Hello and Welcome!

We would like to take a moment and inform you on the policies and instructions of our office. Your healthcare comes first at our office, but we do have to deal with administrative issue related to providing your care.

Insurance

At the beginning of each year or the change of insurance, we will verify your coverage. You will need to provide us with the most up to date insurance card. Your charges are directly based upon the information that your insurance gives us. Please expect to either pay a deductible or a copay the day services are rendered. **New patients will need to pay for appointment prior to seeing the doctor**. We are here to help and will try our best to answer any questions that you have regarding your coverage. **But ultimately the coverage contract is between you and your insurance.**

Your healthcare is very important to us and we will order all appropriate tests that our physicians feel are medically necessary. How your insurance company covers these outside charges for specialists, imaging centers, hospitals, and laboratory work are part of your insurance company's contract and coverage agreement with you. Your insurance plan may not provide everything as we see it online, and we cannot guarantee that all tests ordered will be covered by your insurance. It is your responsibility to take up those uncovered charges with your insurance.

Prescriptions and Samples

If you need a refill of an existing prescription, call your pharmacy and request a refill even if the bottle says zero refills. Refills are **ALWAYS** done through the pharmacy. Please do not call the office to ask for a refill on a medication, unless it is a controlled substance or mail order refill. If the prescription is approved by the physician please give our office 2-3 days to process the refill. **CHECK WITH THE PHARMACY before calling the office** as we do not call the patient after we communicate with the pharmacy. Please give at least 2 hour to process your prescription before you try to pick up your called in prescription, as the pharmacies MAY NOT check their voicemail in a timely fashion. If your doctor chooses not to refill the prescription, the request from the pharmacy will be denied. At this time, call the office for instruction.

If you were given a sample of a medication and would like a prescription for that medication, please leave a message on our pharmacy line voice mail with your name, date of birth, name of medication and pharmacy phone number. Please allow 2-3 days to be called in and processed by your pharmacy.

Labs

The lab hours are Monday through Friday 9:00 a.m. to 4:30 p.m. We only do labs in our office on the same day as your office visit with the doctor, therefore all physicals, pap, diabetic appointments etc. need to come in fasting 4-5 hours prior to seeing the doctor. NO WALK INS FOR LABS. CPL (Clinical Pathology Labs) is our preferred lab and maintains a phlebotomist draw site within our building. The phlebotomist is not our employee, and **we have no authority as regards to CPL's billing**. Please address any lab billing questions to the CPL billing office.

Test Results

Please let **us contact you** regarding your results. Routine or yearly results will be mailed. Other results may be called or mailed to you shortly after our physicians receive them. Ask your doctor or nurse, during your visit, how long it usually takes to get results back on your particular test. A summary of your results will be mailed to you. If you have questions about these results. PLEASE, call the office and schedule an appointment with the doctor. For detailed print outs of your lab results you can request these through CPL's website at https://patient.cpllabs.com/. Pap results will not be called to the patient if they are normal.

Radiology Orders

If the physicians feel that it is necessary for you to have any imaging to help better diagnose and treat your condition, you will receive an order from us to take to separate imaging facility. The facility of your choice will file to your insurance and handles those claims.

Radiology Results

As soon as you complete the requested imaging, the facility will send over a report regarding your results. Please allow 3-5 days for this information to be sent to us. We will inform you in a timely manner as soon as we receive the results either by letter or phone. A summary of your results will be mailed to you. If you have questions about these results. PLEASE, call the office and schedule an appointment with the doctor. If you do not receive results within a week, call us or the facility where you went to be sure we received the report.

Paperwork and Forms

If you have Family Medical Leave Paperwork (FMLA), short-term disability, biometric forms, etc. that needs to be filled out, you will first have to be seen by the physician to gather the information needed to process this paperwork**. This paperwork will not be filled out at the initial office visit**. A fee of $35.00 is required for us to fill out the packet and it will take up to 5 days to be completed. Wellness biometric forms will be filled out with a $15.00 charge. Please allow 3-5 business days for this to be completed. We will contact you as soon as it is done to determine what will need to be done with the paperwork. We can fax it to your company/school if you provide the number and details.

Emergency Room Visits or Hospitalizations

If you go to the Emergency Room, or are admitted to the hospital. Please call and schedule a follow up appointment with Dr. Pifer or Dr. Chavda once you have been discharged. Also, while you are at the hospital please sign a release of records. This allows the hospital to send your reports from that ER visit to our office so that we have it for our records as well. This does not guarantee that the hospital will send anything and we may need to do a request from our office.

Hours

Our office hours are Monday through Friday 8:30 a.m. to 5:00 p.m. We close during the noon hour for lunch from approximately 12:15p.m. (Or after the last patient of the morning) to1:30p.m.
After hours, urgent medical issues may be addressed by calling Dr. Chavda or Dr. Pifer.
If it is a life-threatening emergency call 911 and go to the ER.

Missed Appointments

We ask that you give at least 24 hours' notice if you need to cancel or reschedule an appointment. Canceling within the 24-hour period may result in a $30.00 fee against your account. No-showing an appointment may result in a $50.00 fee against your account. **Two or more missed appointments without notice are grounds for being discharged from the practice**. When you don't allow the office the courtesy of knowing you will be unable to make your appointment, you are taking away appointment opportunities for "same day" sick patients.

Aesthetic Appointments

We offer a wide variety of aesthetic treatments in our office.
These include Coolsculpting, Truesculpt Flex, several Venus treatments, Hydrafacials, Botox, and pellets. These treatments are not covered by insurance and payment for these treatments will need to be paid at the time the treatment is done. Also, if you have any kind of balance for medical care that your insurance says you owe for services by our doctors no appointments will be made till that balance is taken care of in full. If you don't think you owe the balance that is between you and your insurance, we take the payment and deduction we are told to take by the insurance company.

Heritage Family Medicine & Aesthetics

Patient consent for Use and Disclosure of Protected Health Information:
With my consent, Heritage Family providers may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. (TPO) Please refer to Heritage Family's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Heritage Family Medicine & Aesthetics reserves the right to revise its Notice of Privacy Practices at any time. A revised notice may be obtained by forwarding a written request to Heritage Family Medicine & Aesthetics at 4214 Gateway Drive Suite 100 Suite 100, Colleyville, Texas 76034.

With my consent, Heritage Family Medicine & Aesthetics and the employees may call my home or other listed phone numbers and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Heritage Family Medicine & Aesthetics may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that the practice restrict how it uses or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Heritage Family Medicine & Aesthetics use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Heritage Family Medicine & Aesthetics may decline to treat me.

____

Signature of Patient or Legal Guardian Date Printed Name

____

Names of those with whom you may discuss my health/records.

____

Adults who have my permission to bring my minor child in for medical treatment.

____

My minor child has my permission to drive himself/herself to the office for medical treatment in my absence.

PATIENT INFORMATION

Account #____________________ **Date** ____________________

____ **Birth Date**____________________

Patient's Last Name **First** **Middle**

____

Home address **Apt. #** **City** **State** **Zip**

______________ _________________ ________________ ____________________

Home Phone **Cell Phone** **Work Phone** **Social Security Number**

_________________________________ ____

Patient's Occupation **Employer**

___________________________ _______________ _______________________________

Name of Spouse **Birth Date** **Social Security Number**

___________________________ _________________________

Employer **Work Phone**

____

Emergency Contact **Relationship to patient** **Phone**

Referred by______________________________

Children's Names **Age** **Birth Date**

_________________________ ______ _________________________

_________________________ ______ _________________________

_________________________ ______ _________________________

_________________________ ______ _________________________

Email Address _______________________________

____

Pharmacy Number
(Please leave blank if unsure)

____

Patient Signature

History & Physical		**Date:** ________________	
Name	Male Female	Marital Status:	Date of Birth:

Family History: If any blood relative has suffered any of the following – Please circle the number/indicate which relative.

1. Epilepsy	6. Thyroid Disease	11. Osteoporosis	16. Lipid disorder	
2. Migraine	7. Hay fever	12. Arthritis	17. Alcoholism	
3. Mental Illness	8. Asthma	13. Heart disease	18. Hepatitis	
4. Glaucoma	9. Anemia	14. Stroke	19. Cancer	
5. Diabetes	10. Bleeds easily	15. Hypertension		

Hospital Admissions **Not including pregnancies**	**Year**	**Illness or Operation**	**Year**	**Illness or Operation**

LIST ALL MEDICATIONS YOU ARE NOW TAKING			**ALLERGIES**	**Vaccine Year of last**	**Test/ Exam Year of last**
				Tetanus/Td	Rectal/ Stool
				Influenza	Cholesterol
				Pneumonia	Eye
				Hepatitis Tuberculosis	Dental

Medical History:

_ Hearing problems
_Ringing in ear
_Dizzy spells
_ Fainting spells
_Vision problems
_Eye pain
_ Nose bleeds – *recurrent*
_ Sinus trouble
_ Sore throat – *frequent*
_ Hoarseness – *prolonged*
_ Hayfever/allergies
_ Pneumonia/Pleurisy
_ Bronchitis/Chronic cough
_ Asthma/Wheezing
_Shortness of breath:
_ on exertion _lying flat
_ Chest pain
_ High blood pressure
_ Heart murmur
_Swollen ankles
_Irregular pulse
_ Palpitations
_Leg pain
_ Cold numb feet
_Varicose veins/Phlebitis
_Loss of appetite
_Difficulty swallowing

_ Heartburn _Peptic ulcer
_ Nausea/Vomiting
_ Gallbladder disease
_ Abdominal pain – chronic
_ Jaundice/Hepatitis
_ Diarrhea
_Constipation
_Diverticulosis
_Crohn's/Colitis
_ Bloody or tarry stools
_Hemorrhoids _Hernia
Urination – Overactive bladder
_ overnight > than twice
_ More than 8 times/24 hours
_ Urgency to urinate
_ with leakage
_ Decrease in force/flow
_ Painful
_ stress incontinence – urine leakage with exercise/movement
_ Blood in urine _ kidney stones
_Urine infections – *frequent*
_ Sexually transmitted disease
_ Weight loss
_Weight gain
_ Anemia
_ bruise easily
_ Cancer
_ Chronic fatigue

_ Diabetes
_ Thyroid disease
_ Seizures _ Stroke
_ Tremor/hands shaking
_ Headaches – *frequent*
_ Arthritis/Rheumatism
_ Back pain – *recurrent*
_ Bone fracture/ joint injury
_ Osteoporosis
_ Gout
_ Rashes
_ Hives
_ Psoriasis
_ Eczema
_ Sleeping or concentration difficulty
_ Depression _Nervousness
_ Moodiness
_ Suicidal thoughts
_ Memory loss
_ Mental illness
_ Rheumatic fever
_Chicken Pox _Polio
_ Mumps _Tuberculosis
_ German measles _ Measles
_ Herpes
_ AIDS/ HIV

_ Alcohol ______ oz./week
_ Coffee/Tea ______cups/day
_ Smoking – ______ cig/day
_______ # years
Year quit __________
_ Exercise _______________
_ Street drugs ______________

Females – please complete
Menstrual flow:
_ Reg. _ Irreg. _Pain/cramps
Days of flow _______
Length of cycle _________
1st day of last period ________
_ Pain/bleeding during or after sex
Number of:
Pregnancies___ Abortions ___
Miscarriages___
Live birth ___
Birth control method _______
BC pill (name) ____________
_ Flushing/Menopause
Date of last PAP test _______
_ Normal _ Abnormal
Date of last mammogram _____________
_ Normal _ Abnormal

Synopsis:

MINOR REGISTRATION FORM

ACCOUNT__________________ DATE_________________________

PATIENT'S LAST NAME FIRST MIDDLE DATE OF BIRTH

HOME ADDRESS CITY STATE ZIP

HOME PHONE PATIENT'S SOCIAL SECURITY NUMBER

FATHER'S NAME FATHER'S DATE OF BIRTH FATHER'S CELL PHONE

FATHER'S EMPLOYER SOCIAL SECURITY NUMBER WORK PHONE

MOTHER'S NAME MOTHER'S DATE OF BIRTH MOTHER'S CELL PHONE

MOTHER'S EMPLOYER SOCIAL SECURITY NUMBER WORK PHONE

NEAREST FRIEND OR RELATIVE NOT LIVING AT HOME PHONE

REFERRED BY

SIGNATURE OF PARENT OR GUARDIAN