Dr. Lata Pablani, MD, Lissy Joseph, APRN, FNP & Ana Lugo, APRN, FNP-BC
14111 King Road, Bldg.3, Suite 320, Frisco, TX 75036
Phone: 469-888-4890 Fax: 866-292-0929

NEW PATIENT REGISTRATION

Name (First, Middle, Last): _____

Date of Birth MM/DD/YYYY:_____ **Age:**_____**Social Security Number:**_____

Street Address: _____

City:_____**State:**_____**Zip Code:**_____**Sex:** ☐Male ☐Female

Main Phone:_____**Alternative Phone**: _____

Email: _____

Reason for Visit: _____

Primary Care Physician's Name:_____**Primary Care Physician's Phone:** _____

How did you hear about us? ☐Friend/Family ☐Internet ☐Other ☐Drive by ☐Mailer ☐Other

Emergency Contact **Full Name:** _____

Relationship:_____**Phone Number:** _____

Marital Status (Optional) ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Ethnicity (Optional) ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐White
☐Hispanic or Latino ☐Native Hawaiian or Other Pacific Islander

PHARMACY INFORMATION

Pharmacy Name:_____**Pharmacy Phone Number:** _____

Pharmacy Address/Location: _____

INSURANCE INFORMATION

Company Name:_____**Member ID:**_____**Group No:** _____

RELEASE OF INFORMATION

Please list the individuals with whom we may discuss your medical information with OR check the box below:

Name:_____Relationship: _____

Name:_____Relationship: _____

PLEASE ONLY CHECK THE BOX BELOW IF YOU DO NOT AUTHORIZE!

☐ I do **NOT** authorize discussion of medical information to any individual other than medical professionals involved in my care. This includes lab results, radiology reports, physician notes, prescription information, treatment plans, etc.

I certify that by my signature below, I give Pioneer Medical Associates permission to discuss my medical information with the individuals listed above. If you checked the box above, please also sign below.

_____	signature _____	_____
Printed Name	**Signature**	**Date**

PIONEER MEDICAL ASSOCIATES

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LEGAL INFORMATION AND POLICIES

As a patient of Pioneer Medical Associates, I understand that the following policies are currently in effect:

Consent for Treatment: I authorize hereby and voluntarily consent to authorize Pioneer Medical Associates healthcare providers to provide healthcare services to me. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers.
Assignment of Benefits: I authorize my insurance benefits to be paid directly to Pioneer Medical Associates and its related companies. I understand that I am financially responsible for any balance my insurance fails to cover. I also authorize Pioneer Medical Associates, its related companies, or insurance company to release medical information required for claims. I understand I am responsible for knowing what my insurance plan does **and** does not cover.
Consent for Communication: I understand Pioneer Medical Associates will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.
Prolonged Care: In accordance with AMA CPT guidelines, we reserve the right to bill for telephone calls with our medical professionals that include evaluation and management of your medical condition, as well as time spent for extensive medical review or coordination of care.
Payments: Payment is due a**t time of service,** including copays, deductibles, co-insurance, and prior balance due. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments, deductibles, co-insurance, and prior balance from patients can be considered fraudulent. Please help us in upholding the law by paying your patient responsibility at each visit. To make payments convenient we require a card on file. We also accept visa, master card, American Express, cash and checks. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents. If you have any questions regarding this, please call your insurance company. If you are unable to pay for your visit, you will need to **reschedule** until you are able to cover the visit cost.
Deductible Based Plans: A deductible is the amount of money you must pay out-of-pocket before your insurance pays. Pioneer Medical Associates is responsible for collecting an estimated cost for all services rendered in office. The remainder balance due will be reflected upon claim submission and will be billed to you. In the event of an overpayment, we will refund you upon receipt of payment from your insurance.
Card on File: Card on File is **REQUIRED** for all patients to ensure an efficient and smooth check in process, along with reducing collection efforts. The amount of time and effort to collect payments that will be saved will allow our office to focus more on patient care.
Non-payment: It is our office policy that all past due accounts be sent statements regularly. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to our collection agency and may result in discharge from the practice. If this is to occur, you will be notified by regular and certified mail that you have **30 days** to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
Annual/Physical Exams: This type of visit is **PREVENTATIVE ONLY**. If you are here for an Annual/Physical exam and want to be seen for other health issues in addition to this visit, then we will **bill your insurance for both sick AND well visit**. Your insurance might not pay for the combination visit; if this is the case, then you are responsible in paying the complete balance due. To avoid this, you will need to reschedule the Annual/Physical for another day.
Laboratory Services: Laboratory billing is **separate** to the physician bill you receive. We are not responsible for any laboratory billing issues that arise after the service provided. We can suggest labs as part of your annual checkup or medical conditions, but we do not provide any guarantee for its insurance coverage.
Labs & Imaging: All labs are reported to patients within 7 days. Your provider **MUST SEE YOU** within 1-2 weeks or sooner for all abnormal lab and imaging results so that our providers can assist with management and/or treatment plan.
Prescriptions: Your provider **MUST SEE YOU** prior to prescribing a new RX, refills on Antibiotics or Narcotics (Controlled medications) and changing your existing medication. **NO** controlled medication will be prescribed over the phone, out of State, after hours, or weekends. If you have not been seen your provider within the past **3 months** and need a refill, you must schedule an appointment to see provider for your prescription refill. All medications have an appointment refill schedule that must be followed to ensure the safety of our patients. Please check with the staff if you have any questions about the refill schedule.
Referrals: Obtaining a referral from your insurance can take up to **72 hours or more**. Please do not call from the specialist's office at the time of your appointment for a referral. An appointment is **required** to obtain a referral.
Medical Records: There is a $35 fee for printing of medical records for the first 20 pages, & 50 cents for each page thereafter.
No shows: If you do not show up and/or do not call us **24 hours in advance** to cancel or re-schedule your appointment, we reserve the right to charge a $25 fee for the scheduled time that we were unable to give to other patients. After **three consecutive no shows or rescheduling**, we reserve the right to discharge you as our patient.
Disability/FMLA: An appointment is **REQUIRED** for all requests. There is a $35 fee for completing FMLA/Disability documents.

By signing below, I certify that I have read and understand the legal information and policies listed above.

signature

Printed Name	**Signature**	**Date**

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MEDICAL HISTORY

Patient Name:_____ **Age:** _____

Please check off the following that apply to you.

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Blood Clot in Vein
- ☐ Rheumatological Disease
- ☐ Sleep Apnea
- ☐ Sickle Cell Disease
- ☐ Blood Transfusion
- ☐ Diabetes
- ☐ Cancer
  If so, what kind? _____
- ☐ Migraine
- ☐ Congenital Disease
- ☐ Seizures
- ☐ Epilepsy
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Mononucleosis
- ☐ Gallbladder Disease
- ☐ STD
- ☐ Kidney Problems
- ☐ Mood Disorders
- ☐ Depression
- ☐ Anxiety
- ☐ ADHD/ADD
- ☐ Chronic Pain
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Insomnia
- ☐ Anemia
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other: _____

Surgical Procedures / Hospitalizations ***Month/Year***

_____ _____
_____ _____
_____ _____
_____ _____

☐ NO Surgical Procedures ☐ NO hospitalizations

Social History

Do you smoke? ☐Yes ☐No ☐Former Smoker
If yes, how many times per day? _____
Do you use any other Tobacco products? ☐Yes ☐No
Do you drink alcohol? ☐Yes ☐No
If yes, how many drinks per week? _____
How often did you have 6 or more drinks? _____
Have you taken illegal drugs? ☐Yes ☐No
If yes, which ones? _____

Family History

Do any of the following conditions run in your family? If so, please list your relationship to them.

Mother's Age: _____ **Father's Age:** _____

Condition	Relationship	Alive?
☐Stroke		
☐Heart Attack/Disease		
☐ High Cholesterol		
☐ High Blood Pressure		
☐ Thyroid Disorder		
☐ Cancer		
What kind of Cancer?		
☐ Diabetes		
☐ Genetic Condition		
☐ Breast Disease		
☐ My family has NO health conditions.		

What year, if ever, did you last have the following?

- _____Routine Bloodwork
- _____Flu Vaccine
- _____Covid Vaccine
- _____Last Menstrual Cycle
- _____Pap Smear (Women 18+)
- _____Mammogram (Women 40+)
- _____Colonoscopy/Cologuard (45+)
- _____Prostate Screening (Men 50+)
- _____Shingles Vaccine (50 +)
- _____Bone Density Screening (65+)
- _____Pneumonia Vaccine (65+)
- _____Last Fall (65+)
- _____Vasectomy (Men)
- _____Hysterectomy (Women)
- _____Diabetic Eye Exam

MEDICATION LIST			**ALLERGIES**	
Name of Medication	***Dose***	***Frequency***	***Food/Drug Name***	***Reaction***

☐ I am NOT on any medications ☐ I do NOT have any known allergies