# DR. AIMEE WRIGHT, D.O.

**Di**plomat, American Board of Family Medicine

## PATIENT REGISTRATION INFORMATION

Patient's Name: _____ Today's Date: _____
Last First M Preferred Name

Street Address: _____ Is patient a minor? ☐ YES ☐ NO
PLEASE INCLUDE APARTMENT NUMBER

City, State, Zip Code: _____ Home Phone: (_____)_____-_____

DOB: _____/_____/_____ DL NO: _____ STATE: _____ EXP: _____

SSN: _____-_____-_____ Email Address: _____@_____

Employer and Occupation: _____

Work Phone: (_____)_____-_____ Ext #: _____ Cell Phone: (_____)_____-_____

Parent/ Guardian **(If Applicable)**: _____ Daytime Phone: (_____)_____-_____

Spouse/ Partner's Name: _____ Daytime Phone: (_____)_____-_____

Preferred Contact Number: ☐ HOME ☐ WORK ☐ CELL

Is your condition the result of a work injury? ☐ YES ☐ NO Auto Accident? ☐ YES ☐ NO

Marriage Status: ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Widowed

Sex: ☐ Male ☐ Female

***Mandatory* Preferred Pharmacy:** _____
***Name of Pharmacy*** ***Address/ Phone number***

**If the GUARANTOR is someone other than the patient, *please fill out this section*. *Check here if SELF.* ☐**

Guarantor: _____ Guarantor DL#: _____ State: _____ EXP: _____

SSN: _____ Relationship to Patient: _____

Guarantor's Home Address: _____
Street City, State, Zip

Guarantor's Phone No: (_____)_____-_____ Work Phone: (_____)_____-_____ Ext #: _____

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## INSURANCE INFORMATION

☐ *Please check here if you are a cash pay patient*

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST UPON ARRIVAL

Primary Insurance: _____ Secondary Insurance (if needed) _____

Member ID Number: _____ Group Number: _____

Name of Guarantor (if other): _____ DOB: _____/_____/_____ Phone No: (____)_____-_____

Relationship to Patient: _____

How did you hear about us? _____

*Emergency Contact? _____ Phone No: (_____)_____-_____

Relationship to Patient: _____

**I hereby authorize payment of any insurance benefits to ABOVE NAMED PHYSICIAN. I understand I am financially responsible for the charges incurred whether or not they are covered by insurance. I hereby authorize ABOVE NAMED PHYSICIAN to release any and all information necessary to secure the payment of benefits. A photocopy of this document shall be a valid as the original. Guarantor files insurance for reimbursement. If additional physician time is required for formulary changes on your prescription, there will be a $10.00 fee for this service. This will not be covered by insurance and will be the patient's responsibility.**

***Motor vehicle accidents are fee for service. You will be supplied a fee slip to file to your auto insurance. NO EXCEPTIONS!***

**SIGNATURE:** _____ **DATE:** _____

# MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

| Last Name First Middle | | Date of Birth Sex: ___M ___F | Todays Date |
|---|---|---|---|
| Address City State Zip | | Marital Status | Occupation |
| Person to notify in emergency | Daytime Phone | Relationship | Last Physical Exam Date |
| By Doctor | Phone Number | Family or Referring Doctor | Phone Number |
| May I contact either of these Doctors for your past health records? | | What are your medical symptoms? | |

**FAMILY HISTORY**

| | IF LIVING | | IF DECEASED | |
|---|---|---|---|---|
| | AGE | HEALTH Good, Fair, Poor | DEATH AGE | DEATH CAUSE |
| Father | | | | |
| Mother | | | | |
| Brothers (Circle Sex) Sister | | | | |
| 1. M F | | | | |
| 2. M F | | | | |
| 3. M F | | | | |
| 4. M F | | | | |
| 5. M F | | | | |
| Husband ___ Wife ___ | | | | |
| Sons (Circle Sex) Daughters | | | | |
| 1. M F | | | | |
| 2. M F | | | | |
| 3. M F | | | | |
| 4. M F | | | | |
| 5. M F | | | | |
| 6. M F | | | | |

Do you have any blood relatives who have or have had any of the listed conditions?

*Please check:*

| | YES | NO | Relationship | | YES | NO | Relationship | | YES | NO | Relationship |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Asthma | | | | Hay Fever | | | | Nervous Breathing | | | |
| Arthritis | | | | Insanity | | | | Obesity | | | |
| Allergies | | | | Kidney Disease | | | | Rheumatism | | | |
| Anemia | | | | Leukemia | | | | Rheumatism Fever | | | |
| Alcoholism | | | | Migraine | | | | Stoke | | | |
| Bleeding Tend. | | | | Nervous Breathing | | | | Suicide | | | |
| Cancer | | | | Obesity | | | | Stomach Ulcers | | | |
| Colitis | | | | Rheumatism | | | | Tuberculosis | | | |
| Congenital Heart | | | | Rheumatism Fever | | | | | | | |
| Diabetes | | | | Stoke | | | | | | | |
| Epilepsy | | | | Suicide | | | | | | | |
| Goiter | | | | Stomach Ulcers | | | | | | | |
| High Blood Pressure | | | | Tuberculosis | | | | | | | |
| Heart Disease | | | | | | | | | | | |

**HABITS**

| Do you (check) | YES | NO | Daily Consumption |
|---|---|---|---|
| Smoke..... | ___ | ___ | _____ PKGS. |
| Drink Coffee..... | ___ | ___ | _____ CUPS |
| Drink Alcohol..... | ___ | ___ | _____ OZ. |
| Drink Beer..... | ___ | ___ | _____ OZ. |
| Fall Asleep Easily..... | ___ | ___ | |
| Awaken Early..... | ___ | ___ | |

**MEDICATIONS**

(check) If Taken

- ☐ Antacids
- ☐ Antibiotics
- ☐ Aspirin, Bufferin, Anacin
- ☐ Barbiturates
- ☐ Birth Control Pills
- ☐ Blood Pressure Pills
- ☐ Blood Thinning Pills
- ☐ Cortisone
- ☐ Cough Medicine
- ☐ Digitalis
- ☐ Hormones
- ☐ Insulin, Diabetic Pills
- ☐ Vitamins
- ☐ Water Pills
- ☐ Weight Reducing Pills
- ☐ Other(list) _____

| Operations you have had: YEAR | Diseases you have had requiring hospitalization YEAR | Serious illness not requiring hospitalization YEAR |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Drugs that you are allergic to:**

_____
_____
_____
_____

**Describe any serious injuries or accidents you have had:**

_____
_____
_____
_____

**WOMEN ONLY:**

| | (check) YES | NO | |
|---|---|---|---|
| Are you still having regular monthly menstrual periods? ..... | ☐ | ☐ | |
| Have you ever had bleeding between your periods? ..... | ☐ | ☐ | When? _____ |
| Do you have very heavy bleeding with your periods? ..... | ☐ | ☐ | When? _____ |
| Do you feel bloated and irritable before your period? ..... | ☐ | ☐ | |
| Are you now on or have you ever taken the birth control pill? ... | ☐ | ☐ | When? _____ |
| Have you ever had a miscarriage? ..... | ☐ | ☐ | When? _____ |
| Have you ever had a discharge from the nipple of your breast?.. | ☐ | ☐ | When? _____ |
| Do you regularly have the cancer test of the cervix? ..... | ☐ | ☐ | Date of least test: _____ |

How many children born alive..... _____
How many siblings..... _____
How many premature births..... _____
Date of last menstrual period..... _____
How many miscarriages..... _____
How many cesarean operations..... _____
Any complications of pregnancy? (please explain below)

_____
_____
_____
_____

★ **MEN ONLY:** Have you ever had:

| | (check) YES | NO |
|---|---|---|
| Loss of sexual activity? For how long? (_____) | ☐ | ☐ |
| Treatment for genital (private parts)? ..... | ☐ | ☐ |
| Discharge from penis? ..... | ☐ | ☐ |
| Hernia (rupture)? ..... | ☐ | ☐ |
| Prostate trouble? ..... | ☐ | ☐ |

**MEN and WOMEN:**

| | (check) YES | NO |
|---|---|---|
| Do you frequently have severe headaches? ..... | ☐ | ☐ |
| (If yes answer the following) | | |
| Do they cause visual trouble? ..... | ☐ | ☐ |
| Do they occur on one side of the head? ..... | ☐ | ☐ |
| Do they awaken you at night? ..... | ☐ | ☐ |
| Do they feel like a tight hat band? ..... | ☐ | ☐ |
| Do they hurt most in the back of the head and neck? ..... | ☐ | ☐ |
| Does aspirin relieve them? ..... | ☐ | ☐ |

**Have you recently had pains in the stomach which:**

| | (check) YES | NO |
|---|---|---|
| Occurs 1-2 hours after eating? ..... | ☐ | ☐ |
| Is brought on by eating fried foods, gassy foods? ..... | ☐ | ☐ |
| Awakens you at night? ..... | ☐ | ☐ |
| Is relieved by antacid medications? ..... | ☐ | ☐ |
| Is relieved with milk or eating? ..... | ☐ | ☐ |
| Occurs while eating or immediately after? ..... | ☐ | ☐ |
| Is relieved by a bowel movement? ..... | ☐ | ☐ |
| Causes loss of appetite? ..... | ☐ | ☐ |

| (check ) | YES | NO | (check) | YES | NO |
|---|---|---|---|---|---|
| Have you ever fainted? | ☐ | ☐ | Have you ever had a convulsion? | ☐ | ☐ |
| Spells of dizziness? ..... | ☐ | ☐ | Double vision? ..... | ☐ | ☐ |
| Spells of weakness of arm or leg? ..... | ☐ | ☐ | Pains in ear? ..... | ☐ | ☐ |
| Ringing ears? ..... | ☐ | ☐ | Nosebleeds? ..... | ☐ | ☐ |

**Do you frequently have:**

| | (check) YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Bleeding gums? ..... | ☐ | ☐ | A sore tongue? ..... | ☐ | ☐ |
| Trouble swallowing? ..... | ☐ | ☐ | Nausea and vomiting? | ☐ | ☐ |
| Hoarseness? ..... | ☐ | ☐ | | | |

**Have you ever had shortness of breath? (check)**

| | YES | NO |
|---|---|---|
| Doing your usual work? ..... | ☐ | ☐ |
| Climbing a flight of stairs? ..... | ☐ | ☐ |
| Which awakens you at night? ..... | ☐ | ☐ |
| Do you have a chronic cough? ..... | ☐ | ☐ |
| Which causes you to cough? ..... | ☐ | ☐ |
| Accompanied by wheezing? ..... | ☐ | ☐ |
| Have you ever coughed up blood? ..... | ☐ | ☐ |
| Do you cough up much sputum? ..... | ☐ | ☐ |

**Have you had pain or tightness in the chest which begins:**

| (check) | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| When exerting yourself? ..... | ☐ | ☐ | Radiates down the arm? .... | ☐ | ☐ |
| When walking against a wind? | ☐ | ☐ | Disappears if you rest? ..... | ☐ | ☐ |
| When walking up a hill? ..... | ☐ | ☐ | Only occurs at rest? ..... | ☐ | ☐ |
| After a heavy meal? ..... | ☐ | ☐ | When walking fast? ..... | ☐ | ☐ |
| When upset or excited? ..... | ☐ | ☐ | When walking in cold weather? | ☐ | ☐ |
| Palpitations..... | ☐ | ☐ | If you have chest pain or tightness please explain:____ | | |
| Do you sleep on more than one pillow? ..... | ☐ | ☐ | _____ | | |

_____

| Have you had? (check) | YES | NO | When and since when? |
|---|---|---|---|
| Burning when urinating? ..... | ☐ | ☐ | _____ |
| Loss of control of bladder? ..... | ☐ | ☐ | _____ |
| Blood in urine? ..... | ☐ | ☐ | _____ |
| Dark colored urine? ..... | ☐ | ☐ | _____ |
| Trouble starting to urinate? .... | ☐ | ☐ | _____ |
| Trouble holding urine? ..... | ☐ | ☐ | _____ |
| To get up frequently at night? | ☐ | ☐ | _____ |
| Passed a kidney stone? ..... | ☐ | ☐ | _____ |

| Had you recently had: (check) | YES | NO | When and since when? |
|---|---|---|---|
| Pains in calves of legs when walking? ..... | ☐ | ☐ | _____ |
| Cramps in legs at night? ..... | ☐ | ☐ | _____ |
| Pain in the big toe? ..... | ☐ | ☐ | _____ |
| Varicose veins? ..... | ☐ | ☐ | _____ |
| Phlebitis or inflamed leg veins? | ☐ | ☐ | _____ |
| Swelling in the ankles? ..... | ☐ | ☐ | _____ |

**If you have had a change in bowel habit Recently answer the following:**

| (check) | YES | NO | When or since when? |
|---|---|---|---|
| Crampy pain in abdomen? ..... | ☐ | ☐ | |
| Alternating diarrhea and constipation? | ☐ | ☐ | |
| Pain during or after bowel movement? | ☐ | ☐ | |
| Mucous in the stool? ..... | ☐ | ☐ | |
| Blood in the stool? ..... | ☐ | ☐ | |
| Ribbon like stools? ..... | ☐ | ☐ | |
| Black stools? ..... | ☐ | ☐ | |
| Require use of strong laxatives Or enemas? ..... | ☐ | ☐ | |

## Please briefly describe your present medical symptoms and anything else we should know about your health.

# DR. AIMEE L. WRIGHT

Diplomat, American Board of Family Medicine

## Authorization for Use and Disclosure of Protected Health Information

*WHY THIS FORM?*

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. The "privacy" rules within HIPAA require that health care providers and other entities maintain a specified level of security for Protected Health Information (PHI) which includes any *individual identifiable* health data. Therefore your physician must obtain written authorization from *you, the patient*, to release any of your medical information to any other individual. This includes your spouse, other doctors, relatives, or any other individual that may have a need to review your medical information.

It is important that you complete this form so that in the event of an emergency, your physician will have your prior consent to share your medical information with those individuals to whom deem necessary. We recommend that you include your spouse, other doctors, siblings, physicians, or other individuals as you see fit.

You may revoke this disclosure at any time, if you choose to do so, please do it in writing.

Please do not hesitate to ask for further clarification of this document.

I, _____, hereby authorize the release of my **protected health information (PHI)** by Dr. Aimee Wright to the following persons:

_____ RELATIONSHIP: _____

_____ RELATIONSHIP: _____

_____ RELATIONSHIP: _____

_____ RELATIONSHIP: _____

- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.
- I understand that I have a right to revoke this authorization at any time. My revocations must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/ or disclose my protected health information have acted in reliance upon this authorization.
- I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C. F. R. 164.524).

Please sign this form so that we may comply with your request. Completion of this form will not in any way affect your eligibility for benefits.

I certify that I have read and understand this authorization.

_____ _____

Signature Date

_____

Printed Name of Patient or Representative

# Office of Dr. Aimee L Wright CONSENT FORM

## Please Read Thoroughly

**To the use and/ or disclosure of Protected Health Information (PHI) for treatment, payment, health care operations, coordination of care, and as otherwise allowed by law**

Dr. Aimee L. Wright, her associates, and employees will maintain a record of the care and services that you receive at this practice. Your Protected Health Information (PHI) pertains to your diagnoses and treatments received at the practice of, or on the orders of Dr. Aimee L. Wright and/ or her associates; including not limited to information concerning physical and mental illness, use of alcohol, drugs or illicit substances, communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), laboratory and imaging test results, medical and surgical history, treatment progress and any other such related pertinent information.

By signing this form you consent to the use and/or disclosure of Protected Health Information (PHI) for treatment, payment, health care operations, and as otherwise allowed by law, including the exchange of PHI to facilitate the coordination of your care with other physicians or health care providers involved in your care. Our Notice of Protected Health Information Practices provides information about how Dr. Aimee L. Wright, her associates and employees may use and/ or disclose PHI about you for such purposes.

This practice is a member of the UT Southwestern Accountable Care Organization (UTSW ACO). This is a general notice that you will be opted into the Electronic Health Exchange (EHX) with UTSW for sharing information within the UTSW network. You are consenting to have your information shared within the EHX for quality purposes. Your personally identifiable information will not be shared. Only non-identifiable quality measures such as cancer screening tests, disease management, etc., will be shared with the exchange. This practice uses e-prescribing to send prescription and refill requests electronically. You are consenting for this office to send prescription and refill requests electronically to pharmacies on your behalf.

NEW REFILL POLICY **EFFECTIVE 06/18/2018**

We care about your health, and want to work with you to help you attain your best self. This must be a team effort, and will therefore require your participation. We cannot take care of you to the highest standard of care unless we see you in the office.

If you are on regularly scheduled prescription medications, you will be asked to follow up at regular intervals. We recommend that you schedule your follow up on your way out, but in the event that you have not done so, know that we have provided you with a supply of all of your medications sufficient to last until your next visit. Therefore, if you see that you do not have any more refills on your medication, it is time for you to make an appointment. If you do not return for your follow up appointment as instructed, **NO REFILLS WILL BE AUTHORIZED UNTIL YOU RETURN FOR A FOLLOW UP VISIT.** If you miss your follow up appointment and require refills for **URGENT** medications that you **MUST** not miss, we will authorize a 30 day supply to allow you time to get an appointment. However, **THERE WILL BE A $25.00 FEE PER PRESCRIPTION REFILLED.**

By signing this form, you also acknowledge that you have received a copy of Dr. Aimee L. Wright's Notice of Protected Health Information Practices, as well as our new refill policy effective 06/18/2018, and have been given an opportunity to review it before signing this form.

_____ _____

**Signature of Patient or Legal Representative** **Printed name, If *other* than the patient**

_____

**Date**

_____ _____

**Signature of Witness** **Printed name of Witness**

_____

**Date**

# Addendum To Consent

**Consent for Care:**

I, with my signature, authorize Dr. Aimee Wright, and any employee working under the direction of Dr. Aimee Wright to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitation, maintenance, palliative care, counseling, assessments or review of physical or mental status/ function of the body and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Thank you for understanding and cooperating with this policy. It is our privilege to provide your medical care.

I have read and understand the consents policy stated above and agree to accept full responsibility as describes above.

_____ _____

**Patient/ Responsible Party** **Date**

_____

**Patient name if different from responsible party**

# DR. AIMEE L. WRIGHT

Diplomat, American Board of Family Medicine

## Financial Policy

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibility is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss them with us.

It is the responsibility of our patients to provide us with current, valid insurance information and inform our office of address changes. For those insurance plans in which we participate, your predetermined portion of charges set by your insurance plan is **due at the time of service**. It is your responsibility to be aware of your co-payment and if you've met your deductible. Payment is expected at time of each visit, either in full or the extent that a co-payment is required by your insurance. We do not offer charge accounts or payment plans.

We accept cash, Visa, MasterCard and American Express. We do not accept checks.

Delinquent accounts will be turned over to a collections service if not settled within 90 days. For all accounts that must be sent to a collections agency, a $50.00 fee will be added for processing.

### Your Insurance

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only requires you to pay the authorized co-payment, deductible, and co-insurance at the time of service.

If you have insurance coverage under a plan with which we do not have a prior agreement, payment in full will be expected at the time of service. You will be given the paperwork necessary to assist in filing your own claim.

We make every effort to follow the guidelines required by your insurance company. However, every contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect payment from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

After a claim has been processed and it is evident that the patient's financial responsibility is greater than was collected at the time of service, then the financial guarantor will have 30 days to pay the balance owed in full. A late fee of $50.00 will be added to all account balances in excess of 90 days past due (even if the payment delay is due to the insurance company). Accounts with balances will be turned over to a collection company if not paid in completion of 90 days.

### Precertification

We will try to fulfill all the requirements your insurance has for precertification, but we will not be responsible for any reductions in benefits of this is done.

Be sure and tell us if precertification is necessary BEFORE you have a procedure.

### Minor Patients

For all service rendered to minor patients, we will look to the adult accompanying the patient and the custodial parent and/ or guardian for payment. We do not see minors for ADD or transgender services- you must be over the age of 17.

### Missed Appointments

Failure to keep your appointment prevents other patients from being able to see the doctor during that time. This causes patients who are ill to wait unnecessarily for appointments and wastes both the doctor's and other patient's time. When you have to cancel, we ask for the courtesy of at least 24 hours advance notice so we may offer your time slot to another patient. Patients who do not cancel or reschedule their appointment at least 24 hours prior to their scheduled appointment may be charged a fee of $45.00.

## Rescheduled Appointments

Rescheduling appointments may be necessary if:

- Patient is greater than 15 minutes late for appointment
- Patient is unable to meet the financial requirements for appointment
- Patient is unwilling to pay previous balanced owed on account
- Patient is unwilling to pay for visit, when insurance in unverifiable

## From to be Completed by Physician

If you require a form to be filled out by our physician, you will be charged a fee. The fee is typically $10.00 per page, *BUT* for more thorough and detailed paperwork, prices may vary depending on the time spent by our physician. Please leave the blank forms with receptionist. Please allow at least five business days for completion. Payment is due when the form is returned to you.

If addition physician time is required for formulary changes, and rewritten prescriptions, there will be a $25.00 for this service.

## Office Hours

| | |
|---|---|
| Monday and Tuesday | 9AM-7PM |
| Wednesday: | 9AM-4PM |
| Thursday: | 11AM-7PM |
| Friday: | 11AM-4PM |

## Hours starting 2019:

| | |
|---|---|
| Monday, Wednesday, Thursday | 9AM- 4 PM |
| Tuesday | 11AM- 7PM |
| Friday | 11AM- 4PM |

Please note: We are open every SECOND Saturday of the month from 9AM-12PM.

Telephone calls will be returned **by the staff, AFTER** review with the Doctor. All call are returned by the next business day.

All telephone requests for prescription refills, appointments, and all other business of a non-emergency nature, must be made Monday through Thursday between 8:30 a.m. and 4:00 p.m. and Friday 9:00 a.m. to 12 noon. If you should have an URGENT need to speak with the provider on call after hours you may call the provider on call. The provider will respond to bonafide urgent calls within two (2) hours. "Urgent" suggests a call needing a response within two (2) hours. After hour phone calls made to the provider on call may incur a charge. If you should have a true medical emergency, please call 911.

**I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.**

**I authorize the release of medical records to determine liability for payment or treatment, and to obtain reimbursement. I assign all medical and/ or surgical benefits to Dr. Aimee L. Wright. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not they are paid by my insurance company.**

_____

Printed Name of Patient or Legal Representative

_____ _____

Signature of Patient or Legal Representative — Date

_____ _____

Printed Name of Patient — Date of Birth