Jenkins Medical Associates

R. Doug Jenkins, M.D. **Tammie D. Jenkins, M.D.**

PATIENT RESPONSIBILITY: You are responsible for understanding the benefit contract you have with your insurance company**. WE DO NOT VERIFY INSURANCE BENEFITS**. Please contact your insurance company with any questions you have regarding your coverage.

PROOF OF INSURANCE: New patients will be required to provide a current insurance card and driver's license before being seen by the doctors. Existing patients will be required to present a current insurance card at **EACH VISIT**. If you fail to provide us current information in a timely manner, you may be responsible for the full payment of the claim, in addition to an administrative fee for re-filing your claim(s) of $25.

INSURANCE: Claims will be filed with contracted insurance companies as a courtesy to you. We file on the primary carrier only; we will not file on any secondary insurance. We are **NOT** contracted with Medicare or Medicaid. You are expected to pay your co-pay at the time of service. If your health plan determines a service "***not covered***", you will be responsible for the services performed. Insurance companies provide you with an EOB (Explanation of Benefits) following each claim presentation. You are responsible for understanding your EOB. If we have not received payment from your insurance company within 45 days, you will be responsible for contacting them.

MISSED APPOINTMENTS AND CANCELLATIONS: We require a 24 hour notice of cancellation. If you fail to contact us within 24 hours prior, there may be an administrative fee of $25-$50 depending on the type of appointment. Three (3) missed appointments, without prior notification, will result in your dismissal from this practice.

MINOR PATIENTS: Minor patients must be accompanied by a parent or a legal guardian at the time of service. If a parent or legal guardian is unable to accompany the minor, a dated and signed note from the parent or guardian must be presented prior to treatment of the minor for each visit.

PAYMENT ARRANGEMENTS: Statement balances from this office are due within thirty (30) days to avoid late payment penalty charges. If your account is 90+ days past due, you will receive a letter from this office stating that you will have 20 days to pay your balance in full. Failure to pay your balance will result in your account being referred to a collection agency further resulting in you and your family members being dismissed from this practice. If this occurs, you will be given thirty (30) days to find alternative medical care. During this time, we will provide care to you on an emergency basis only. We accept cash, personal checks, VISA, MasterCard and Discover. There is a $30 service charge for returned checks.

REFERRALS: If your insurance carrier requires referrals to specialists or imaging, it is your responsibility to inform this office that you will need a referral. We require 48-hours notice for a requested referral and will not issue retroactive referrals. We refer to specialists that we trust; however, we cannot control their office policies for timely reporting of tests/procedures.

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FORMS NEEDING COMPLETION: Forms including, but not limited to, camp physicals, FMLA, disability, and prior authorizations will be subject to an administrative fee.

REQUEST FOR MEDICAL RECORDS: Texas law allows 15 days to get the requested records to you or requesting facility, upon receipt of a written request. There may be an administrative fee associated with the preparation of these records and will be based on current Texas law.

Signature _____ **Date**_____

Jenkins Medical Associates

305 W. Spring Creek Pkwy, Bldg D, Suite 101

Plano, TX 75023

Phone - 972-964-9600 Fax – 972-964-6611

Consent to Release Patient Medical Information

The Health Insurance Portability & Accountability Act (HIPAA) was signed into law in 1996. The federal regulation includes mandates that set standards for protecting the privacy of medical & health information; now referred to as Protected Health Information (PHI).

I authorize Jenkins Medical Associates to release my medical information to me.

If unavailable (or minor), release to the following: (list family members or other)

Name: _____Relationship_____ Phone # _____

Name: _____Relationship_____ Phone # _____

Best method for the Doctor/Nurses to reach <u>patient</u>:

Home _____(number)

Ok to leave message on answering machine/voice mail? _____Yes _____No

Work _____ (number)

Ok to leave message on answering machine/voice mail? _____Yes _____No

Cell_____ (number)

Ok to leave message on answering machine/voice mail? _____Yes _____No

_____ _____

Print Patient Name **Date**

_____

Patient Signature (If patient is a minor: Parent/Guardian Signature)

_____

E-Mail Address (optional)

Jenkins Medical Associates – New Patient Information Form

R. Doug Jenkins, M.D. **Tammie D. Jenkins, M.D.**

PATIENT NAME: _____

PAST MEDICAL HISTORY

List all conditions for which you have received medical therapy: (for example: hypertension, diabetes, seizures)

Condition	Treatment	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries and Hospitalizations /Doctors Names		Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications/Dose/# of times a day (include over the counter)

_____	_____
_____	_____
_____	_____
_____	_____

Drug Allergies (name/reaction)

_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

(Required for Insurance Companies)

Do you smoke? Yes_____ No_____ If yes, how many pack a day? _____ How many years?_____

Do you drink alcoholic beverages? Yes_____ No _____ If yes, how many in a week? _____

Do you drink caffeinated beverages? Yes _____ No _____ If yes, how many in a day? _____

Do you exercise? Yes_____ No_____ If yes, how many times per week? _____

What type of exercise? _____

Do you use illicit drugs? Yes_____ No _____ If yes, what type and how often? _____

Who do you work for?_____ Position_____

FAMILY HISTORY

Name	Age	Medical Conditions	Treatment
Mother _____	_____	_____	_____
Father _____	_____	_____	_____
Siblings _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Spouse (Significant Other)_____

Children_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Symptoms Questionnaire

Please review the following list of symptoms under each category. Circle all of the symptoms that you have had in the previous 12 months. This will help the physicians provide you with the most thorough care by reviewing each of the medical systems.

GENERAL: Sense of Well Being, Change in Energy Level, Fever, Chills, Change in Weight, Change in Sleep Pattern

EYES: Change of Vision, Eye Pain, Eye Discharge, Swelling of Eye Lids, Seeing Spots/Holes in Vision

EARS: Buzzing, Ringing, Drainage, Vertigo or Room Spinning, Pain, Change in Hearing, Dizziness

NOSE: Bleeding, Congestion, Polyps, Sinus Pain, Postnasal Drainage, Change in Smell, Deviated Septum

MOUTH: Sore Throat, Fever Blisters, Canker Sores, Tongue Problems, Dental Problems, Swollen Glands

CARDIAC: Chest Pain, Irregular Heartbeat, Decreased Ability to do Regular Activity, Swollen Ankles, Leg Pains, Phlebitis or Blood Clots in Legs, Varicose Veins, Cold Feet, Pain in Leg(s) When Walking

RESPIRATORY: Cough, Shortness of Breath, Wheezing, Chest Pain, Coughing up Blood

GI: Trouble Chewing, Trouble Swallowing, Nausea, Vomiting, Abdominal Pain, Change in Appetite, Indigestion, Heartburn, Bloating, Diarrhea, Change in Bowel Movements, Constipation, Hemorrhoids, Bloody Stools, Black Stools, Chalky Stools, Mucous in Stools, Jaundice

GU: Burning with Urination, Blood in Urine, Frequent Urinary Infections, Pelvic Pain, Difficulty Starting or Stopping Urine Stream, Urinary Leakage, Increased Night-time Voiding, Prostate Problems, Genital Pain, Genital Lesions, Urethral/Vaginal Discharge, Sexual Dysfunction

JOINTS: Muscle or Joint Pain, Swelling, Weakness, Warmth, Muscle Aches, Stiffness

SKIN: Acne, Moles, Lumps, Rashes, Eczema, Psoriasis, Hives, Pigment Changes

PSYCH: Sadness, Depression, Anxiety, Irritability, Feeling Helpless/Hopeless, Thoughts of Suicide

NEURO: Difficulty with Balance, Memory Changes, Fainting, Dizziness, Change in Speech, Change in Senses/Smell/Taste, Change in Coordination, Tremors, Jerking Movements, Headaches

ENDOCRINE: Heat/Cold Intolerance, Thirst, Easy Bruising/Bleeding, Fatigue, Excessive Urination, Excessive Dry/Oily Skin, Excessive Hair Growth/Loss

ALLERGY: Eye Itching, Eye Pain, Nasal Congestion, Sinus Pain, Headache, Recurrent Sinus Infections, Cough, Postnasal Drainage, Eczema, Hives

PATIENT'S NAME_____ **DOB**_____

PATIENT'S SIGNATURE _____ **TODAY'S DATE**_____

MD SIGNATURE_____ **TODAY's DATE**_____

Jenkins Medical Associates REVISED May, 2011

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