Elena Gurova, MD, PA

BOARD CERTIFIED INTERNAL MEDICINE

519 N Main Street, Cleburne, Texas, 76033
www.gurovamed.com

Phone 817-645-5915 • Fax 817-645-5935
info@gurovamed.com

PATIENT INFORMATION

NAME (LAST, FIRST, MI)

DATE OF BIRTH: SOCIAL SECURITY #:

MARITAL STATUS: SINGLE / MARRIED / OTHER PREFERRED PHARMACY:

HOME ADDRESS:

HOME PHONE: CELL PHONE:

WORK PHONE: E-MAIL:

EMPLOYER:

SPOUSE / S.O. NAME:

EMERGENCY CONTACT (NAME/PHONE):

HOW DID YOU FIND US?

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: INSURANCE PHONE #:

INSURANCE GROUP #: INSURANCE ID #:

GUARANTOR'S NAME: COPAY:

GUARANTOR'S DOB: PATIENT'S RELATIONSHIP TO GUARANTOR: SELF / SPOUSE / DEPENDENT

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: INSURANCE PHONE #:

INSURANCE GROUP #: INSURANCE ID #:

GUARANTOR'S NAME: COPAY:

GUARANTOR'S DOB: PATIENT'S RELATIONSHIP TO GUARANTOR: SELF / SPOUSE / DEPENDENT

PATIENT SIGNATURE: **DATE:**

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FINANCIAL POLICY

We accept payment by cash, check, VISA, MasterCard, American Express and Discover. It is your responsibility to provide us with your most current insurance information. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

It is your responsibility to know and understand the level of services covered by your insurance company. Some services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

We charge what is usual and customary for our area. Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company.

If you have any questions about your bill, call us at: **817-645-5915**

If You Have...	You Are Responsible For...
HMO & PPO plans with which we have a contract	<u>If the services you receive are covered by the plan</u>: All applicable copays and deductibles are requested at the time of the office visit. <u>If the services you receive are not covered by the plan</u>: Payment in full is requested at the time of the visit.
HMO with which we are <u>not contracted</u>	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.
Medicare	If you have Regular Medicare, and have not met your $120 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. <u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap</u>: No payment is necessary at the time of the visit. <u>If you have Regular Medicare as primary, but no secondary insurance</u>: Payment of your 20% copay is requested at the time of the visit.

If you fail to make payments as agreed upon, your account may be referred to a professional collection agency. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable. If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from Elena Gurova, MD PA. Failure to accept this certified letter serves as notice of termination of services.

In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

I have read, understand, and agree to the above Financial Policy. I authorize the payment of medical benefits to Elena Gurova, MD PA. I understand that I am ultimately responsible for all services whether covered by insurance or not.

______________ ______________________________ ______________________________

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

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CONSENT FOR TREATMENT and NOTICE OF PRIVACY PRACTICES

By signing this consent I authorize Elena Gurova, MD PA and/or other individuals she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Elena Gurova, MD PA unless revoked by me orally or in writing.

Your protected health information may be used and disclosed by Elena Gurova, MD PA and the office staff involved in your care to:

- other health care professionals and institutions involved in your health care and treatment;
- any third party payor covering the medical services of the patient;
- the proponent of any legally sufficient subpoena, or in response to a court order;
- pharmacies;
- and other parties as otherwise required by law.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described above. You may revoke this authorization, at any time, in writing, except where information has already been released.

____ ____________________

Patient's Printed Name Date of Birth

____ ____________________

Patient/Legal Representative Signature Date

____ ____________________

Relationship to Patient Date

____ ____________________

Witness Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Elena Gurova, MD PA to share my protected health information with:

________________________________ ______________________________

Name Relationship

________________________________ ______________________________

Name Relationship

________________________________ ______________________________

Name Relationship

Elena Gurova, MD, PA

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Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME ______________________ **DATE** __________

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Elena Gurova MD PA may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Elena Gurova MD PA has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Elena Gurova MD PA will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Elena Gurova MD PA to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Elena Gurova MD PA has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) ______________________ **DATE** __________

Relationship to Patient if signed by another party ______________________ **DATE** __________

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Elena Gurova MD PA, 624 N Main Street, Cleburne, TX 76033, 817-645-5915 Phone, 817-645-5935 Fax.

FORM Us

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HIPAA Compliance Program

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Dear Patient

As a part of recently passed American Recovery and Reinvestment Act, medical practices are required to obtain additional information for Federal Government Reporting and surveillance regarding healthcare conditions.

The Federal Government now **requires** medical practices to gather additional information about their patients.

Please check or circle one answer for each question.
You may check or circle **"I prefer NOT to answer this question".**

RACE

- American Indian/Alaska Native
- Asian
- Black or African American
- Black Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- White
- White Hispanic or Latino
- I prefer NOT to answer this question

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino
- I prefer NOT to answer this question

PREFERRED LANGUAGE

- English
- Chinese
- French
- German
- Italian
- Japanese
- Korean
- Portuguese
- Russian
- Spanish

- I prefer NOT to answer this question

______________________________ Patient Name

______________________________ Patient Signature

PRE-APPOINTMENT QUESTIONNAIRE - NEW PATIENT-

Name: ____Today's date: ______________________

To help us get the most out of today's visit, please answer the following questions:

1. What is your main purpose in coming to our office today? (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be.)

____

____

2. Are you experiencing any of the following symptoms in relation to your main concern?
(Answer "yes" by circling the appropriate symptom.)

Constitutional symptoms: fever, weight loss, extreme fatigue
Eyes: double vision, sudden loss of vision
Ears, nose, mouth and throat: sore throat, runny nose, ear pain
Cardiovascular: chest pain, palpitations
Respiratory: cough, wheezing, shortness of breath
Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools
Genitourinary: irregular menses, vaginal bleeding after menopause, frequent or painful urination, bloody urine, impotence
Skin: rash, changing mole
Neurological: headache, persistent weakness or numbness on one side of the body, falling
Musculoskeletal: joint pain, muscle weakness
Psychiatric: depression, anxiety, suicidal thoughts
Endocrine: excessive thirst, cold or heat intolerance, breast mass
Hematologic: unusual bruising or bleeding, enlarged lymph nodes
Allergic: hay fever

4. List your surgeries, hospitalizations and major health events: ☐ No past surgical or medical history

____

____

____

5. List your allergies (medications or others): ☐ No allergies

____

____

6. List your ongoing medical problem: ☐ No ongoing medical problem

____

____

7. List diseases or health conditions occurring in your family? ☐ No significant family history

____

____

8. List your medications (name and dosage): ☐ No current medication(s)

____

____

____

9. Do you use tobacco? ☐ Yes ☐ No

DO NOT FILL THE OTHER SIDE OF THIS SHEET

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Authorization to Disclose Protected Health Information

This form is for all record requests.

RELEASE INFORMATION FROM:
Specify Provider/Organization Name and Facility Address

Organization Name: ______________________

Address: ______________________
____
____

RELEASE INFORMATION TO:
Specify Provider/Organization Name and Facility Address

Organization Name: **Elena Gurova MD PA**

Address: **519 N Main Street, Cleburne, TX 76033**
817-645-5915 (phone)
817-645-5935 (fax)

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENT'S FULL NAME ______________________

MAIDEN OR OTHER NAME ______________________

DATE OF BIRTH ____/____/______ **SSN/MEDICAL RECORD #** ______________________

ADDRESS ______________________
Mailing Address, City, State, Zip
____

Covering the period(s) of health care:

FROM (Date) ____/____/______ **TO** (Date) ____/____/______

1. **Information authorized for disclosure**, *if included in my records*:
   - ☐ Complete Health Record
   - ☐ Visit/Discharge Summary
   - ☐ Clinical Documentation of Physical
   - ☐ Documentation of Consultation
   - ☐ Immunization Records
   - ☐ Progress Reports
   - ☐ Radiology and Diagnostic Imaging Reports
   - ☐ Photographs, Videos, Digital or Other Images
   - ☐ Pathology Reports

FORM Js

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HIPAA Compliance Program

☐ Laboratory tests *(please specify)*

☐ Other *(please specify)*

2. ***If applicable,* I also give permission** for the following "Sensitive Protected Health Information" to be disclosed ***(please initial below):***

   ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)

   ☐ Behavioral Health Services / Psychiatric Care

   ☐ Treatment for Alcohol and/or Drug Abuse

   ☐ Sexually Transmitted Diseases (STD)

   ☐ Genetic Counseling / Testing

   _____ **I understand** that the information disclosed pursuant to this Authorization, **except** information
   Initial protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

3. **The purpose for which disclosure is authorized** *(check where applicable)*:
   ☐ Medical Care ☐ Insurance ☐ Benefit eligibility ☐ Immunization

   Other: ____

4. **I understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care.
   I understand that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   (Date) / / . **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (**Initial here ________**) it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

5. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____

Signed: Patient – (or Legal Representative, Parent or Legal Guardian) *(Relationship if not Patient)*

ID Provided ______________________________ Date ____/____/_____

____

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and or court.

Official Use Only

Name/Title of Person Releasing Information: ______________________________

Date ____/____/_____

FORM Js

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