Diagnostic Medical Associates of North Texas
Jennifer Attmore, M.D., P.A. - Agnes Kinra, M.D., P.A.
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3900 W. 15th Street, Suite 404
Plano, Texas 75075
Office: 972-596-1803 Fax: 972-867-4970

Dear Patient:

Thank you for making an appointment with us.

Please arrive 15 minutes before your appointment time so that we will have time to create your patient file.

The office is located in the medical complex near the SE corner of Coit and 15th Street, just behind the Chevron gas station. We are in Building 400, Suite 404.

Please complete the new patient registration forms prior to coming in for your appointment. You must present your current insurance card (with mailing address, ID number and group number). If time allows, please mail the completed forms back to the office at least FIVE days prior to your scheduled appointment .

If you know that your insurance plan includes Wellness Benefits, YOU must inform the doctor during your visit. You may have to contact your Member Services department to obtain this information.

For morning appointments **ONLY**: **You will need to come in fasting for 12 hours. You may have as much water, BLACK coffee, or tea (no sweetener) as you like.**

If your insurance information is not available, you will be responsible for the entire bill at the time of service. Payment can only be made with a CHECK, CASH, MasterCard or Visa.

If you need to cancel or reschedule this appointment, please notify us at least 48 hours in advance.

We look forward to meeting you.

Patient Registration

Name: _____ Age:_____ Birthdate: _____

Address:_____ City, State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

SSN:_____ Medicare #:_____

Employer:_____ Occupation:_____

Bus. Address:_____ City, State:_____ Zip:_____

Driver's License #:_____ State:_____ Marital Status:_____

Emergency contact:_____ Emergency contact phone:_____

Referred by:_____

Insurance Information

Insured's name:_____ Birthdate:_____

Insured's employer:_____ Insurance carrier:_____

Group #:_____ ID#:_____ PPO? YES __ NO__

Insurance company address:_____

City:_____ State:_____ Zip:_____

Secondary Insurance Information – If None, Check Here:_____

Insured's name:_____ Birthdate:_____

Insured's employer:_____ Insurance carrier:_____

Group #:_____ ID#:_____ PPO? YES __ NO__

Insurance company address:_____

City:_____ State:_____ Zip:_____

PAYMENT POLICY

Agnes K. Kinra, M.D., P.A.
Catheryne M. Zavodny, M.D., P.A.
Michelle V. Sun M.D., P.A.
Jennifer Attmore, M.D., P.A.

Internal Medicine
3900 W. 15th Street, Suite 404
Plano, Texas 75075
972-596-1803

We hope to provide you with quality and affordable care for your internal medicine needs. We hope that this payment policy will answer your questions regarding patient and insurance responsibilities for services rendered in our office. Please read it carefully, ask any questions you may have, and sign as an agreement in the space provided.

Method of Payment. Our practice accepts checks, cash, Master Card, and Visa.

Insurance. We participate in most insurance plans and Medicare, Humana Medicare, and Aetna Medicare. We do not accept Medicaid. If our practice is not contracted with your insurance plan, payment in full is expected at each visit. If you are insured by a plan with which we do business, but you do not have an up-to-date insurance card, you MUST have the insurance companies name, group number, type of plan (PPO, POS, HMO), the claims address, and your co-payment amount, otherwise, payment in full for each visit is required until you can update your coverage. **KNOWING and PROVIDING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY.** Please contact your insurance company with any questions you may have regarding your coverage, including whether or not you have well or preventive coverage. Please allow your insurance carrier 45 days to process your claim.

Co-payments and deductibles. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Your insurance company considers it fraud if we fail to collect co-payments from its members. Please help us abide by the law in paying your co-payment at each visit.

Non-covered services. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered necessary by Medicare or other insurance companies. You must pay for these services in full after your insurance company makes their determination. Due to the contract language between physician and insurance company, you must understand that you are financially responsibility for all charges deemed to be "non-covered benefits" by your insurance even if the insurance's Explanation of Benefits states the procedure is a "non-covered benefit" and "patient is not responsible".

Proof of Insurance. All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. The patient information form and copy of valid insurance card may need to be completed again upon change of that information, but no less than every twelve months. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the full payment of a claim.

Claims submission. We will submit your primary claim and your secondary claim. Due to increasing administrative costs, we will not submit third and fourth insurance claims. We will assist you in any reasonable way we can to help you get your claims paid, but your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. Please understand that the balance of your claim is your responsibility whether or not your insurance pays your claim.

Coverage changes: If your insurance changes, please notify us before or at your next visit, so we can update your insurance information to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you for prompt payment.

Self-Pay Patients. If you do not have insurance coverage, full payment is **expected** at the time of service. We offer a 20% discount to those patients who pay **IN FULL** at the time of service.

Nonpayment. If your account is over 90 days past due, you will be expected to pay the past due balance in full within 21 days. Partial payments will not be accepted unless approved by the office manager. Be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged as a patient from this practice. If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find another physician. During that 30-day period, our physician will only be able to treat you on an emergency basis.

MISSED APPOINTMENTS. Our practice reserves the right to charge $25.00 for missed appointments not cancelled at least 24 hours in advance. These charges will be your responsibility and billed directly to you. Please help us to better serve you by being on time for your scheduled appointments.

Thank you for reviewing our payment policy. Please let us know if you have any questions or concerns. Our practice is committed to providing the best treatment for our patients. Our prices are representative of the reasonable and customary charges for our area.

_____ _____

Patient/Legal Guardian Signature **Date**

_____

Print Name

New Patient Medical History

Patient's name:_____ Date of visit:_____

DOB:_____ Age:_____ Height:_____

Use a separate sheet of paper if you need more space

- **Medical History**—List all medical conditions you have had (including high blood pressure, diabetes, thyroid disease, heart disease, blood transfusions, etc.) and the dates of diagnosis:

_____

_____

_____

_____

- **Surgical History**—List all operations you have had and the dates of the surgeries:

_____

_____

_____

- **Other physicians / specialists you see**

_____

_____

_____

- **Ob/Gyn History**—This section for women only

Age at first menstrual period:_____ Date of 1st day of last period:_____

Number of pregnancies:_____ Live births:_____ Stillborn:_____

Miscarriage:_____ Abortion:_____

Have you had a hysterectomy?_____If so, when?_____ Ovaries removed?_____

- **Health Maintenance**—Level of Activity/Exercise:_____

Dates of last test—Blood in stool:_____ Colonoscopy:_____EKG:_____

Tetanus vaccine:_____ Flu shot:_____ Pneumonia vaccine:_____

(Men only – PSA Test:_____) (Women only: pap smear:_____

Breast exam:_____ mammogram:_____ bone density:_____)

- **Medications**—List all medications you take on a regular basis, including over-the-counter medicines, vitamins, and herbal supplements:

_____

_____

_____

- **Allergies**—to medications or foods and reaction:_____

_____

_____

- **Social History**—Marital status:_____ Occupation:_____

Alchohol: (how much, how often?)_____

Tobacco: (how much, how often?)_____

Illicit drug use:_____

- **Family History**—Please include any history of medical or psychiatric condition in your blood relatives including heart disease, stroke, diabetes, cancer, osteoporosis, depression, etc.

Relative	Age (current/at death)	Medical Illnesses
Mother	_____	_____
Father	_____	_____
Sibling	_____	_____
Grandparents	_____	_____
_____	_____	_____

Review of Systems

Constitutional	Yes/No	Comments
Fever		
Chills		
Night Sweats		
Unintentional weight gain		
Unintentional weight loss		
Excessive fatigue		
Eyes	**Yes/No**	**Comments**
Dryness		
Redness		
Change in vision		
Ear/Nose/Throat/Mouth	**Yes/No**	**Comments**
Hearing loss		
Ringing in ears		
Nose bleeds		
Chronic sinus congestion		
Heavy snoring		
Change in voice		
Respiratory	**Yes/No**	**Comments**
Cough		
Phlegm/sputum production		
Sneezing		
Shortness of breath		
Cardiovascular	**Yes/No**	**Comments**
Chest discomfort or pressure		
Palpitations		
Leg swelling		
Calf or buttock pain with walking		
Gastrointestinal	**Yes/No**	**Comments**
Change in appetite		
Difficulty swallowing		
Nausea/Vomiting		
Heartburn/indigestion		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool/black stool		
Genitourinary	**Yes/No**	**Comments**
Urination at night		
Frequent urination		
Burning with urination		
Blood in urine		
Incomplete emptying		
Leakage of urine		
Sexual problems		

Women	Yes/No	Comments
Vaginal discharge		
Abnormal vaginal bleeding		
Pelvic pain		
Breast lumps		
Nipple discharge		
Musculoskeletal	**Yes/No**	**Comments**
Persistent or severe neck pain		
Persistent or severe back pain		
Persistent or severe joint pain		
Muscle pain or cramping		
Skin	**Yes/No**	**Comments**
Rash		
Itching		
Growths/ lesions		
New or changing moles		
Acne		
Neurologic	**Yes/No**	**Comments**
Frequent or severe headache		
Falls		
Numbness/tingling		
Tremor		
Involuntary movement		
Muscle weakness		
Memory loss		
Dizziness		
Psychosocial	**Yes/No**	**Comments**
Anxiety/nervousness		
Panic		
Felling sad or depressed		
Insomnia		
Endocrine	**Yes/No**	**Comments**
Cold/heat intolerance		
Hot flashes		
Excessive thirst		
Blood/Lymphatics	**Yes/No**	**Comments**
Excessive bruising		
Easy bleeding		
Swollen lymph nodes		
Allergy / Immunity		
Severe allergic reactions		
Hives		
Frequent infections		