TPG
THE PHYSICIANS' GROUP

The Piedmont Clinic
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63 Gooder Simpson Blvd. • Piedmont, OK 73078
Phone (405) 373-0380 • Fax (405) 373-0457

New Patient Information

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST	FIRST	MIDDLE INITIAL	SEX:	BIRTH DATE:	AGE

SOCIAL SECURITY NO.:	MARITAL STATUS: ▪ Single ▪ Married ❑ Widowed ▪ Divorced ▪ Separated	SPOUSES NAME:	EMAIL:

PATIENT'S ADDRESS:			REFERRING PHYSICIAN:
CITY:	STATE:	ZIP CODE:	ARE YOU: ▪ Employed ▪ Full-Time Student ▪ Part-Time Student ❑ Retired
HOME PHONE: ( )	WORK PHONE: ( )		CELL PHONE: ( )

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Company _____

Name of the Person who carries the Insurance Policy _____ Relationship to Patient _____

Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

Secondary Insurance _____

Carrier Name _____ Relationship to Patient _____

Not Applicable ▪

Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

EMPLOYMENT INFORMATION

Patient's Employer _____ Ph# _____

Insured Employer _____ Ph# _____

If the patient is a minor, please list both parents names and employer

Mother _____ Employer _____ Ph# _____

Father _____ Employer _____ Ph# _____

NEXT-OF-KIN INFORMATION

NEAREST RELATIVE (OR FRIEND, NOT SPOUSE) NOT LIVING WITH YOU:	
HOME PHONE: ( )	RELATIONSHIP TO THE PATIENT:

THIRD PARTY BILLING

Is Your Injury Work Related?	▪ Yes	▪ No
Is This Injury Due To An Accident?	▪ Yes	▪ No
If Your Injury Is MVA Related Have You Obtained an Accident Report?	▪ Yes	▪ No

I Authorize the RELEASE of any MEDICAL INFORMATION if necessary, to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I, acknowledge and agree that I have received a copy of the TPG Privacy Notice.

Signature _____ Date _____

CLINIC PRACTICE CONSENT FORM

PATIENT INFORMED CONSENT:

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1. **Consent for Treatment.** The patient voluntarily presents to the practice for medical evaluation, diagnosis and/or treatment. The undersigned patient or patient's authorized representative (hereafter referred to as "I" or "me") consent and authorize the providers of this practice, their assistants and/or other healthcare personnel designated by the providers (the "providers") to provide diagnostic and therapeutic treatment, which may be necessary or advisable in their professional judgment. I further consent to the provision of general medical services, such as diagnostic laboratory (for the testing of blood and other bodily fluids) and x-ray and other imaging procedures, deemed necessary by the providers, I understand that I may be asked to sign a separate surgery or procedure consent form. By signing this consent form, I do not waive my right to refuse recommended tests or treatment. I understand that this Consent will be valid and remain in effect as long as I attend or receive services from the practice, unless revoked by me in writing.

2. **Consent to Photograph or Other Digital Images.** I hereby consent to the taking of photographs, videos or images taken in connection with diagnosis, care and treatment, for other internal purposes, such as identification of the patient for medial record purposes, and for scientific, educational or research purposes.

3. **Medical Record.** I understand that the practice will create and maintain medical record of the care and services provided to me. I understand that the practice participates in an electronic medical record exchange and that if I seek treatment from other healthcare facilities or providers participating in this exchange, my health information may be shared with such providers for the delivery of care and services to me.

4. **Assignment of Benefits.** I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, under any insurance policy, health plan, workers compensation or other third party payor liable to me, to this practice. I understand it is my responsibility to pay any deductible and/or co-payment amount and that I am financially responsible for all charges whether or not paid or denied by insurance. I agree to pay all costs of collection in connection with enforcement of my payment obligations, including reasonable attorneys' fees and court costs incurred by the practice. I have been informed that some lab studies may go to an outside lab, and I may receive a separate bill for these services. The practice is authorized to use and disclose my medical information for treatment, payment, healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for my treatment.

5. **Payment Responsibility.** I understand that I, or another person who specifically agrees to guarantee payment for me, is responsible for the payment of all charges of the practice relating to services rendered by the practice to me that remain after any third party payment (which include, but are not limited to, applicable coinsurance, co-payments, deductibles and amounts for services or treatments that are not covered or for which payment has been denied by any third party). Payment of these amounts shall be due within ten (10) days of billing date. I understand that any phone numbers, including cell phone numbers, provided during registration may be used to contact me, or another person who specifically agrees to guarantee payment for me, and may include auto-dialed and prerecorded message calls from the practice or its third party collector. Parents of minor children are jointly and separately liable for the child's medical expenses absent a court order limiting the liability of one parent.

6. **Disclosure of Information.** I understand that all records relating to my treatment at the practice shall remain property of the practice. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim, as such the practice is authorized to disclose all or part of my medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of my account.

7. **Acknowledgment of Notice of Privacy Practices.** I understand that a description of how my medical information will be used and disclosed is set forth in the Notice of Privacy Practices which is posted in the Clinic. By signing below, I acknowledge that I have been offered or have received a copy of the Notice of Privacy Practices.

I ATTEST I HAVE READ THIS PATIENT CONSENT, UNDERSTAND ITS CONTENTS, ACCEPT ITS TERMS, AND HAVE RECEIVED A COPY. I UNDERSTAND THAT THIS CONSENT IS VALID FOR ONE YEAR FROM THE DATE BELOW AT ALL TPG CLINICS.

WHEN PATIENT IS A MINOR OR INCOMPETENT TO GIVE CONSENT

Patient Signature	Patient's Authorized Representative
Date/Time:	Relationship to Patient
	Witness: (If signed by patient's representative)

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The following information will give you a better understanding of the difference between a Wellness Exam/Preventative and what is **NOT COVERED** under your Preventive Wellness Visit. This became effective in 2010 with the Affordable Care Act.

NOT COVERED:

Which services are "not covered" as preventive at my Preventive Wellness Visit?

You may have noticed that many of the services patients have historically received from a healthcare provider are not included on the list. You may also be subject to a copay or deductible fee from the insurance company. Some notable examples of services that many patients need from their primary care provider but will not be covered at a preventive wellness visit include:

- **Chronic conditions.** The covered services are considered "preventive" and designed mostly as a screening tool to identify possible health problems early and educate patients on their plan of care to address minor problems before they turn into major ones. It does not include care or treatment for issues or problems that have already been diagnosed.
- **Surgical procedures.** There is no definition of "wellness" that would require a surgical procedure. Generally, a surgical procedure requires its own separate visit apart from anything else.
- **Medication refills.** With the exception of contraceptives for women and aspirin for certain risk groups, any discussion of refills on current medications or prescribing new medications is not covered as a preventive service. At our office, you can choose to discuss your medications and continue with a regular medical visit, or you can choose to proceed with your preventive wellness visit and address any questions about your medications at another time.

THINGS INCLUDED IN A PREVENTIVE WELLNESS EXAM

- **History:** Past illnesses, surgeries, medications, allergies, family and social histories, status of chronic conditions
- **Exam:** Blood pressure, height, weight, BMI, hearing screening, depression screening, hematological
- **Counseling/Anticipatory Guidance:** Nutrition, physical activity, healthy weight, injury prevention, misuse of tobacco, alcohol, and drugs, sexual behavior, dental health, mental health, fall prevention, immunizations, recommended screenings for age/gender
- **Screening Services:** Cholesterol, diabetes, colorectal cancer
- **For Women:** Breast cancer, cervical cancer, osteoporosis beginning at 65
- **For Men:** Abnormal aortic aneurysm (one time for men 65-75 years with history of smoking), prostate cancer

I have read and understand the above. I understand that if I discuss anything listed in the **"NON-COVERED"**, I will be billed for a copay and/or deductible.

Patient Signature _____ Date _____

HISTORY AND PHYSICAL

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Date _____

Name _____ Birth Date _____

Pharmacy _____ Pharmacy Phone _____

Do you have any condition or impairment that would prevent you from learning about your medical condition? _____

Check preferred method of learning: ☐ Visual ☐ Oral ☐ Verbal ☐ Video ☐ Pamphlet

Would you like information on advanced directive (living will)? ☐ Yes ☐ No DNR? ☐ Yes ☐ No

DRUG ALLERGIES

SOCIAL HISTORY

☐ Smoke: Packs Daily _____ How long? _____
When stopped? _____

☐ Exercise Routine: _____

☐ Coffee: Cups Daily _____ Other Caffeine's _____

☐ Alcohol: Type/Amount _____

Diet: Salt Intake _____ Fat Intake _____

Sleep: ☐ Difficulty Falling Asleep ☐ Continuity Disturbances
☐ Snoring ☐ Early Morning Awakening
☐ Daytime Drowsiness

☐ Contact with blood or body fluid at work

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATION or SURGERY

Reason	Date

SERIOUS ILLNESS, INJURY OR PROCEDURE

Reason	Date

Women Only: Pregnant? ☐ Yes ☐ No **Planning Pregnancy?** ☐ Yes ☐ No

PAST MEDICAL HISTORY

☐ Headache
☐ Shortness of Breath
☐ Heart Palpitations
☐ Heart Murmur
☐ Chest Pain
☐ Dizziness/Fainting
☐ Peripheral Vascular Disease
☐ Allergies / Hay Fever
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Ulcer
☐ GI Disorder
☐ Lactose Intolerance
☐ Gall Bladder Disease
☐ Prostate Disease
☐ Bowel Irregularity
☐ Incontinence
☐ Sexual / Menstrual Dysfunction
☐ Venereal Disease
☐ Frequent Infections
☐ Hepatitis
☐ Anemia
☐ Arthritis
☐ Osteoporosis
☐ Nervousness
☐ Depression
☐ Gout
☐ Scarlet Fever
☐ Chronic Rashes
☐ Rheumatic Fever
☐ Mumps
☐ Measles
☐ Rubella
☐ Polio
☐ Diphtheria
☐ Tetanus

Chart No. _____

The Physicians' Group

Authorization to Release Information via Phone/Family/Friends

Patient Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of TPG regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ Work Phone: _____ Cell phone: _____

Email Address: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____
Patient Signature Date

TPG STAFF ONLY:

Documented by:

_____ _____
Initials Date