Welcome!

Ministering Physicians, PA is a home visiting, palliative care practice. We provide and coordinate medical care to achieve the best quality of life and comfort to the whole person. Evaluating health status, ordering and interpreting diagnostic tests, and anticipating challenges in order to prevent them, are all part of our routine visits.

Since we are a home visit practice, we build teams with families, advance practice nurses, home health nurses and therapists, physician specialists, and hospices to provide the optimum trust, communication and care. While we are not an emergency service, many acute situations can be resolved by our team as the hands, ears, eyes and feet of the physician so you don't have to leave your home.

Just like your office-based physicians and providers, we are required by law to have new patient paperwork completed and signed prior to seeing you or your loved one. To best serve you, please complete and/or have the assisted living community or responsible party supply the following essential items:

1. Authorization to Provide Treatment
2. Acknowledgement of Receipt of Notice of Privacy Practices
3. Demographic Data (or Facility's form)
4. Patient History (or Facility's form or recent history & physical)
5. Medication List (or Facility's MAR)
6. Copy of insurance card(s)

Ministering Physicians is a Texas company that supports medical missions and gives all the glory to God! It is an honor and a privilege for us to provide your care.

Sincerely,

The Physicians, Nurse Practitioners and Staff

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO PROVIDE TREATMENT

A Ministering Physicians P.A. medical practitioner can provide medical care, including medical exams, evaluation and treatment of acute and chronic health conditions, ordering lab tests, prescriptions, ongoing monitoring and treatment. Ministering Physicians P.A. bills third party payers for "medically necessary visits".

_____

Patient Last Name *First* *Initial* *Social Security Number*

_____

Patient Address

I (patient name),_____authorize Ministering Physicians P.A. to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers or any other commercial insurance company, any information needed for this or a related health care services claim. I permit a copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits either to myself or to the care provider who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

By Consenting to this Agreement, you designate Ministering Physicians to provide Chronic Care management (CCM) services. Only one practitioner can furnish CCM services to you during a 30-day period. You authorize electronic communication of you medical information with other treating providers to facilitate the coordination of your care.

Additionally, services that are not covered by my insurance company and are determined to be payable, such as coinsurance, deductibles, and amounts that exceed the annual or lifetime maximum benefits, are my responsibility. Please remember that Medicare and other insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with the insurer).

I also hereby grant permission for Practitioners employed by Ministering Physicians P.A. to assess and treat me for medical problems. I understand that the Practitioner is a licensed healthcare professional in the State in which I reside. This Agreement may be revoked at any time by notifying our practice.

_____ _____

Signature of Patient or Responsible Party Date

NOTICE OF PRIVACY INFORMATION PRACTICES

I, [name of Patient],_____, acknowledge that I have received or have access to a copy of Ministering Physicians, P.A. notice of privacy information practices.

_____ _____

Patient or Legal Representative Signature Date

DEMOGRAPHIC DATA

(Or provide facility form)

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Address (or Facility) _____

Phone # _____ Soc Sec #_____ SEX: M / F

Marital status _____ Name of Spouse _____

Note: We are unable to schedule appointments unless insurance information is provided. **Please provide copies of all insurance cards.** Thank you.

Medicare Number _____ Is Medicare Primary? Y / N

Secondary Insurance _____ Phone Number: _____

Name of Policy holder _____ Relationship to Policy holder _____

Policy Number _____ Group Number _____

Emergency Contact (POA) _____ Relationship _____

Address _____

Cell Phone _____ Home Phone _____Work Phone _____

Email address _____

Billing Party (if different from above) _____ Relationship _____

Address _____

Cell Phone _____ Home phone _____ Work phone _____

Other Contact Person(s): Name, relationship, cell phone

_____

_____

Previous Physician _____ Phone# _____

Specialist _____ Specialty _____ Phone_____

Specialist _____Specialty _____ Phone_____

Home Health Agency _____ Hospice _____

DME Company _____

Dialysis _____ When _____

Additional Information:

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize _____ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, for purposes of continuity of care, to:

Ministering Physicians, P.A. 3000 Joe DiMaggio Blvd, Ste. 15, Round Rock, TX 78634

Patient Name _____ DOB _____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial: _____ Date _____**

The information you may release subject to this signed release form is as follows:

___ Complete records	___ Hospital records	___ Medication record
___ Lab reports	___ Progress notes	___ Care plan
___ Operative reports	___ Radiology reports	___ Treatment record
___ History & Physical	___ Pathology reports	___ Other _____

I understand this information will be provided within 15 days from receipt of request, and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

_____ Date _____
Signature of Patient or Personal Representative

_____
Printed Name **Relationship to Patient**

Patient's name: _____

Medical History: Do you have or have you ever had: (please check all that apply)

___Impaired hearing
___Seasonal allergies
___Difficulty swallowing
___Macular degeneration
___Glaucoma
___Cataracts
___Pneumonia
When _____
___Inhaler/nebulizer use
___Asthma
___COPD
___Emphysema
___Smoked cigarettes
Packs/day _____
How long _____
When did you quit _____
___Currently drink alcohol
___Eczema
___Psoriasis
___Skin breakdown
Where _____
___High blood pressure
___Atrial fibrillation
___Heart attack
When _____

___Bypass or stints
When _____
___Valve problems
___Stomach ulcer
___Heartburn
___GERD
___Appendix removed
When _____
___Gallbladder removed When
_
___Hemorrhoids
___Hernia
___Anemia
___Cancer
Type _____
___Urinary tract infection
When/last _____
___Hysterectomy
When _____
___Prostate surgery
When _____
___Chronic pain
Where _____
___Arthritis
___Osteoporosis

___Joint surgery
Type _____
When _____
___Seizure
When/last _____
___Stroke/TIA
When/last _____
___Paralysis
Where _____
___Diabetes
___Thyroid disorder
___Parkinson's disease
___Alzheimer's disease
___Other dementia
___Depression
___Mood disorder
Type _____
Date of last:
Flu shot _____
Pneumovax _____
ChestXray _____
Mammogram _____
Colonoscopy _____
Other comments:

Medication List

Allergies: _____

Name of Pharmacy _____ Phone # _____

Address _____

Medications I currently take: (or provide MAR)

Name of Medication Dose How often/when I take it (example: Lasix 40mg daily in am)

_____

_____

_____

_____

_____

_____

_____