFUSE TO UNDERTAKE MY CARE.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, ADMINISTRATION OF ANY NEEDED ANESTHETICS, AND PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I UNDERSTAND TRACY PIPKIN MD, PA MAY INCLUDE CONSENT AT SATELLITE OFFICES UNDER COMMON OWNERSHIP.

MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO TRACY PIPKIN MD, PA.

HIPAA ACKNOWLEDGEMENT: I HAVE RECEIVED AND READ TRACY PIPKIN MD, PA'S NOTICE OF PRIVACY PRACTICES. IN MY ABSENCE OR FOR THE BENEFIT OF OBTAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING _____ (PLEASE LIST AUTHORIZED REPRESENTATIVE OR MARK N/A)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT. ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

_____ (Patient/Guardian Signature)

**DR. TRACY PIPKIN MD, PA
2870 LEWIS LANE, SUITE 229
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Consent to Treatment:

The services provided by Tracy Pipkin MD, PA are by a licensed physician to treat medical problems. I have read the above statement and hereby consent to the treatment for myself or the minor in my care.

Assignment of Benefits:

I authorize payment of any medical benefits to the contracted providers with Tracy Pipkin MD, PA for charges that may be billed on my behalf. I authorize release of any information necessary to secure payment.

Payment Policies:

I understand and agree that payment for services rendered is due at the time of service, and any other arrangements must be made prior to service. I understand that all co-payments or co-insurance amounts are due at the time of service and that I may be billed for any balance remaining after my insurance processes the claims.

Notice of Privacy Practices:

I acknowledge that I have seen the written privacy practices of Tracy Pipkin MD, PA.

Patient Name(Please Print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Prescription History Consent:

I give my consent to have Tracy Pipkin MD, PA to obtain my prescription history from external sources.

Patient or Authorized Person's Signature: _____

*****Dr. Pipkin is not a pain specialist and will not write monthly pain prescriptions*****

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OFFICE POLICIES

THANK YOU FOR CHOOSING DR. TRACY PIPKIN MD, PA FOR YOUR HEALTH CARE!!

PRIVACY PRACTICES:

You will be asked to read and sign notification of our Privacy Practice. We also have another form for communicating with another person regarding your health or messages, e.g. spouse, mother, father, etc. It gives us permission to discuss the patient's protected health information. Unless we have this form with the person's name on file, we will not be able to discuss the patient's protected health information with another person other than you.

GENERAL OFFICE POLICIES:

APPOINTMENTS: Patients are seen by appointment only. We pride ourselves in being able to offer same-day acute-visit appointments, if requested early in the day.

We try our best to run on time. Therefore, if you are more than 15 minutes late, it is up to the discretion of the provider whether we will be able to see you at your time slot. You may be asked to reschedule.

We call/text one day in advance for appointment reminders. This allows us to see all the patients who have requested appointments times that day. We do request that you cancel your appointment 24 hours in advance, or you may be billed \$25.00. After three No-Call No-Show appointments, patients may be dismissed from the practice.

Dr. Tracy Pipkin MD, PA will always see the patient by themselves first, if the patient wishes family members to join the exam room, they will be called in at the appropriate time.

Office Hours: Our office hours are 8:00am to 4:30pm Monday, Tuesday, Thursday and 8:00am to 3:00pm on Wednesday. We are closed Friday, Saturday, Sunday and all major holidays. Dr Tracy Pipkin MD, PA or a covering physician is available 24 hours a day for urgent situations, just call the office phone and follow the directions. Please leave a number that will accept blocked number calls when leaving a message.

New Patient: Dr. Tracy Pipkin MD, PA welcomes new patients of all ages to our practice. It is a good idea to verify Dr. Tracy Pipkin MD, PA name as a provider on your insurance web site.

Terminating Relationship: Unfortunately, It is sometimes necessary to terminate the patient/physician relationship. We will provide written notice of the termination and comply with regulations stipulated by the Texas Medical Board.

FINANCIAL POLICIES:

INSURANCE CARDS: You will be asked to present your insurance card at every visit. Although this might be inconvenient, it is necessary. Insurance plans and ID numbers change in order to keep social security numbers off the ID card.

BENEFITS: Insurance benefits can be very confusing. Each company has many different types of policies. Our office will try to help you as best we can. Ultimately, it is your responsibility to know your benefits, including limitations and exclusions, as you are responsible for payment. If you have any questions regarding any of this including covered services, deductibles, maximum benefits, please contact the insurance administrator of your employer or your insurance company.

NEW INSURANCE: If you have new insurance, please let us know at the time of your scheduled appointment in order for us to verify benefits prior to your appointment. If we are unable to verify, you will be responsible for the total allowable charges. When your insurance company does pay, we will refund your overpayment.

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FAX: (903)737-4577

CO-PAY: Co-payment will be collected at check in, unless you have a co-insurance plan (e.g. 80/20). If this is your plan, we will try to calculate as best we can your estimated co-insurance after you have seen Provider. This may take a little extra time, as we will look up the allowable charges from your insurance company. If you have a deductible, insurance companies require you to meet this before they make payment. Some PPO plans have co-pay only for sick visits, and a deductible for other services, e.g. labs, immunizations, procedures.

HMO/POS: You are required to be directed/referred by our Primary Care Physician (PCP) that you have selected or been assigned to by our insurance company before your appointment with Dr. Tracy Pipkin MD, PA. If you have not done this, your insurance will not pay for your visit and you would be responsible for payment in full.

INSURANCE PAYMENTS: We will sometimes ask your assistance to get the insurance company to pay the submitted charges. If they request some information from you, it is extremely important that you get them the information they request in a prompt manner. Always keep a copy of what you send them, along with the person's name to send it to. Please follow up with that person within 24 hours to verify that they have received the information you sent and will be processing your claims. Ultimately, it is your responsibility for payment of services provided.

RESPONSIBLE PARTY: If the patient is a minor, the parent or guardian bringing the child to the appointment is responsible for all co-payments, co-insurance, and outstanding balances. We will provide a receipt of payment in order that retrieval of payment can be refunding to the paying parent.

SELF PAY: Payment is required in full at the time of Service.

TREATMENT:

Your treatment will be based on medical necessity. Some procedures and labs may not be covered under your particular plan. It is not our responsibility to verify that everything is covered before treatment is provided.

MEDICATION: We prescribe the medication that we feel is best suited to your condition. If this medication is not covered, or has a very high co-pay, we would need to be provided with alternatives that are financially acceptable to you.

REFILLS: Please plan ahead for your prescription refills. If your prescription says no refills, please call your pharmacy. They will process an electronic fax request to us. We need at least 24 hours' notice to process the authorization.

REFERRALS: Sometimes it is necessary for you to obtain a referral authorization from your primary care physician in order to see a specialist for the patient's condition. Please verify that your primary care physician has obtained a referral authorization and you receive documentation of that authorization. We can schedule the patient without documentation of the referral but the physician will not be able to treat the patient without the documentation. Most Primary care physicians require at least 48 hour notice to process the referral authorization.

HOSPITALIZATION: If the situation arises that the patient requires hospitalization, Dr Tracy Pipkin MD, PA or a physician that is covering admissions for her will care for you while you are in hospital, if the physician has appropriate privileges at the hospital for which the patient is admitted.

MEDICAL RECORDS AND FORMS:

Our office follows the rules set forth by the Texas Medical Board when preparing and furnishing medical records. A \$25.00 charge for the first 20 pages and .05 per page for every copy thereafter, is what they consider reasonable fee. This fee includes the cost of copying and postage. Payment must be made prior to release of records. We ask that you allow 15 business days to process this from the date of the written request. Copies of diagnostic test will be provided at no charge with a 48 hour notice. If you require a form or letter be completed by the physician (other than excuse notes), a 48 hour notice is required.

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OFFICE POLICY REGARDING PAYMENT

OFFICE VISITS

All accounts are to be paid in full at the time of service. If a check is returned, all services will be rendered on a cash basis. There will be a \$35.00 charge on all returned checks.

SURGERY

Surgery usually involves a larger fee than office procedures; therefore, these fees may be made over several months. We will prepare a payment plan that is acceptable to both you and Dr. Pipkin MD, PA. Insurance payments are to be assigned to the office. In the event of overpayment, Dr. Tracy Pipkin MD, PA will issue you a check for the overpayment. If you do not wish to assign the insurance benefits to us, the full surgical fee is payable in advance.

We will not accept Medicaid after treatment is rendered.

OBSTETRICAL

The Obstetrical fee covers your office visits and your delivery. It does not cover non-routine lab or ultrasound charges. We will prepare a payment plan that is acceptable to both you and Dr. Tracy Pipkin MD, PA for the amount you are responsible for. If at any time during your pregnancy, you transfer to terminate your care with us, you will be charged per visit for each time you were seen. **Once you begin your care with us (whether you are private pay or have insurance) we will not change or file Medicaid.** You may apply for Medicaid to help with the hospital bill, but Dr Tracy Pipkin MD, PA will not accept Medicaid for her fee after your initial visit is private pay or if you have insurance. In the event, your private insurance terminates and Medicaid is then active, previous payments will apply to antepartum care and will not be returned/refunded.

MEDICARE

Our office is a Medicare participating facility. We will file your claims as assigned. Medicare requires lab fees to be filed as assigned; however, should Medicare find your lab charges "not reasonable or necessary", you will be responsible for these charges.

PATHOLOGY

If you have a procedure that requires a reading from Pathologist, you may receive an additional bill from his/her office.

DELINQUENT ACCOUNTS

If you have difficulty paying your account balance, please speak with our Office Manager to arrange a payment plan that is acceptable to both you and Dr. Tracy Pipkin MD, PA. If your account becomes 60 days or more past due without correspondence or payment from you, your account will be turned over to our Collections Department. If this should occur, you WILL NOT be seen by Dr. Tracy Pipkin MD, PA until special arrangements have been made regarding your past due account.

REFUNDS

Refund checks for overpayment will be issued monthly.

Your Signature below indicated you have read and understand the above.

Signature: _____

Date: _____