

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

Jonathan C Piga, MD
Naomi C Piga, MD FAAP
Versallie R Capote-Piga, MD FAAP



Patient Demographic Information

Patient Name _____
Gender _____ Date of Birth: _____ Marital Status: _____
Social Security #: _____ Driver License #: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____
Whom can we thank for your referral? _____

Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____
Work Phone #: _____ Position: _____

For pediatric patients only: Information regarding Parent/Guardian/Legal Representative

Mother's Name _____
Date of Birth: _____
Social Security #: _____ Driver License #: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____
E-mail Address: _____
Employer Name: _____ Work Phone #: _____

Father's Name _____
Date of Birth: _____
Social Security #: _____ Driver License #: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____
E-mail Address: _____
Employer Name: _____ Work Phone #: _____

Billing Responsibility: (Circle One) *Father Mother Other*

Name if Other: _____
Date of Birth: _____ Relationship to Patient _____
Social Security #: _____ Driver License #: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____

Emergency Information

Emergency Contact Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____

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Insurance Information *Please skip if you have no insurance coverage*

Insurance Company: _____ Phone #: _____
Claims Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____ Group #: _____
Effective Date: _____
Name of Primary Insured: _____
Primary Insured Date of Birth: _____ Social Security #: _____

Preferred Pharmacy Information *Pharmacy on file for medications and refills*

Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Authorization to Release Information and Assignment of Benefits

- By checking the box on the left, I certify that information I have reported about my insurance is correct.
- By checking the box on the left, I authorize the release of any medical information necessary to process my insurance claims.
- By checking the box on the left, I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment be made directly to my doctor or to the party who accepts assignment.
- By checking the box on the left, I acknowledge that any insurance billing done is at the discretion of my doctor. I understand that any co-pays, co-insurances and deductions deemed my responsibility are payable in full by me.
- By checking the box on the left, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.

Signature of Patient/Parent/Legal Guardian _____ Date _____



Adult Medical History Form

Please complete All **3** PAGES

Name _____

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.
Thank you!

PRESENT HEALTH CONCERNS: _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose	Times per day

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS: (Please include all skin allergies)

Medication	Reaction or Side Effect

Do you take any BLOOD THINNERS (e.g. Aspirin, Advil, Ibuprofen & Motrin)? No Yes

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

<input type="checkbox"/> Congenital Heart disease: <i>specify type</i> _____ <input type="checkbox"/> Myocardial Infarction (Heart attack) <input type="checkbox"/> Hypertension (High blood pressure) <input type="checkbox"/> Diabetes <input type="checkbox"/> High cholesterol _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Thyroid problem <i>specify type</i> _____	<input type="checkbox"/> Coagulation (bleeding/clotting) disorder <input type="checkbox"/> Cancer (Malignancy) <i>specify type</i> _____ <input type="checkbox"/> Depression/suicide attempt <input type="checkbox"/> Alcoholism <input type="checkbox"/> If you have ever had a blood transfusion, please specify date _____ <input type="checkbox"/> Abnormal Pap smear	Other problems _____ _____ _____ When was your last Tetanus shot? _____
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------

Have you ever been treated for skin cancer? No Yes

SURGICAL HISTORY (Please list all prior operations and dates):

Operation	Date

Operation	Date

WOMEN'S GYNECOLOGIC HISTORY:

Are you pregnant? No _____ Yes _____
 For Women: # pregnancies: _____ # deliveries: _____ # abortions: _____ # miscarriages: _____
 1st day, most recent period: _____ Age at 1st period: _____ Frequency of periods: _____ Length of each: _____
 Do you have any concerns about your periods? No Yes: _____
 Do you have any concerns about menopause? No Yes: _____

FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives	Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism								Genetic diseases							
Anemia								Glaucoma							
Anesthesia problem								Hay fever (Allergic Rhinitis)							
Arthritis								Hearing problems							
Asthma								Heart Attack (Coronary Artery Disease)							
Birth Defects								High Blood Pressure (Hypertension)							
Bleeding problem								High cholesterol (Hyperlipidemia)							
Cancer, Breast								Kidney diseases							
Cancer, Colon								Lupus (Systemic Lupus Erythematosus)							
Cancer, Melanoma								Mental retardation							
Cancer, skin (except melanoma)								Migraine headaches							
Cancer, Ovary								Mitral Valve Prolapse							
Cancer, Prostate								Osteoarthritis							
Cancer (not noted)								Osteoporosis							
Depression								Rheumatoid Arthritis							
Diabetes, Type 1 (childhood onset)								Stroke							
Diabetes, Type 2 (adult onset)								Thyroid disorders							
Eczema								Tuberculosis							
Epilepsy(seizures)								Other:							

SOCIAL HISTORY

SUBSTANCES

Tobacco Use

Cigarettes

Quit: Date _____

Never

Current: Smoker: packs/day _____ # of yrs _____

Other Tobacco: Pipe Cigar Snuff Chew
 Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? No Yes: # drinks/week _____

Is alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreational drugs? No Yes

Have you ever used needles? No Yes

EXERCISE:

Do you exercise regularly? No Yes

SOCIOECONOMICS:

Occupation: _____

Education completed: Grade school High school
College Graduate school
Years of education _____

Marital status: Single M Sep D W Co-habiting
Engaged... Other: _____

Spouse/Partner's name: _____

Number of children: _____

Who lives at home with you? _____

Are you interested in being screened for sexually transmitted diseases? No Yes

Other concerns? _____

SAFETY:

Do use seatbelts consistently? No Yes
Do you use a bike helmet regularly? NA No Yes
Is violence at home a concern for you? No Yes
Do you feel safe in your current relationship? NA No Yes
Do you have a gun in your home? No Yes

Other concerns? _____

SEXUALITY

Sexual Activity

Sexually Active: Yes No Not currently
Current sex partner(s) is/are: male female

Contraception and Protection

Birth Control method: _____ None needed

If sexually active, do you practice safe sex? NA No Yes

Have you ever had any sexually transmitted diseases (STDs)?
No Yes

If yes, please include:
_____ date _____
_____ date _____

EMOTIONS:

- 1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? No Yes
- 2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? No Yes
- 3. Have you felt depressed or sad much of the time in the past year? No Yes

IMMUNIZATIONS:

Please list your most recent immunizations. You do NOT need to include any immunizations given at Piga Primary Care Associates. Please include your best estimate of the month and year of each immunization:

Hepatitis A _____ Measles _____ Mumps _____ Rubella _____ Pneumovax (Pneumonia) _____
Hepatitis B _____ MMR _____
Tetanus (Td) _____ Varicella (chicken pox) shot _____ Other _____

REVIEW OF SYSTEMS: Please check (√) any current problems you have on the list below.

- Constitutional*
___ Fevers/chills/sweats
___ Unexplained weight loss/gain
___ Fatigue/weakness
___ Excessive thirst or urination
- Eyes*
___ Change in vision
- Ears/Nose/Throat/Mouth*
___ Difficult hearing/ringing in ears
___ Problems with teeth/gums
___ Hay fever/allergies
- Cardiovascular*
___ Chest pain/discomfort
___ Leg pain with exercise
___ Palpitations
- Chest (breast)*
___ Breast lump/discharge
- Respiratory*
___ Cough/wheeze
___ Difficulty breathing
- Gastrointestinal*
___ Abdominal pain
___ Blood in bowel movement
___ Nausea/vomiting/diarrhea
- Genitourinary*
___ Nighttime urination
___ Leaking urine
___ Unusual vaginal bleeding
___ Discharge: penis or vagina
___ Sexual function problems
- Musculo-skeletal*
___ Muscle/joint pain
- Skin*
___ Rash or mole change
- Neurological*
___ Headaches
___ Dizziness/light-headedness
___ Numbness
___ Memory loss
___ Loss of coordination
- Psychiatric*
___ Anxiety/stress
___ Problems with sleep
___ Depression
- Blood/Lymphatic*
___ Unexplained lumps
___ Easy bruising/bleeding
- Other (please specify)* _____

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Notice of Privacy Practices (HIPAA)

*This notice describes how medical information about you may be used/disclosed and how you can get access to this information.
Please read it carefully.*

This office may use and disclose medical and financial information related to your care that may be necessary to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes for evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

The type and amount of information to be used or disclosed is as follows:

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

___ **All Health Care information.**

___ All Health Care Information **excluding** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

Please circle your response to the following:

May we leave messages concerning appointments with a co-worker, receptionist or secretary who regularly answer your calls?	Yes	No	N/A
May we leave messages on a voice mail at your home?	Yes	No	N/A
May we leave messages on a voice mail at work?	Yes	No	N/A
May we discuss appointments/treatment with other parent/guardian/caregiver/family members?	Yes	No	N/A

Who? _____

For minor patients less than 17 years of age, all treatment and medical information will be discussed with both biological parents unless otherwise specified.

I understand that I have a right to revoke this authorization at any time. I understand that I need to inform the office, in writing, of any changes in my directives. I understand that this HIPAA notice will be kept in my file. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8380 Warren Parkway Ste 305, Frisco, Texas 75034

(214) 618 2222

www.pigaprimarycare.com

Revised: 3/18/2010

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I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that without disclosure, I will be responsible for payment of services when they are rendered and will file my claims directly to my own insurance company. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

For Pediatric Patients:

I authorize the release of immunization records that have been requested verbally to schools/camps/daycares. I understand that there is a **\$2 fee** per request. _____ (initial here)

Name of patient: _____ Date of birth: _____

Signature of patient/legal representative: _____

Date: _____

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Requesting only: (circle one)

Immunization records
Insurance information
Labs/x-rays other: _____

Physical form
All records

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: **Initial:** _____ **Date:** _____

Please send records requested (circle one)

TO

FROM

Clinic/Hospital/ School name: _____

Address: _____

Phone: _____

Fax: _____

Reason for records release: _____

For period of: _____

Patient name: _____ DOB: _____

Address: _____

City, State, Zip code: _____

Social security: _____

Responsible party name (printed): _____

Signature: _____

Date: _____

The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is in violation of the Federal Law, Health Insurance Portability and Accountability Act (HIPAA) and will be reported as such. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners

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WAIVER FOR SERVICES PROVIDED BY PIGA PRIMARY CARE ASSOCIATES

Piga Primary Care Associates provides several services to patients that may not be covered by insurance or covered fully. These services are offered as a convenience for families, but they are not required in order for a patient to receive care in the office. Insurance companies vary according to what services they cover and how much they pay for the service. Examples include EKG, spirometry, hearing testing and vision testing. Patients always have the right to choose if they would like to have the procedures performed in our office. If a patient wishes to have the service performed elsewhere, the appropriate instructions and lab request or prescription will be given if needed. Patients may elect to have the service performed in our office, but will need to pay the fee if it is not covered.

We appreciate you selecting Piga Primary Care Associates for your family's health care needs. As a provider for your company's health plan, we are committed to quality health care. Services recommended for our patients may not be a benefit of your insurance plan. Please be advised that any expense not covered by your plan, such as check-ups, immunizations, immunization administration, procedures, and laboratory tests, will be your responsibility and will be billed to you. Our routine schedule of these services follows the recommendations of the American Academy of Pediatrics and the American College of Physicians.

Well/annual exams cover preventive care. Anything that is discussed outside of preventive care, including, but not limited to, the treatment of chronic conditions may incur fees that may be applied to your co-pay, deductible or co-insurance. These fees are the responsibility of the patient.

By signing below, you agree to take full financial responsibility for the cost of the indicated medical services or procedures if not covered by your insurance.

Patient's name _____ DOB _____

Patient or Guardian's signature _____ Date _____

8380 Warren Parkway Ste 305, Frisco, Texas 75034

(214) 618-2222

Fax: (972) 668-5831

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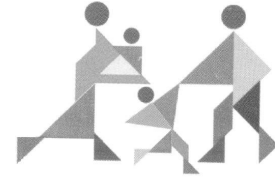
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Office Billing Policies

Appointments

Patients are seen by appointment only. You may call our office to schedule an appointment anytime during normal business hours. Should you have any special issues or complex medical problems to discuss with the doctor, please inform our staff when making the appointment so that adequate time is allotted to address them. Time will be available each day for sudden illness and same-day sick visits.

Please arrive on time for your appointment. When you arrive, please inform us of any changes to insurance, address, or responsible party. You will be asked to present a current insurance card at every visit. If you are late for an appointment or you walk-in without an appointment, you will be seen when the schedule allows. If you are more than 30 minutes late, you may be asked to reschedule.

If you are running late for an appointment, please call our office so we may help you find an appointment that better fits your schedule. If we are not notified or you walk-in without an appointment, you will be seen when the schedule allows. If you are more than 30 minutes late, you may be asked to reschedule.

If you cannot keep an appointment, please provide notice 24 hours in advance. Appointments missed without notification hinder us from seeing other patients who may be ill. After 3 "no shows", you will be billed a \$25 fee per missed appointment.

After-Hours Telephone Calls

We believe that our patients should have 24-hour access to medical advice should an urgent situation arise. Beginning December 15, 2011, all pediatric after-hours telephone calls will be answered by a specially trained pediatric nurse. In addition, one of our physicians is on-call everyday and can be reached by the triage nurse for complex problems. Please limit after hours calls to urgent problems that cannot or should not wait until the office reopens. Routine problems (such as colic, reflux, diaper rash, appetite, sleep, development, etc.), prescription refills, medication dosages and prior authorizations will not be entertained after hours. These problems are best handled when the physicians have the office staff and patient charts available during regular business hours and can give uninterrupted service. All after-hours calls incur a charge of \$15.00 per call which is applied to the patient's account. Our practice is billed for every after hours call that is placed, and we pass only a portion of this cost on to our patients. Please allow 30 minutes for your call to be returned. We ask that you keep your phone line clear and disable the anonymous call block feature

Immunization Records

An updated shot record will be provided free of charge after every check-up. Any additional copies requested will be subject to a \$2.00 charge per immunization record.

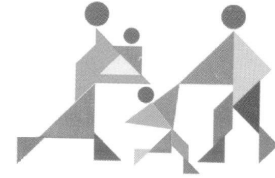
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Prescriptions

Antibiotics are not prescribed over the phone. Since there are many things that could be wrong, we prefer to examine each patient for proper diagnosis.

Prescription refill requests are handled most efficiently by calling your pharmacy directly to request a refill. If refills remain from the original prescription, the pharmacy simply fills your prescription. If there are no refills remaining, the pharmacy will contact our office for authorization to fill the prescription.

Refills on controlled substances, such as ADHD medications and some pain medications, require 48 hours to complete and you must pick up these prescriptions at our office. Please note that, by law, a prescription for a controlled substance must be filled within 7 days, so a \$5.00 charge applies if a new prescription has to be written.

“Lost prescriptions” – if a 90-day/mail order prescription is lost, a \$5 fee will be charged. All mail order prescriptions will be given to the patient and it is the patient’s responsibility to submit the prescriptions along with the necessary forms to the pharmacy.

Medical Records

If you are moving or need a copy of your medical record for other purposes, please make your request at least 2 weeks in advance. An Authorization to Release Medical Information Form must be signed prior to release and a \$25.00 fee will be charged per record.

Because of privacy concerns, we will only fax medical records when requested by other physicians or medical facilities. Immunization records can be faxed with a verbal request only from the parent or legal guardian of the patient.

Forms (sports, school, camp, FMLA, etc.)

Please be advised that we complete these forms only if a complete check-up or physical examination has been done in the past year. Due to the number of forms we receive, we require at least 48 hours for completion. FMLA forms and Medicare Medical Necessity Certifications are subject to a \$10.00 charge. These forms are available for pick-up only.

Year end/ Summary Statements

All requests for Summary Statements required 48 hours to complete. There is a \$10 fee per family account per year. Please note that if you would like the statement faxed to you, you must provide written authorization per HIPAA.

I understand the above listed policies and I acknowledge the associated fees.

Patient’s name _____ DOB _____

Patient or Guardian’s signature _____ Date _____