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 Staus: □ 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 loner 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
□ D&C	_____	□ Ovarian Surgery	_____
□ Hysteroscopy	_____	□ L cyst(s) removed ovarian	_____
□Infertility Surgery	_____	□ R cyst(s) removed ovarian	_____
□ Tuboplasty	_____	□ L ovary removed	_____
□ Tubal Ligation	_____	□ R ovary removed	_____
□Laparoscopy	_____	□ Vaginal or Bladder repair for prolaspsed or incontience	_____
□ Hysterectomy(vaginal)	_____		
□ Hysterectomy (adominal)	_____	□ Other (Specify)_____	_____
□ 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**
□ Cryotherapy	_____	□ Cone Biopsy	_____
□ Laser	_____	□ 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

☐ Venereal Warts ☐ Herpes-genital ☐ Syphilis ☐ Pelvic Inflammatory Disease
☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea ☐ Vaginal Infections
☐ HPV ☐ Other (Specify) _____

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

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

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)
□ Diabetes	_____	_____
□ Ovarian Cancer	_____	_____
□ Heart Diseae	_____	_____
□ Endometrial Cancer	_____	_____
□ Breast Cancer	_____	_____
□Colon Cancer	_____	_____
□Other (Specify)	_____	_____

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

□ Weight Loss □Hair Growth □ Change in Energy
□ Weight Gain □Hair Loss □ Change in Exercise Tolerance
□ Breast Discharge □Hot Flushing/Flashing □ Change in Urinary Function
□ High Cholesterol □Physical Abuse/Domestic Violence □ Other (Specify): _____
_____

O) **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**

DR. TRACY PIPKIN MD, PA
2870 LEWIS LANE, SUITE 229
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(903)739-9006
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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 of Guardian Date

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

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 herby 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 basd 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
2870 LEWIS LANE, SUITE 229
PARIS, TX 75460

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

DR. TRACY PIPKIN MD, PA
2870 LEWIS LANE, SUITE 229
PARIS, TX 75460

REGISTRATION FORM

TODAY'S DATE:	PCP:

PATIENT INFORMATION

PATIENT LAST NAME:	FIRST:	MIDDLE:	☐ MR ☐ MISS ☐ MRS ☐ MS	MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOWED

IS THIS YOUR LEGAL NAME ☐ YES ☐ NO	IF NOT WHAT IS YOUR LEGAL NAME:	FORMER NAME:	BIRTH DATE: / /	AGE:	SEX: ☐ M ☐ F

STREET ADDRESS:	SOCIAL SECURITY NUMBER:	HOME PHONE NUMBER: ( )

PO BOX:	CITY:	STATE:	ZIP CODE:

OCCUPATION:	EMPLOYER:	WORK PHONE NUMBER:

REFERRED BY:	☐ DR	☐ INSURANCE	☐ HOSPITAL	☐ FAMILY	☐ OTHER:

OTHER FAMILY MEMBERS SEEN HERE:

RACE:	ETHNICITY: ☐ HISPANIC ☐ 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: _____

DR. TRACY PIPKIN MD, PA
2870 LEWIS LANE, SUITE 229
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

DR. TRACY PIPKIN MD, PA
2870 LEWIS LANE, SUITE 229
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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

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

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 OR 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 TH 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 OF PART OF MY (PATIENT'S) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OF 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 OFR 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 T HE 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 INTENT 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 GAINGIN 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 SONTENT. 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
PARIS, TX 75460
(903)739-9006
FAX: (903)737-4577

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*****