BRUCKERHOFF INTERNAL MEDICINE ASSOCIATES

Please complete all fields.

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____State:_____Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ___Male ___Female SS#: _____

Marital Status: _Single_Married_Divorced_Widowed Occupation:_____

Previous PCP name/Location: _____

Patient Referred By: _____ Spouse's Name: _____

Spouse's Date of Birth: _____ Main Contact #: _____

Local Pharmacy: _____ City: _____ Phone #: _____

Intersection: _____

Mail Order Pharmacy:_____Phone Number:_____

Preferred Pharmacy: ☐Local ☐ Mail

INSURANCE INFORMATION

Primary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____

Group/Acct#:_____ Employer:_____

Employer Address: _____City: _____ State: _____ Zip Code: _____

Work #: _____

(See Back)

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

I hereby give my permission to Bruckerhoff Internal Medicine Associates to disclose and discuss information related to my medical condition(s) to/with the following persons:

Name: _____ Relationship: _____ Ph#:_____

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____Ph#: _____

____ I do not wish to give consent for any person to have access to any information regarding my medical condition(s).

Emergency Contact: _____ Relationship: _____ Ph#: _____

This authorization shall remain in effect unless otherwise revoked in writing, I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any records.

Signature of Patient or Legal Representative: _____

Printed Name and Relationship: _____ Today's Date: _____

MEDICAL HISTORY

NAME: _____ _____ _____ **D.O.B.** ____/____/_____
LAST FIRST M.I.

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

ALLERGIES (Include medications, foods, xray dyes) or write N/A if no known allergies.

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or write N/A if no medications

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		
4		
5		
6		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or NONE

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual cycle: _____

TOBACCO HISTORY

Are you an active cigarette smoker? Have you ever been a cigarette smoker? Yes No Yes No

If yes, I smoked an average of_____packs/day for_____years. I quit in_____(year)
Do you use other tobacco products? Yes No
If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? Yes No
Do you currently drink alcohol regularly? Yes, currently Never/rarely
If yes, approximately how many drinks per week (beer, wine, or liquor)_____ Have you ever used intravenous drugs? Yes No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack			
Diabetes			
Prostate cancer			
Kidney cancer			
Kidney stones			
Other significant disease			

NAME: _____ _____ _____ **D.O.B.** ____/____/_____
LAST FIRST M.I.

Medical History

Please circle the complaints that pertain to you. Put a ? If you are unsure.

General	Fatigue / Tired	Yes	No
	Fever / Chills	Yes	No
	Malaise	Yes	No
	Night Sweats	Yes	No
Eyes	Blurry Vision	Yes	No
	Loss of Vision	Yes	No
	Other:_____		
Head Ears Nose Throat	Dry Mouth	Yes	No
	Hearing Problems	Yes	No
	Hoarseness	Yes	No
	Lumps/Swelling in Neck	Yes	No
	Sore Throat	Yes	No
	Trouble Swallowing	Yes	No
	Congestion	Yes	No
	Runny Nose	Yes	No
	Other:_____		
Cardiac (Heart)	Chest Pain	Yes	No
	Irregular Heartbeat	Yes	No
	Pain with Walking	Yes	No
	Palpitations	Yes	No
	Swelling in Feet/Ankles	Yes	No
	Other:_____		
Neuro	Dizziness	Yes	No
	Fainting	Yes	No
	Headache	Yes	No
	Memory Loss	Yes	No
	Numbness	Yes	No
	Weakness	Yes	No
	Other:_____		
Respiratory	Cough	Yes	No
	Shortness of Breath	Yes	No
	Use of Inhaler	Yes	No
	Wheezing	Yes	No
	Other:_____		
Gastro Intestinal	Abdominal Pain	Yes	No
	Blood in Stool	Yes	No
	Change in Bowel Habits	Yes	No
	Constipation	Yes	No
	Heartburn	Yes	No
	Loss of Appetite	Yes	No
	Nausea	Yes	No
	Vomiting	Yes	No
	Other:_____		

Males Only	Blood in Urine	Yes	No
	Difficulty Achieving Erection	Yes	No
	Foul Odor in Urine	Yes	No
	Pain in Testicles	Yes	No
	Trouble Urinating	Yes	No
	Frequency Urinating at Night: _____ times		
Females Only	Breast Discomfort	Yes	No
	Irregular Bleeding	Yes	No
	Last Menstrual Cycle: _____(Date)		
	Painful Intercourse	Yes	No
	Post Menapausal Bleeding	Yes	No
	Vaginal Discharge	Yes	No
	Other:_____		
Musculo-skeletal	Back Pain	Yes	No
	Joint Pain	Yes	No
	Muscle Pain	Yes	No
	Joint Swelling	Yes	No
	Falls	Yes	No
	Arthritis	Yes	No
	Other:_____		
Mental Health	Anxiety	Yes	No
	Depression	Yes	No
	Difficulty Sleeping/Concentrating	Yes	No
	History of Physical/Mental Abuse	Yes	No
	Mood Swings	Yes	No
	Stress	Yes	No
	Suicidal	Yes	No
	Other:_____		

<u>Recent Tests/Health Maintenance</u>

Give Month/Year of last exam.

Health Maintenance Check:_____

Bone Density:_____

Colonoscopy:_____

Diabetic Foot Exam:_____

Eye Exam:_____

Mammogram:_____

Pap Smear:_____

Physical:_____

PSA:_____

Tetanus:_____

Covid-19 Vaccination:_____

Medical History

List all medical problems you have ever been diagnosed or treated for.

Diabetes			History of Transmplant	
Hypertension			Cataracts	
Cholesterol			Glaucoma	
Obesity			Macular Degeneration	
Coronary Heart Disease			Blindness	
CHF			Hearing Loss	
A-Fib			Anxiety	
COPD/Emphysema			Depression	
Asthma			PTSD	
OSA			H/O Abuse	
HypoThyroid			Dementia	
HyperThyroid			Arthritis	
Other Thyroid			Osteoarthritis	
Cancer			Rheumatoid Arthritis	
History of Chemo			Psoriasis	
History of Radiation			Lupus	
Anemia			Fibromyalgia	
Blood Clots			Other Arthritis	
Fatty Liver			Gait Abnormality	
Hepatitis			Loss of Balance	
Other Liver			Falls	
Chronic Kidney			Osteopenia	
Kidney Stones			Osteoporosis	
Enlarged Prostrate			History of Benzodiazepine Use Over 1 Year	
UTI			History of Opiod Use over 1 Year	
Incontinence			Abnormal Mammogram	
Other Kidney			Abnormal Pap Smear	
Indigestion/Reflux			History of Colon Polyps	

Other Diagnosis or Treatment: (Please Explain)

_____

_____

_____

_____

_____

Specialists

Name	Location & Phone Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

Bruckerhoff Internal Medicine Associates Phone 817-755-1005 / Fax 817-755-8499

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

1900 Matlock Drive, Building 6, Suite 604, Mansfield TX 76063

Address (Street, City, State and ZIP)

FROM:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient

Bruckerhoff Internal Medicine Associates

Financial Policies

Welcome to our practice and thank you for choosing Bruckerhoff Internal Medicine Associates to care for you and/or your loved ones. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Because some of our patients have had questions regarding patient and insurance responsibilities for services rendered, we have developed this financial policy. Our billing office can be reached at 214-536-7150 if you need assistance.

INSURANCE:
We participate in most insurance plans. Please bring your up-to-date insurance card with you to each visit. It is your responsibility to make sure that our providers are on your specific plan and in-network for you. If you are insured by a plan we accept, but do not have an up-to-date insurance card, payment in full is required until we can verify your insurance coverage. If you are not insured by a plan we do business with, payment is required in full at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

PROOF OF INSURANCE:
We must obtain a copy of your driver's license and a current valid insurance card to provide proof of insurance. If your health insurance changes, please notify us before your next visit so we can make the appropriate changes to help you maximize your benefits. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim. We never guarantee insurance coverage for in office, laboratory testing , or referred care. You are always welcome to take lab orders to outside labs for an estimated lab cost prior to being drawn.

CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES:
All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. We accept cash, check, Visa, MasterCard and Discover.

CLAIM SUBMISSION:
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any reason, our office cannot be responsible for that bill. It is your responsibility as the patient to pay the denied amounts in full. If your insurance

company does not pay your claim in 45 days, the balance will automatically be billed to you. It is your responsibility to know if our providers are in-network for your insurance plan and what your specific insurance plan's benefits are.

NON-COVERED SERVICES:
Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. Concerns dealing with mental health issues such as anxiety, depression, attention deficit disorder, and stress-related problems, etc. might not be covered by your insurance. If you are seeing our doctor for any of these problems, you may want to contact you insurance company to see if they are covered if seen by any physician other than an approved mental health provider. As with all non-covered services, you will be expected to pay in full whatever the insurance companies do not reimburse. We never guarantee insurance coverage for in office, laboratory testing , or referred care. You are always welcome to take lab orders to outside labs for an estimated lab cost prior to being drawn.

NONPAYMENT:
If your account is over 90 days past due, you will receive a letter stating that the balance should be paid in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. Should this occur, you will be notified by certified mail and will have 30 days to find a new physician.

PHONE CALLS:
By providing contact information, I authorize Bruckerhoff Internal Medicine Associates, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

MISSED APPOINTMENTS:
If you cannot keep your appointment, you will need to reschedule your appointment 24 hours in advance. This will allow us to schedule another patient in that time slot. If any appointment is no-showed, cancelled with less than 24 hours notice or rescheduled due to late arrival, a minimum $50.00 charge will be billed to your account. This charge is not payable by your insurance company and is due prior to your next scheduled appointment. The amount of this fee may change without notice. If multiple appointments are missed and we identify a problem with you keeping appointments, we will not be able to provide care for you at this office.

FORMS:
There is a $25.00 charge for the completion of FMLA, disability and other forms. Since insurance companies do not cover this service, this charge is your responsibility. Payment is due at the time the forms or requests are dropped off at the clinic.

Bruckerhoff Internal Medicine Associates

Patient Name:_____ DOB:_____

Consent to Treat

I hereby authorize employees and agents (including physicians, physician assistants, and nurse practitioners) of this medical office to render routine medical care to me, the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) I hereby authorize employees and agents of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, medical care will not be provided except in a case of emergency.

Financial Responsibility

I hereby authorize payments from Medicare or other insurance companies of medical benefits directly to Bruckerhoff Internal Medicine Associates and/or the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I appoint Bruckerhoff Internal Medicine Associates to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Bruckerhoff Internal Medicine Associates. I further understand that should by account become delinquent, I shall pay the reasonable fees or collection expenses, if any. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier. The duration of this authorization is indefinite and continues until revoked in writing.

Release of Information

Authorization is hereby granted to release of information contained in my medical record as may be necessary for medical treatment or to process and complete my insurance claims. I understand that this release of information may include information regarding communicable diseases such as, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The duration of this authorization is indefinite and continues until revoked in writing.

Financial Policies

I have read and received a copy of the financial policies for Bruckerhoff Internal Medicine Associates.

Acknowledgement of Receipt of the Notice of Health Information Practices for Bruckerhoff Internal Medicine Associates

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Bruckerhoff Internal Medicine Associates and associated physicians are committed to securing the privacy of your health information. We have made available to you a copy of the notice which provides information about how its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Bruckerhoff Internal Medicine Associates' Notice of Health Information Practices.

I have read all of the above and agree to these terms.

_____ _____

Signature of Patient/ Legal Guardian (if patient is a minor) Date

Bruckerhoff Internal Medicine Associates
1900 Matlock Road, Building 6, Suite 604
Mansfield, TX 76063

AUTHORIZATION TO RETRIEVE MEDICATION RECORDS

I_____authorize Bruckerhoff Internal Medicine Associates to retrieve my complete medication profile from my insurance, pharmacy, or other third party source. I understand this information will be kept confidential and used only to aid in my ongoing treatment.

I understand this authorization will remain in effect until/unless I revoke it in writing.

_____
Signature of Patient (or Authorized Representative)

_____
Date

Bruckerhoff Internal Medicine Associates
Denise Bruckerhoff, D.O.
1900 Matlock Road, Building 6, Suite 604, Mansfield, TX 76063
P: 817-755-1005
www.bimadr.com

Below you will find the definition of a Preventive Care Visit (Wellness Exam) and an Office Visit.

PREVENTIVE VISIT

A Preventive Visit is a yearly, *prevention-focused appointment* intended to prevent illnesses and detect health concerns early, before symptoms are noticeable. Insurance often only pays for a Basic Wellness Exam. EKG's are usually not covered and you may need to pay a portion of the EKG at time services are rendered. Acute issues are not included in this visit and if discussed may result in an additional office visit charge.

OFFICE VISIT

An Office Visit is a *problem-focused appointment* designed to discuss new or existing health problems or symptoms. To address these specific health concerns, your provider may order tests, prescribe medication, refer you to a specialist or provide advice and education. **Office Visits are covered by a standard insurance co-pay or deductible.**

MEDICARE ANNUAL WELLNESS VISIT

Annual preventative screening visit that does not include a physical, labs, EKG, or other diagnostic testing and is required by medicare once a year.

Your doctor can also discuss abnormal labs or issues that are not covered by your preventative visit. If you do not want to discuss abnormal results please schedule a follow up appointment to do so.

____ I decline to discuss any abnormal results. I will make a follow up appointment.

Your follow up appointment is on: _____

____ I decline to discuss any abnormal results and will NOT schedule a follow up appointment at this time. I understand that failure to schedule a follow up visit could adversely impact my health.

____ I agree to discuss all abnormal findings and understand that the doctor will bill an additional code (office visit) to my insurance and may have an out of pocket expense.

By signing this form, you agree that you have read this and understand the terms listed above. If you have any questions, please address them with the staff.

_____ _____

Signature of Patient **Date**

Allergy History/ Historial de Alergias

Patient/Paciente: **DOB/FDN:**

Contact number/Numero De Contacto: **Date:**

Email/Correo Electronico:

Check Conditions Affecting Symptoms/ Seleccione condiciones que afectan los sintomas

1) During which months do symptoms occur?/Durante que meses ocurren los sintomas?

□ All Months/Todos los meses

□ January/Enero □ March/Marzo □ May/Mayo □ July/Julio □ September/Septie bre □ November/Noviembre
□ February/Febrero □ April/Abril □ June/Junio □ August/Agosto □ October/Octubre □ December/Diciembre

2) Are your symptoms worse?/ Sus sintomas son peor?

□ Morning/Mañana □ Afternoon/Medio Dia □ Evening/Tarde □ Night/Noche
□ At home/En casa □ At work/School/En el trabajo o escuela □ Other location/Otro lugar:_____

3) Are symptoms?/ Los sintomas son?

□ Constant/ Constantes □ Erratic/Irregular □ Rare/Poco comun

4) Do symptoms interfere with your activities?/ Los sintomas interfieren con sus actividades?

□ Not at all/No del todo □ A little/Un Poco □ Moderately/Moderadamente □ All the time/Todo el tiempo

5) Family History/Historial Familiar:

□ Asthma/Asma □ Eczema □ Sinus problems/Problemas de sinusitis □ Migraines/Migrañas
□ Hay Fever/Rinitis alergica □ Ulcer/Ulceras □ Nervous Disorder/Desorden Nervioso □ Colitis
□ Other:_____

6) Please rate your symptoms 1 – 5 (#1 is low degree of symptom, #5 is high degree of symptom)
6) Por favor, califique sus síntomas 1 – 5 (#1 es un bajo grado de síntoma, #5 es un alto grado de síntoma)

CIRCLE THE NUMBER/CIRCULE EL NUMERO

Eyes (itchy, watery or swelling)/Ojos (picazon, llorosos o hinchazón)	1	2	3	4	5
Ears (itchy, draining or congested)/Orejas (picazon, drenante o congestionada)	1	2	3	4	5
Nose (runny or congested)/Nariz (moquea o congestionada)	1	2	3	4	5
Headaches (allergy related)/Dolores de cabeza (relacionados con la alergia)	1	2	3	4	5
Cough (allergy related)/Tos (relacionada con la alergia)	1	2	3	4	5
Sneezing/Estornudos	1	2	3	4	5

7) Are you currently being treated for allergies?/ ¿Está recibiendo tratamiento para alergias Yes/Si No

Signature/Firma: **Date/Fecha:**

Circle your provider:
Circule su proveedor: