Pioneer Medical Associates, PLLC

Primary Care & Cardiology

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NEW PATIENT REGISTRATION

PATIENT INFORMATION

Name (First, Middle, Last) _____

Date of Birth (MM/DD/YYYY) _____ **Age** _____ **SSN (optional)** _____

Street Address _____

City _____ **State** _____ **ZIP** _____

Preferred Language _____ **Interpreter Needed?** _____

Email _____ **Reason for Visit** _____

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex ☐ Decline to answer

Gender Identity: ☐ Male ☐ Female ☐ Transgender (FTM) ☐ Transgender (MTF) ☐ Non-binary ☐ Decline to answer ☐ Other: _____

Sexual Orientation: ☐ Lesbian / Gay ☐ Straight / Heterosexual ☐ Bisexual ☐ Decline to answer ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Decline to answer

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

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

CONTACT INFORMATION

Main Phone _____ **Alternative Phone** _____

Primary Care Physician _____ **PCP Phone** _____

EMERGENCY CONTACT

Full Name _____ **Relationship** _____

Phone Number _____ **Alternate Phone** _____

PHARMACY INFORMATION

Pharmacy Name _____ **Phone Number** _____

Pharmacy Address / Location _____

INSURANCE INFORMATION

Primary Insurance Company _____

Member ID _____ **Group No.** _____

Policy Holder Name _____ **Relationship to Patient** _____

Secondary Insurance _____ **Member ID** _____

RELEASE OF INFORMATION

Please list the individuals with whom we may discuss your medical information, or check the box below.

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

CHECK HERE ONLY IF: ☐ I do **NOT** authorize discussion of my medical information with any individual other than the medical professionals involved in my care. This includes lab results, radiology reports, physician notes, prescription information, 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.

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

CONSENT FOR COMMUNICATION

Telephone and Email. I authorize Pioneer Medical Associates to contact me by telephone and email at the number(s) and address I have provided regarding my appointments, test results, billing and account matters, and coordination of my care. Providing a phone number is required so that the practice can reach me about my care.

Text Messaging. Text messaging is a separate, optional service. If you would like to receive text messages from us, please complete the SMS Consent section below or the standalone SMS Consent Form. You do not have to agree to texting to become or remain a patient.

TEXT MESSAGING (SMS) CONSENT — OPTIONAL

This consent is optional. It is **not a condition of treatment, of purchase, or of receiving any service**. Leaving the box below unchecked will not affect your care in any way. You may withdraw this consent at any time.

Mobile Number (required for texting) _____ **Mobile Carrier** _____

☐ I agree to receive text messages from Pioneer Medical Associates, including appointment, account, and marketing messages. Msg frequency varies. Msg & data rates may apply. Reply STOP to opt out, HELP for help.

Your mobile information will not be sold or shared with third parties for promotional or marketing purposes. Our full Privacy Policy and Terms of Service are available at pioneer.clinic/privacy-policy.

By signing below and providing my mobile number, I agree to receive SMS appointment reminders, account and billing notifications, care and health-related updates, and marketing and promotional messages from Pioneer Medical Associates, PLLC. Message frequency may vary. Standard message and data rates may apply. Reply STOP to opt out. Reply HELP for help. Consent is not a condition of purchase or of treatment.

Patient Signature — Text Messaging Consent

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

NOTICE OF PRIVACY PRACTICES

☐ I acknowledge that I have been offered and given the opportunity to review a copy of the Notice of Privacy Practices of Pioneer Medical Associates, PLLC, which describes how my protected health information may be used and disclosed.

Notice of Electronic Disclosure — Texas Health & Safety Code § 181.154

Because Pioneer Medical Associates, PLLC creates, stores, and electronically transmits medical and billing records, we are required to notify you that your protected health information is subject to electronic disclosure. Texas and federal law prohibit electronic disclosure of your protected health information to any

person without a separate authorization for each disclosure, except for disclosures made for treatment, payment, or health care operations, or as otherwise authorized or required by state or federal law.

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 hereby voluntarily consent to and 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.

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 at 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, MasterCard, 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.

Termination: Patients who are non-adherent to treatment plans, follow-ups, office policies or are violent / verbally abusive to providers and/or staff may result in discharge from the practice.

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 a sick AND well visit. Your insurance might not pay for the combination visit; if this is the case, then you are responsible for 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 from the physician bill you receive. We are not responsible for any laboratory billing issues that arise after the service is 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 by your provider within the past 3 months and need a refill, you must schedule an appointment to see the 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, and 50 cents for each page thereafter. For electronic records, the fee is $25 for 500 pages or less, and $50 for more than 500 pages. Where you request a copy of your own records under the HIPAA individual right of access, any fee charged will be limited to a reasonable, cost-based fee as required by 45 C.F.R. § 164.524(c)(4).

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 reschedulings, 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.

Acknowledgment

By signing below, I certify that I have read and understand the legal information and policies listed above, and I consent to treatment at Pioneer Medical Associates, PLLC.

Printed Name	Signature	Date

MEDICAL HISTORY

Patient Name _____ **Date of Birth** _____

PERSONAL MEDICAL HISTORY

Please check off the following that apply to you.

- ☐ Rheumatological Disease
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Chronic Pain
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Blood Clot in Vein
- ☐ Heart Disease
- ☐ Sleep Apnea
- ☐ Migraine
- ☐ Congenital Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Seizures
- ☐ Insomnia
- ☐ Anemia
- ☐ Thyroid Disorder
- ☐ ADHD / ADD
- ☐ Arthritis
- ☐ STD
- ☐ Kidney Problems
- ☐ Mood Disorders
- ☐ Depression
- ☐ Anxiety
- ☐ Osteoporosis / Osteopenia
- ☐ Coronary Artery Disease
- ☐ SOB at rest
- ☐ SOB on exertion
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Palpitations
- ☐ Atrial Fibrillation
- ☐ Peripheral Arterial Disease

If Cancer, what kind? _____

ADDITIONAL HISTORY / NOTES

Please describe any other conditions, ongoing symptoms, or concerns you would like your provider to know about.

SURGICAL PROCEDURES / HOSPITALIZATIONS

Surgical Procedure / Hospitalization	Month / Year

☐ I have had NO surgical procedures ☐ I have had NO hospitalizations

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 (type: _____)		
☐ Diabetes		
☐ Genetic Condition		
☐ Breast Disease		

☐ My family has NO known health conditions

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No ☐ Former Smoker

If yes, how many per day? _____ **If former, when did you stop?** _____

Do you use any other tobacco or nicotine products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks per week? _____ **How often 6 or more drinks?** _____

Have you used recreational or illegal drugs? ☐ Yes ☐ No

If yes, which ones? _____

Occupation _____ **Exercise (days/week)** _____

PREVENTIVE SCREENING HISTORY

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

Routine Bloodwork	_____	**Flu Vaccine**	_____
COVID Vaccine	_____	**Pneumonia Vaccine (65+)**	_____
Shingles Vaccine (50+)	_____	**Pap Smear (Women 18+)**	_____
Mammogram (Women 40+)	_____	**Last Menstrual Cycle**	_____
Colonoscopy / Cologuard (45+)	_____	**Prostate Screening (Men 50+)**	_____
Bone Density Screening (65+)	_____	**Last Fall (65+)**	_____
Vasectomy (Men)	_____	**Hysterectomy (Women)**	_____
Diabetic Eye Exam	_____	**Dental Exam**	_____

MEDICATION LIST

Please list ALL medications you currently take, including over-the-counter drugs, vitamins, herbal products, and supplements.

Name of Medication	Dose / Strength	How Often (Frequency)

☐ I am NOT currently taking any medications

ALLERGIES

Please list all known food, drug, and environmental allergies and the reaction each one causes.

Food / Drug / Substance	Reaction	Severity (Mild / Moderate / Severe)

☐ I do NOT have any known allergies

Office Use Only

Reviewed By _____ **Date** _____ **Chart #** _____