

**BORGER INTERNAL MEDICINE**  
50 Medical Drive Ste. 400 Borger, TX 79007  
(806) 467-5804 Fax (806) 274-9512



**PATIENT INFORMATION**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Sex: Female / Male Marital Status: S M W D  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Patient Employer \_\_\_\_\_ Phone # \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Emergency Contact Phone # \_\_\_\_\_  
Personal Physician \_\_\_\_\_ Referred by Dr. \_\_\_\_\_ Dental Provider: Dr. \_\_\_\_\_

**RESPONSIBLE PARTY / BILLING INFORMATION**

Same as **PATIENT** information

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex: Female / Male Relation to Patient: \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_ Occupation \_\_\_\_\_

**INSURANCE INFORMATION**

Do you have Insurance? [ ] Yes [ ] No Is this an on the job injury? [ ] Yes [ ] No Date of injury? \_\_\_\_\_

\*You must provide our office with a current Insurance card.

1) Insurance Carrier Name \_\_\_\_\_ 2) Insurance Carrier Name \_\_\_\_\_

**INSURED / POLICY HOLDER INFORMATION**

Same as **PATIENT** information

Same as **RESPONSIBLE PARTY** information

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex: Female / Male Relation to Patient: \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_ Occupation \_\_\_\_\_

**AUTHORIZATIONS AND ACKNOWLEDGEMENT**

Do you have an advanced directive? [ ] Yes [ ] No If so we will need a copy for your file. Copy provided [ ] Yes [ ] No

Do you have a Durable Power of Attorney for Healthcare? [ ] Yes [ ] No If so we will need a copy for your file. Copy provided [ ] Yes [ ] No

I voluntarily request that Borger Internal Medicine and such assistants as they may deem necessary, manage/treat my condition and I hereby release Borger Internal Medicine, Golden Plains Community Hospital and any other participating health care providers from any and all liability. The duration of this consent is identified and continues until revoked in writing.

**BENEFITS TO PHYSICIAN:** I hereby authorize the release of information relating to all claims for referral and benefits submitted on behalf of myself and/or dependents

I hereby authorize payments directly to Golden Plains Community Hospital and/or the health care provider of the medical and/or surgical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicated that I have read the above and grant the request of authorizations.

**X** \_\_\_\_\_  
Signature of Patient or legal guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

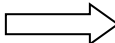


**PATIENT HISTORY FORM**

NAME: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

D.O.B. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ PREFERRED PHARMACY: \_\_\_\_\_

<b>A. REVIEW OF SYSTEMS</b>		<b>B. Obstetrical History</b>				
YES NO GENERAL		(please list ALL pregnancies in order, including miscarriages, premature births, stillbirths, ectopic (tubal) and abortions)				
	1. Unexplained weight loss more than 10 lbs. in the past year?	Year	M / F	Wt.	Type of Delivery	Length of pregnancy
	2. Night sweats					Problems
						Age
<b>CARDIO-RESPIRATORY</b>						
YES NO						
	3. Hypertension (high blood pressure)					
	5. Chest Pain					
	6. Blood Clots					
	7. Swelling of legs or feet					
	9. Shortness of breath					
<b>GASTROINTESTINAL</b>		<b>GYN HISTORY ( Check ALL that apply)</b>				
YES NO		Age of first Period? _____		Last Menstrual period? _____		
		Cycle length every _____ days		Lasting _____ days		
	11. Constipation	Periods are: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular			Flow is: <input type="checkbox"/> Light <input type="checkbox"/> Light to moderate	
		<input type="checkbox"/> Painful <input type="checkbox"/> not bothersome			<input type="checkbox"/> Moderate to heavy <input type="checkbox"/> Very Heavy	
	12. Diarrhea	Date of last PAP Smear _____			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
	13. Blood in stools	<b>METHOD OF BIRTH CONTROL</b>				
	14. Liver Problems	<input type="checkbox"/> Condoms	<input type="checkbox"/> Pills	<input type="checkbox"/> Patch	<input type="checkbox"/> Vaginal Ring	
	15. Gallbladder Problems	<input type="checkbox"/> Tubal	<input type="checkbox"/> Essure	<input type="checkbox"/> IUD	<input type="checkbox"/> Other	
	16. Trouble Swallowing	<input type="checkbox"/> Partner with Vasectomy		<input type="checkbox"/> Natural family planning		
<b>MUSCULOSKELETAL</b>		<b>SEXUAL HISTORY</b>				
YES NO		YES NO				
	22. Swollen or painful joints / Where? _____			Are you sexually active?		
	23. Osteoporosis			Virginal?		
	24. Gout			New partners?		
<b>SKIN</b>		Number of lifetime partners? _____				
YES NO		Sexual preference?				
	25. Acne	<input type="checkbox"/> Heterosexual (Opposite Sex)	<input type="checkbox"/> Same Sex	<input type="checkbox"/> Bi-sexual		
	26. Rash	<b>MEDICATION LIST</b>				
<b>NEUROLOGICAL</b>		1.				
YES NO		2.				
	27. Headache	3.				
	28. Seizures	4.				
	29. Dizziness	5.				
<b>PHYCHOLOGICAL</b>		<b>HOSPITALIZATION AND SURGERIES</b>				
YES NO		Year	Reason			
	30. Depression / Anxiety					
	31. Bipolar Disorder					
<b>YES NO ENDOCRINE</b>						
	30. Thyroid problems	<b>COMMENTS:</b>				
	31. Diabetes					
<b>YES NO PREVENTATIVE</b>						
	32. Colonoscopy after age 50? Date: _____					
	33. Mammogram after age 40? Date: _____					
<b>HEMATOLOGICAL / LYMPHATIC</b>						
YES NO						
	34. Anemia					
	35. Blood clotting disorder					
<b>ALLERGY (please list)</b>						
	1.					
	2.					
	3.					
	4.					



**CONTINUED NEXT PAGE**



**PATIENT HISTORY FORM (CONT'D)**

NAME: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

D.O.B. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ PREFERRED PHARMACY: \_\_\_\_\_

<b>C. FAMILY HISTORY</b>			
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have your biological (parents, brothers, sister) had any of the following?			
<b>YES</b>	<b>NO</b>	<b>Diagnosis</b>	<b>Relative</b>
		Heart disease/ heart attack/stroke before age 50	
		High blood cholesterol	
		Genetic problems	
		Cancer What Type?	
		Diabetes	
		Osteoporosis	
		Blood Clots	
Race _____			
Ethnicity _____			
Preferred Language _____			
<b>D. SOCIAL HISTORY</b>			
ALCOHOL HISTORY: <input type="checkbox"/> Current <input type="checkbox"/> Former Type _____ <input type="checkbox"/> None		<b>EDUCATION</b>	High School / College
Per Day # _____ Years Used _____ Years Quit _____			Year
SMOKING HISTORY: <input type="checkbox"/> Current <input type="checkbox"/> Former Type _____ <input type="checkbox"/> None			
Per Day # _____ Years Used _____ Years Quit _____			
EXPOSURE TO SECOND HAND SMOKE <input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> In the home <input type="checkbox"/> Other: _____			
DRUG USE: <input type="checkbox"/> Current <input type="checkbox"/> Former Type _____ <input type="checkbox"/> None			
Per Day # _____ Years Used _____ Years Quit _____			
<b>IMMUNIZATIONS (Check the ones you have received)</b>		<b>Does not receive</b>	Verified by :
<input type="checkbox"/> Flu Vaccine			<input type="checkbox"/> Verbal <input type="checkbox"/> Record <input type="checkbox"/> Immtrac
<input type="checkbox"/> Pneumococcal			<input type="checkbox"/> Verbal <input type="checkbox"/> Record <input type="checkbox"/> Immtrac
<input type="checkbox"/> Varicella (chicken pox)			<input type="checkbox"/> Verbal <input type="checkbox"/> Record <input type="checkbox"/> Immtrac
<input type="checkbox"/> Zostavax (shingles)			<input type="checkbox"/> Verbal <input type="checkbox"/> Record <input type="checkbox"/> Immtrac
<input type="checkbox"/> T-dap			<input type="checkbox"/> Verbal <input type="checkbox"/> Record <input type="checkbox"/> Immtrac
<input type="checkbox"/> Other			<input type="checkbox"/> Verbal <input type="checkbox"/> Record <input type="checkbox"/> Immtrac
<input type="checkbox"/> Other			<input type="checkbox"/> Verbal <input type="checkbox"/> Record <input type="checkbox"/> Immtrac



***Welcome to our practice!***

We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

**PARTICIPATING PROVIDER**

We are providers for a select group of major PPO and HMO networks. However due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. Therefore it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list before an appointment. You will be responsible for payment in full for services rendered by a physician if he/she is not in your plan.

**YOU MUST PRESENT A VALID ID CARD AND INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.**

**REFERRALS**

It is your responsibility to obtain from your primary care physician referrals required by your insurance company to see a specialist, as well as to track the number of your visits and keep your referrals current. Without a current referral at the time of the visit, your appointment will have to be rescheduled.

**CO-PAYMENTS**

We are required to collect your co-payment at the time of service. If the co-pay amount is not listed on your card, or you have a standard traditional plan, we will collect the percentage of the services rendered that is applicable to your plan.

**NON-MANAGED CARE**

For non-managed care of traditional plans, we will file a claim as a courtesy. However, the contract with your insurance company is between you and this company. We are not a party to that contract. You are ultimately responsible for your bill, regardless of any non-payment by the insurance carrier. If within 45 days payment is not relieved by your insurance company, payment will be due by you, regardless of the status of your claim.

**DEDUCTIBLE**

If you have a deductible, and it is likely that the services rendered will go toward your deductible, payment in full must be made at the time of service. Unless other arrangements have been made with our office

**PRECERTIFICATION OF HOSPITAL ADMISSION OR SPECIAL SERVICES**

Pre-certification of hospital admissions and other special services is an area in which we strive to help. With the exception of some HMO plans, it is ultimately the patient's responsibility to inform this office when pre-certification is a requirement of your plan. Due to the varying policy provisions of all the different plans, it is impossible for us to know each patient's specific plan provisions. If you fail to disclose pre-certification requirements PRIOR to services being rendered, you will be responsible for payment of all related fees in full.

**FOR ALL SERVICES PROVIDED OUTSIDE OF OUR OFFICE, YOU MUST BE AWARE OF; AND INFORM US, WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN. THIS INCLUDES X-RAY, LABORATORY, DIAGNOSTIC, AND REHABILITATION FACILITIES.**

**SECONDARY INSURANCE**

We will file secondary insurance as a courtesy for you. Please keep in mind that payment of your account is ultimately your responsibility, and we will look to you for payment of your account if we are unsuccessful in obtaining reimbursement by your insurance.

**RESPONSIBLE PARTY (GUARANTOR)**

The guarantor of the account is the patient who comes in for treatment or the adult who brings in the minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings in the minor child, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of our office to become involved in medical bill disputes resulting from divorce, etc.

**LIABILITY OR AUTO ACCIDENT CLAIMS**

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to file your claim.

**PAYMENT PLANS**

We understand that from time to time unexpected circumstances may arise which make paying for medical care difficult. With this understanding, we provide payment plans to assist you in the management of your account. Please notify us if you need this service.

**NSF CHECKS**

Once a check is returned for NSF, we will accept only cash or money orders for future visits.

**NON-PAYMENT OF ACCOUNTS / NON-COMPLIANCE**

Accounts for which we are unable to collect, the balance will be discharged. Our physicians /providers reserve the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

**ACCEPTANCE OF FINANCIAL POLICY**

The undersigned hereby certifies that he/she has read, understood, and agrees to the policy of this office.

**X**

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Date



**ACKNOWLEDGEMENT**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I acknowledge that **Golden Plains Community Hospital** provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative Signature (if applicable)

\_\_\_\_\_  
Relationship to Patient



**Permission to Disclose Information  
To those involved in my care**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby allow BORGER INTERNAL MEDICINE to disclose the following information to the people listed below.

(Please give full name)

- Spouse: \_\_\_\_\_
- Family friend(s): \_\_\_\_\_
- Children: \_\_\_\_\_
- Others: \_\_\_\_\_  
\_\_\_\_\_

In the following forms of communications

- Home Telephone
- Work Telephone
- Home voice messaging system
- Work voice messaging system
- Cellular phone
- Cellular voice messaging system
- Other: \_\_\_\_\_
- All of the above

• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department. Revocation will not apply to information that has already been disclosed in response to this authorization.

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date: