ROSEMARY BATES, MD
WELLNESS, WELL DONE

Rosemary Bates, M.D. PA
Internal Medicine
6300 Stonewood Drive, Suite 302
Plano, Texas 75024

PATIENT INFORMATION

Name (Last) _____ (First) _____ (Middle Initial) ____
Birthday _____/_____/_____ Age_____ Social Security #_____-_____-_____
ADDRESS (Hm) _____ CITY _____STATE ____ ZIP_____
PHONE (Home) (____)_____ Cell (____)_____ Work (____)_____
EMAIL _____
DRIVER'S LICENSE # _____ MARITAL STATUS _____
OCCUPATION _____ EMPLOYER _____
BUSINESS ADDRESS _____CITY _____STATE ____ ZIP_____
HOW DID YOU HEAR ABOUT US? Plano Profile (website) _____ (magazine ad) _____
Allen Image Magazine _____ Allen Image Newcomers Guide _____ Web Search _____
Other_____

PRIMARY INSURANCE INFORMATION

INSURANCE CARRIER'S NAME_____
ADDRESS _____ CITY _____STATE ____ ZIP_____
GROUP# _____ ID# _____ PPO___HM___POS___EPO___IND___
SECONDARY INSURANCE_____

GUARANTOR'S INFORMATION*

(IF PATIENT IS NOT THE POLICY HOLDER OF THE INSURANCE POLICY - PLEASE FILL IN BELOW)

INSURED'S NAME (Last) _____ (First) _____
BIRTHDAY ____/____/____ AGE_____ SOCIAL SECURITY #_____-_____-_____
ADDRESS (Hm) _____ CITY _____STATE ____ ZIP_____
PHONE (Home) (____)_____ Cell (____)_____ Work (____)_____
DRIVER'S LICENSE # _____ MARITAL STATUS _____
EMPLOYER _____ IS POLICY THRU INSURED'S EMPLOYER (Y)____ (N)____
BUSINESS ADDRESS _____CITY _____STATE ____ ZIP_____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP TO PATIENT _____
ADDRESS (Hm) _____ CITY _____STATE ____ ZIP_____
PHONE (Home) (____)_____ Cell (____)_____ Work (____)_____
REFERRED BY _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Rosemary Bates, M.D. PA to release any information requested by my insurance company, it's representatives, or Plano Medical Assoc., P.A. physician management company.

ASSIGNMENT OF BENEFITS: In consideration of services rendered, I authorize payment of benefits directly to Rosemary Bates, M.D. PA.

RELEASE OF INFORMATION: I DO____ I DO NOT____ allow release of information and/or test results to my family and/or relatives. Please list names we can release to:

_____

PATIENT SIGNATURE_____ DATE_____

Please fill out this form and bring to our office. For privacy purposes, do not email forms.

NEW PATIENT HISTORY AND PHYSICAL

PATIENT NAME_____ DOE _____ DOB _____ AGE _____

Please be as complete as possible. Information is extremely important in order for you to receive proper care.

CURRENT COMPLAINTS

_____

_____

MEDICATIONS (Name, Dosage)

_____ _____ _____

ALLERGIES _____

PAST MEDICAL HISTORY (Check All That Apply)

(Date Diagnosed)

1. Chicken Pox___ Measles___ Mumps___ Rubella___
2. Rhaumatic Fever___ Scarlet Fever___ Polio___
3. Tuberculosis___ Mononucleosis___
4. Last Vaccines: Tetanus___ Hepatitis(3)___
   TB Test___ Flu___ Pneumonia___
5. X-Ray Treatments___
6. Alcoholism___ Anemia___ Asthma___ Arthritis___
7. Birth Defects___ Blood Transfusions___ Blood Clots___
8. Cancer___ Colitis (Irritable Bowel Syndrome, Spastic Colon)
9. Cataracts___ Glaucoma___ Other Eye Problems___
10. Depression___ Other Mental Illness___
11. Diabetes___ Diverticulitis___ Emphysema___
12. Epilepsy___ Fatigue___ Gout___ Weight Problems___
13. Goiter___ Thyroid Disease___ Gallbladder Problem___
14. Hernias (location)___
15. Heart Arrhythmias___ Heart Attack___ Heart Failure___
16. High Cholesterol___ Triglycerides___
17. Hypertension___ Other___
18. Headaches___ Migraine___
19. Hepatitis___ Other Liver Disease___
20. Kidney Disease___ Stones___ Infection___
21. Menopause (19_____ or 20_____) Peptic Ulcer___
22. Pancreatitis___ Sickle Cell___ Shingles___
23. Stroke___ Vascular Disease___ Venereal Disease___
24. Fibrocystic Breast Disease___
25. Pregnancies___ Live Births___
    Miscarriages___ Abortions___
26. Pregnancy Complications (Yes___ No___)

DO NOT WRITE IN THIS SPACE

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CURRENT COMPLAINTS

1. Nose Bleeding___ Polyps___ Deviated Septum___
   Sinus Congestion/Infections___ Allergies___
2. Fever Blister___ Tongue Problem___ Dentures___
3. Wheezing___ Shortness of Breath___
   Persistent Cough___ Pneumonia___ Pleurisy___
   Bronchitis___
4. Chest Pain___ Inability to Exercise___
   Irregular Heartbeat___ Swollen Ankles___ Leg Pain___
   Phlebitis___ Varicose Veins___ Cold Feet___
5. Difficulty Chewing or Swallowing___ Nausea___
   Diarrhea___ Vomiting___ Indigestion___ Cramps___
   Abdominal Pain___ Constipation___ Hemorrhoids___
   Bloody/Black/Chalky Stool___
6. Urination Burns___ Frequent Urination___
   Difficulty Starting or Stopping Stream___
   Prostate Problems___ Genital Lesions___
   Sexual Dysfunction___ Urethral/Vaginal Discharge___
   Sexually Active/Inactive
7. GYN: (Women Only)
   Last Pap Date_____
   Last Menstrual Date_____ Any Changes Y___ N___
   Monthly Self Breast Exams Y___ N___
   Last mammogram Date_____
8. Heat/Cold Intolerance___ Excessive Thirst___
   Excessive Urination___ Excessive Dry/Oily Skin___
   Excessive Growth or Loss of Hair___
   Bruise or Bleed Easily___
9. Difficulty With: Balance___ Memory___
   Fainting___ Dizziness___ Speech___ Tremors___
   Sense of Smell___ Sense of Taste___ Coordination___
   Jerking Movements___ Numbness___ Tingling___
   Irritable___ Loss of Sensation___ Loss of Movement___
   Anxious___ Emotional___ Depressed___
   Feeling Helpless/Hopeless___ Thoughts of Suicide___
   Preoccupation with Death___
10. Muscle/Joint: Pain___ Swelling___ Weakness___
    Ache___ Stiffness___
11. Other _____

_____

_____

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PAST SURGICAL HISTORY (Please List and Date in Sequence):

_____ _____

_____ _____

_____ _____

HEALTH MAINTENANCE

Colonoscopy Y___ N___ Date: _____ Doctor: _____

Bone Density Y___ N___ Date: _____ Doctor: _____

Stress/Cardio Testing Y___ N___ Date: _____ Doctor: _____

SOCIAL HISTORY

Married:___ Single___ Divorced___ Widowed___

Live Alone___ Share Home With: _____

Children (Please give names, year of birth, pertinent medical problems):

_____ _____

_____ _____

TYPE AND AMOUNT PER DAY

Substance Abuse _____

Tobacco Abuse _____

Alcohol Abuse _____

Exercises _____

DIET: Check All That Apply

General___ Low Salt___ Low Fat___ High Fiber___ Diabetic___ Vegetarian___

HOBBIES & INTERESTS

_____

_____

PETS (Type and Number)

_____

_____

Do You Drive Y___ N___

Toxic Exposures Y___ N___

FAMILY HISTORY (Please give names, date of birth, date deceased, and any medical problems)

Mother _____

Father _____

Siblings _____

OTHER FAMILY DISEASES (Check All That Apply)

Alcoholism___ Cancer___ Diabetes___ Heart Attack___ Hypertension___

Psychiatric___ Stroke___ TB___

Other: _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of April 14, 2003.

Patient Signature _____ Date _____

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ROSEMARY BATES, MD
WELLNESS, WELL DONE

Rosemary Bates, M.D. PA
Internal Medicine
6300 Stonewood Drive, Suite 302
Plano, Texas 75024

Thank you for choosing the office of Rosemary Bates, M.D. PA for your internal medicine needs.

Although we have agreed to file your insurance claim, **YOU ARE ULTIMATELY RESPONSIBLE FOR THE FEES INCURRED**. Also understand that due to contract language between physician and insurance companies, you understand that you are financially responsible for all charges deemed to be "NON-COVERED BENEFIT" by your insurance company even if the insurance Explanation of Benefits states the procedure is a "non-covered benefit" and/or "patient is not responsible."

NON-PPO PATIENTS - Please call your insurance co. and select Dr. Bates as your "PCP" ("Primary Care Physician") prior to your appointment. If Dr. Bates is not your PCP, you will be expected to pay in full at the time of service.

PPO PATIENTS - You are responsible for your co-payment as well as meeting your annual deductible and any out of pocket expenses. If your deductible has been met, you will owe a co-payment to be paid at the time of service. If your deductible has not been met, you are responsible for the charges up to the amount of deductible and co-insurance.

CASH/SELF-PAY PATIENT - You will be responsible for all charges IN FULL at time of service.

If you have any questions regarding covered services, deductibles, out-of-pocket expenses, etc., please contact your Insurance Carrier directly or benefits director at your place of employment. **Regretfully, it is impossible for our office to know which services are or are not covered on your plan, as each plan differs.** Our office realizes that managed care issues can be very confusing and frustrating. Unfortunately, as more and more restrictions are placed on physicians by managed care, it becomes very important for patients to be well informed regarding their insurance benefits.

Again, thank you for choosing our office. We will make every attempt to assist you.

Patient/Legal Guardian Signature _____ Date _____

Please fill out this form and bring to our office. For privacy purposes, do not email forms.

Patient Name _____

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

EXPIRATION DATE OF AUTHORIZATION: There is no expiration of this authorization. However, this authorization can be terminated at any time at the written request of the patient.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION: You may revoke this authorization by submitting a written revocation to Rosemary A. Bates, M.D., P.A. You should contact the Business Manager to terminate this authorization.

POTENTIAL FOR RE-DISCLOSURE: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulation.

AUTHORIZATION TO REVIEW PHARMACY RECORDS RELATING TO E-PRESCRIPTIONS: I authorize Dr. Rosemary Bates and staff to access my prescription history from my pharmacy(ies), including e-prescriptions.

AUTHORIZATION TO CONTACT AND/OR LEAVE NOTICE: Rosemary A. Bates, M.D., P.A. contacts patients by mail or phone to remind or inform of future appointments and other medical information. This authorization allows us to contact you, either by mail or by leaving a message, for such purposes. Please list the contact phone number and names of persons we may discuss your protected health information with:

TELEPHONE COMMUNICATION PREFERENCES:	***Can we call you here?***	***Can we leave a message?***
Home # _____	Yes___ No___	Yes___ No___
Work # _____	Yes___ No___	Yes___ No___
Mobile Phone #_____	Yes___ No___	Yes___ No___

Please list two people other than your insurance company or healthcare provider with whom we can talk about your healthcare information:

_____

Name (Print or Type) Relationship Phone Number

_____

Name (Print or Type) Relationship Phone Number

SIGNATURE:

_____ _____

Signature of Patient Signature of Patient Representative

_____ _____

Name of Patient (Print or Type) Name of Patient Representative

_____ _____

Date Date

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6300 Stonewood Drive, Suite 302, Plano, TX 75024-5290

When using any driving directions or map, it's a good idea to do a reality check to make sure the road still exists, watch out for construction, and follow all traffic safety precautions. This is only to be used as an aid in planning.