Welcome to Argyle Health Services

We are so happy you have chosen AHS to be your primary care provider.

Please fill out the enclosed new patient packet completely and sign.

Scheduling appointments: Call our office at 214-518-5016 to schedule your appointment. Or our office will call you the day before a scheduled appointment to confirm. Please note that if you are do not confirm your appointment within 24 hours, your appointment may be canceled.

We normally schedule follow up appointments approximately every 4 weeks depending on your medical needs. For acute issues, please call our office and we will get you scheduled as soon as possible, based on your needs. We try to do same day appointments if medical need dictates, so please do not hesitate to call.

Office Hours: Monday through Friday 9:00 am to 5:00 pm. If you call during business hours and leave a message our staff will return your call by no later than the following business day. If a message is left after hours, we will return the call the following business day for non-urgent matters.

X-rays and Labs: Normal lab work and x-rays will be discussed at your next scheduled visit. For abnormal labs or abnormal findings, our office will contact you directly for medication changes or directions for appropriate action to resolve your issue.

Prescription Refills: For all prescription refills, please call your pharmacy at least 5 days in advance of your medication running out. If there are no refills left, the pharmacy will contact our office to request additional refills. Please ensure the pharmacy has our correct office number and fax number, to ensure a quicker refill process.

Again, thank you for choosing AHS,

Office phone: 214-518-5106

Fax: 214-237-1280

Argyle Health Services

New Patient Data Sheet

Name: _____

Date of Birth: _____

Address: _____

Sex: **M** or **F**

Primary Insurance: _____ Policy #:_____ Group #:_____

Secondary Insurance: _____ Policy#_____ Group#_____

Emergency Contacts:

Name: _____ Email:_____

Address:_____

Phone Number:_____ Cell:_____

Service Providers:

Specialist: Name:_____ Type:_____

Phone Number:_____ Fax:_____

Specialist: Name:_____ Type:_____

Phone Number:_____ Fax:_____

Pharmacy:_____ Phone Number:_____

Hospital of Choice:_____

Resident has Living Will: **Y** or **N** Medical Power of Attorney: **Y** or **N**

Do Not Resuscitate: **Y** or **N** Please provide copies of all if applicable

Consent and Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing AHS as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payment due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

Please initial in each space below

_____ AUTHORIZATION TO MAIL, CALL, OR E-MAIL: NAME_____PHONE #_____

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize an Argyle Health Services, PLLC dba Adult Health Services representative or my practitioner to mail, call, or e-mail me/ or above mentioned with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the Argyle Health Services PLLC dba Adult Health Services to that effect in writing.

_____**LAB/ X-RAY/ DIAGNOSTIC SERVICES:** I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam, or physical , lab testing, X-Ray, EKG, and any other screening services or diagnostic testing ordered by the practitioner's staff. I understand that I may receive a separate bill for these services.

_____**CONSENT TO TREATMENT:** I hereby consent to evaluation, testing, and treatment as directed by my Argyle Health Services PLLC dba Adult Health Services or his/her designee.

_____**FINANCIAL:** I understand that if my account is not paid in full within 90 days of a statement, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current. **Person Financially Responsible (Guarantor)** if other than patient.

Name: _____ DOB: _____ Relationship to patient: _____

_____**FINANCIAL:** Argyle Health Services will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Argyle Health Services if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT US UP TO ME TO KNOW MY INSURANCE BENEFITS.

_____**FINANCIAL:** I understand that some primary insurances pay only a certain percentage of the visit and the secondary cost is either covered by my secondary insurance or if I do not have a secondary insurance the remaining balance is my responsibility. Also, my insurance may require me to pay a copay when services are rendered.

Copay_____ Costs not covered by primary insurance, excluding deductible: _____

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending practitioner.

Signature of Responsible Party: _____ Date: _____

Assignment of Benefits: We require insured patients to complete assignment of benefits authorizing insurance to remit payment to practitioner's office.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled private insurance and any other health plans to Argyle Health Services PLLC dba Adult Health Services. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges were or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure payment.

Signature of Responsible Party: _____ Date: _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for purposes required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your practitioner, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills to support the operation of the practitioner’s practice and any other use required by law.

Treatment We will use and disclose your protected health information to provide coordinate or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you OR you protected health information may be provided to a practitioner to whom you have been referred to ensure that the practitioner has necessary information to diagnose or treat you.

Payment Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician’s practice. These activities include, but are **NOT** limited to:

- **Quality Control**
- **Licensing**
- **Employee Reviews**
- **Training of medical students**

We may use or disclose our protected health information in the following situation without your authorization. These situations include, as Required by Law, Public Health Issues, Communicable Disease Health Oversight, Abuse, or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity, and National Security, Workers Compensation, Inmates, Required Uses, and Disclosures. Under Law, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your practitioner or the practitioner’s practice has taken an action in relation to the use or disclosure indicated in the authorization.

Argyle Health Services

Your rights

Following is a statement of your rights with respect to your Protected Health Information:

You have the right to inspect and copy your Protected Health Information Under federal law, however, you may not inspect or copy the following records- psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of you Protected Health Information This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations. You may, also, request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restrictions and whom they apply.

Your practitioner is not required to agree to a restriction that you may request. If practitioner believes your restriction is unreasonable and it is in your best interest to permit, use, disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the right to request and received confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically or by fax.

You may have the right to have your practitioner amend your Protected Health Information If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of you Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints- You may complain to the U.S. Department of Health and Human Services. 200 Independence Ave. S.W. Room 509F HHH Building, Washington D.C. 20201. If you believe your privacy rights have been violated by us you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on February 1, 2016.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices

Print Name: _____

Signature: _____

Date: _____

Authorization and Request for Release of Medical Information

Patient Name: _____
Last 4 of SSN: _____
Date of Birth: _____

RELEASE RECORDS __TO __FROM
Argyle Health Services, PLLC DBA Adult Health Services
1490 Commons Circle #200, Argyle TX 76226
Phone: (214)518-5016

RELEASE RECORDS TO FROM
_____
_____
_____

Request is made and permission is granted to release the following:

___ Admission History and Physical
___ Alcohol or Substance Abuse Records
___ Discharge Summary
___ EKG / Echo / Stress Results
___ Entire Health Record
___ Eye Exam Results
___ Imaging Results
____ Lab Results
___ Mammogram Results
___ Mental Health Records / Notes
___ Office Visit Notes
___ Operative / Procedure Reports
___ Pathology / Biopsy Reports
___ Treatment of AIDS or HIV records

Dates of service to include date from_____to _____

This authorization shall expire on the earlier of 6 months from the date signed, or on (Date)
_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Argyle Health Services, PLLC dba Adult Health Services Attention Medical Release Correspondent, at the above address.

I hereby authorize AHS or Adult Health Services to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

Patient Name: _____
Patient Signature: _____ **Date:** _____
Phone: _____

Legal Representative: Date: _____
_____
Relationship: _____

Witnessed by: _____ Date: _____