DERI M. LEWIS, MD

PATIENT INFORMATION

(PLEASE PRINT OR TYPE)

Patient Information:

Patient Name _____Age _____Sex M / F

Address _____ Birth Date_____

City, State _____ Zip Code _____

Phone (HM) _____ (WK)_____ (Cell) _____

SSN_____ Drivers License # _____ State_____

E-Mail Address _____

Employer_____Occupation_____

Marital Status (circle) Single Married Widow(er) Divorced Separated

Spouse Name_____ Birth Date_____

SSN_____ Employer _____

Primary Care Dr. _____ Referred By_____

Insurance Information:

Primary Insurance _____ Phone _____

ID_____ Group _____

Insurance Address _____

Policy Holders Name _____ Self / Spouse / Parent / Other

Policy Holders SSN _____ Date of Birth_____

Secondary Insurance _____ Phone _____

ID_____ Group _____

Insurance Address _____

Policy Holders Name _____ Self / Spouse / Parent / Other

Policy Holders SSN _____ Date of Birth_____

Deri M. Lewis, MD PA

Patient Information and Review of Systems

Patient Information

Name_____**Age**_____**DOB**_____
Referring MD _____**Primary MD**_____
Other treating physicians and specialties_____

_____

Reason for visit _____

_____

Medical and Surgical History

Please list any medical conditions for which you are taking medications or are under the care of a physician.

_____
_____
_____

Please list all previous surgeries, dates and locations of surgeries.

_____
_____
_____
_____

Please list medications and dosages.

_____
_____
_____
_____
_____

Allergies

_____**None** _____**Tape or Adhesive** _____**Latex**
Medicine_____
Reaction(s)_____

_____

Family History

	#/Age if Living	Age if Deceased	Illness	Cause of death/age
Father				
Mother				
Siblings				

Is there a family history of cancer (relationship and type of cancer)?

_____

_____

Social History

Do you currently smoke? _____ # packs/day_____ # years_____
Did you previously smoke? _____ # packs/day_____ # of years_____
When did you quit? _____
Do you consume alcohol? _____ How often?_____ Drinks/day_____
Occupation _____
Marital Status_____
Children _____

Review of Systems

Do you now or have you recently experienced any of the following:

General	Yes	No	Eyes	Yes	No	Musculoskeletal	Yes	No
Weight gain/loss			Pain/discharge			Muscle/joint pain		
Fever/Chills			Light sensitivity			Joint swelling		
Fatigue			Blurred Vision			Weakness		
Loss of appetite			Other:			Poor balance		
Night Sweats			**Genitourinary**			Other:		
Other:			Frequency			**Endocrine**		
Cardiovascular			Incontinence			Excessive sweating		
Chest Pain			Blood in Urine			Excessive thirst		
Palpitations			Other			Excessive heat/cold		
Calf/leg pain			**Hematological**			Other:		
Shortness of breath			Easy bruising			**Gastrointestinal**		
Other:			Swollen glands			Abdominal pain		
Respiratory			Other:			Nausea/vomiting		
Wheeze			**ENT**			Diarrhea		
Cough			Sore Throat			Constipation		
Bloody sputum			Hoarseness			Heartburn		
Other:			Ringing in ears			Blood in stool		
Neurological			Nose bleeds			Other:		
Headaches			Hearing loss			**Skin/Breast**		
Confusion			Other:			Rash		
Dizziness			**Psychological**			Moles		
Memory Loss			Anxiety/stress			Sores		
Seizures			Depression			Breast discharge		
Other:			Other:			Other:		

Please describe symptoms:

_____
_____
_____
_____
_____
_____

Deri M. Lewis, M.D. ,P.A.
Medical City Dallas - 7777 Forest Lane, Suite C-522 - Dallas, TX 75230
Phone: 972-566-5880

PATIENT CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations I understand that as part of my healthcare, *Deri M.Lewis, M.D. P.A."*originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of health care professionals.

Deri M. Lewis, M.D. PA's. Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand the *Deri M. Lewis, M.D; P.A.* reserves the right to change the *Notice of Privacy Practices.* Prior to implementation of the Revised *Notice of Privacy Practices,* the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that *Deri M. Lewis, M.D. P.A.* is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that *Deri M. Lewis, M.D. P.A.* has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

Please list names of individual's you would like to allow us to be able to discuss your health care situation. ***(Do not include physicians)***

_____

_____

_____ I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed *Deri M. Lewis, M.D. P.A. ' Notice of Privacy Practices.*

_____ _____
Signature of Patient or Legal Representative Date Witness, Date

_____ _____
Print Name of Patient or Legal Representative Print Name of Witness

OFFICE USE ONLY:

Refused to Sign _____ Physically unable to sign _____

Employee Signature _____ Date _____

DERI M. LEWIS M.D. P.A.

Your insurance carrier may determine that your visit is *"ROUTINE" or "NOT MEDICALLY REASONABLE OR NECESSARY" or "PRE-EXISITING",* in which case no reimbursement will be made. Should this occur in the case of your individual carrier, the responsibility of the payment will remain yours as the recipient of these services.

I understand that I am responsible for charges not covered or reimbursed by my insurance carrier.

If you are part of a Managed Care or HMO plan, failure to obtain a valid referral from your PRIMARY CARE PHYSICIAN may result in no benefits being payable. You will be responsible for any non-payment from your insurance carrier.

Should your carrier no longer honor claims for whatever reason, such as bankruptcies or failure to have premiums paid timely, you acknowledge that services received will be paid for by you the recipient or responsible party.

****I also authorize the physician to release any information required by the above insurance company.**

****I also authorize my insurance carrier to release information regarding my coverage to Deri M. Lewis, M.D., P.A.**

_____

Signature

I request that Dr. Deri Lewis file insurance on my behalf. I understand that I will be expected to pay my portion of estimated fees at each visit, and that credit is extended to my account for the remaining fees while the insurance company processes the claim. Pursuant to the office policy of Dr. Deri Lewis, I provided the following credit card number to secure my account. *(This will not be used without first contacting you.)*

_____ VISA _____ MASTERCARD _____ DISCOVER

Account #_____

Patient Name: _____

Cardholder Name: _____

Expiration Date: _____

After 90 days, I am responsible for the balance regardless of my insurance company's decision on the claim. At this time, I will be mailed a statement and have the option of using an alternate form of payment to settle the balance. If I do not honor my financial obligations to this office within a month of receiving the statement, I understand that Deri M. Lewis, M.D., P.A. reserves the right to charge the account listed above.

_____

Signature

Notice of privacy practices

deri m. Lewis, md pa

7777 forest lane, suite c-522

Dallas, Texas 75230

972-566-5880

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 and for other purposes that are permitted or required by law. it also describes your right to access and control your phi, which is information about you, including demographics, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

your phi may be used and disclosed by your physician, 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, paying your health care bills, supporting the operation of our practice, and any other use as required by law.

treatment: we will use and disclose your phi to provide, coordinate, or manage your health care and any related services. this includes the coordination or management of your health care with a third party such as physician to whom you have been referred, an anesthesia provider, or a home healthcare agency.

payment: your phi will be used, as needed, to obtain payment for your health care services. for example, obtaining approval for a hospital stay may require that your relevant hi be disclosed to your health plan.

healthcare operations: we may use or disclose, as needed, your phi in order to support the business activities of our practice, such as quality assessment employee review, physician training, licensing, and conduction or arranging for other business activities of our practice, such as quality assessment, employee review, physician training, licensing, and conducting or arranging for other business activities. for example, we may call you by name in the waiting room. we may use or disclose your phi, as necessary, to contact you to remind you of your appointment.

we may use or disclose your phi, without your authorization. in the following situations: as required by law, health oversight, research, public health issues, communicable diseases, abuse or neglect, fda requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, criminal activity, military duty, national security, workers' compensation, inmates and any other required uses and disclosures. under the law, we must make disclosures to you and when required by the secretary of the department of health and human services to investigate or determine our compliance with 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 physician or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

you have the right to inspect and copy your phi. however, under federal law, you may not inspect or copy the following records: psychotherapy notes; information complied in anticipation of or use in civil, criminal, or administrative action or proceeding; and phi that is subject to law that prohibits access to phi.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PHI. THIS MEANS YOU MAY ASK US NOT TO USE OR DISCLOSE ANY PART IF YOUR PHI FOR THE PURPOSE OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. YOU MAY ALSO REQUEST THAT ANY PART OF YOUR PHI NOT BE DISCLOSED TO FAMILY OR FRIENDS WHO MAY BE INVOLVED IN YOUR CARE OR FOR NOTIFICATION PURPOSES AS DESCRIBED IN THIS NOTICE OF PRIVACY PRACTICES. YOUR REQUEST MUST STATE THE SPECIFIC RESTRICTION REQUESTED AND TO WHOM YOU WANT THE RESTRICTION TO APPLY.

YOUR PHYSICIAN IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST. IF YOUR PHYSICIAN BELIEVES IT IS IN YOUR BEST INTEREST TO PERMIT USE AND DISCLOSURE OF YOUR PHI, IT WILL NOT BE RESTRICTED. YOU THEN HAVE THE RIGHT TO USE ANOTHER PHYSICIAN.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE 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.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PHI. 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 A COPY.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE OF YOUR PHI.

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. YOU MAY COMPLAIN TO US OR THE SECRETARY OF HEALTH AND HUMAN SERVICES IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED. YOU MAY FILE A COMPLAINT BY NOTIFYING OUR PRIVATE OFFICER. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT. WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF PHI AND PROVIDED INDIVIDUALS WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT OF PHI. IF YOU HAVE ANY OBJECTIONS TO THIS NOTICE, PLEASE ASK TO SPEAK WITH OUR PRIVACY OFFICER. THIS NOTICE BECAME EFFECTIVE ON NOVEMBER 30, 2009.

Deri Lewis, MD
7777 Forest Lane C522
Dallas, TX 75230

February 1, 2014

My office will be implementing a new policy to try and keep the cost and paperwork associated with healthcare to a minimum.

As a participating doctor on your insurance plan, I am willing to accept assignment and discounted rates on claims and await payment from the insurance company for all but the copay amounts due at the time of service. However, it has become increasingly difficult to keep up with the number of statements we must send for balances due after insurance has paid. Some of these balances may be minimal but still require a great deal of time and energy to collect. Accordingly, we will implement a policy which we hope will alleviate this growing problem.

From this day forward when checking in at my office, you will be asked for a valid credit card. This information will be securely held until your insurance company has paid their portion and has notified us of the amount, if any, which is your responsibility. At that time you will receive one billing statement in the mail. You may send your payment in at that time or call the office to make payment arrangements. If after 30 days no payment has been received the balance will be charged to your credit card and a copy of the charge will be mailed to you. ***(We will notify you that we are running your card before the charge is made.)*** This new policy does not compromise your ability to dispute a charge or question your insurance company's determination of a payment.

I strive to provide the best care for my patients and hope you find this policy works to our mutual advantage.

I acknowledge and give my consent to the above policy as it relates to charge my credit card for payments due according to my insurance plan.

Signed: _____ Date:_____
Signature of patient or guardian

Please print name: _____