

Jeffrey A. George, M.D.

Board Certified in Family Medicine

4510 Medical Center Drive, Suite 210

McKinney, TX 75069

972-548-1717

Fax 972-548-9190

FamilyDoctorOfMcKinney.com

NEW PATIENT (WEBSITE) PACKET

Thank you for choosing our office for your healthcare needs. Please bring the following items to your appointment:

1. Your **COMPLETED NEW PATIENT PAPERWORK:**

- Complete and sign **PATIENT YEARLY REGISTRATION FORM.**
- Complete both pages and sign **MEDICAL HISTORY FORM.**
- Review **STATEMENT OF OFFICE POLICIES.** Please keep for your records.
- Sign **ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICIES.**
- Complete and sign **AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION.** (This allows our office to receive or send your records.)

2. Your **COMPLETED HIPAA PAPERWORK:** (HIPAA or the Health Insurance Portability and Accountability Act enacted by the U.S. Congress in 1996, includes a privacy rule creating national standards to protect personal health information.)

- Review **NOTICE OF PRIVACY PRACTICES.** Please keep for your records.
- Sign **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES.**
- Complete and sign **PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.**
- Complete and sign **PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.**

3. Our policy states that you must bring your **INSURANCE CARD** to each visit, so that your insurance company will be billed correctly.

4. **DRIVER'S LICENSE** (or other photo identification).

5. For children & adolescents, a copy of **IMMUNIZATION RECORDS.**

6. **MEDICATION LIST,** including drug names and dosages.

Thank you for your time and patience in completing this paperwork. If you have any further questions, feel free to contact our office. We look forward to seeing you as a patient!

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PATIENT YEARLY REGISTRATION FORM

Patient's Legal Last Name:		Legal First Name:		Middle:	
Patient's Preferred Name:				Marital Status: (Check One) Single Mar Div Sep Wid	
Email Address:		Social Security #:	Birth Date:	Age:	Sex: M F
Home Phone: ()	Work Phone: ()	Cell Phone: ()		Preferred Contact: Home Work Cell	
Mailing Address:			City:	State:	Zip Code:
Referred to Clinic By: (please check one box): Family Friend Close to home/work Yellow Pages Web Site Insurance Plan Hospital Dr. _____ Other _____			Family Members seen by Dr. Brinkman, DeShazo or George: _____ _____		

PAYMENT & INSURANCE INFORMATION *Please present your insurance card to the receptionist at each visit*

Person Responsible for Bill: (if different than patient)			Social Security #:	Birth Date:	
Is this person a patient here?	Yes	No	Home Phone: ()	Cell or Work Phone: ()	
Is this person insured?	Yes	No	Patient's Relationship to this person: Spouse Child Other		
Mailing Address: (if different than patient)			City:	State:	Zip Code:
PRIMARY Insurance:	Group #:	Policy #:	Co-Payment:	Effective Dates: to	
Subscriber's Name: (if different than patient)			Subscriber's S.S. #:	Subscriber's Birth Date:	
Patient's Relationship to Subscriber: Self Spouse Child Other					
SECONDARY Insurance:	Group #:	Policy #:	Co-Payment:	Effective Dates: to	
Subscriber's Name: (if different than patient)			Subscriber's S.S. #:	Subscriber's Birth Date:	
Patient's Relationship to Subscriber: Self Spouse Child Other					

CONTACT IN CASE OF EMERGENCY

Name:	Home Phone: ()
Relationship to Patient:	Cell or Work Phone: ()

The above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Jeffrey A. George, M.D. or insurance company to release any information required to process my claims.

 Patient or Guardian Signature

 Date

**PLEASE CHECK ANY CURRENT OR RECENT (Within 90 days) SYMPTOMS OR COMPLAINTS
AND/OR WRITE IN ANY OTHER SYMPTOMS OR COMPLAINTS**

GENERAL HEALTH	FATIGUE	WEAKNESS	WEIGHT PROBLEMS		
HEENT	HEADACHE HOARSENESS	HEARING PROBLEM EYE PROBLEM	EAR RINGING	SINUS PROBLEMS	
RESPIRATORY	COUGH WHEEZING	COUGH UP BLOOD PLEURISY	SHORTNESS OF BREATH		
CARDIAC	CHEST PAIN OR TIGHTNESS LEG PAIN WITH WALKING	HEART MURMUR ANKLE SWELLING	PALPATATIONS		
GASTROINTESTINAL	SWALLOWING TROUBLE BLACK OR BLOODY STOOLS JAUNDICE	INDIGESTION ABDOMINAL PAIN CHANGE IN BOWEL MOVEMENTS	ULCERS DIARRHEA	VOMITTING BLOOD CONSTIPATION HEMMORHOIDS	
NEURO-PSYCH PROBLEMS	TENSE FAINTING	IRRITABLE DIZZINESS	DEPRESSED SEIZURES	INSOMNIA SEXUAL DIFFICULTY	MARITAL OR JOB
MUSCULOSKELETAL	ARTHRITIS OR JOINT PAIN	GOUT	BACK PAIN	BUSITIS	TENDONITIS
GENITOURINARY	BLADDER OR KIDNEY INFECTIONS OR PROBLEMS DIFFICULTY OR PAINFUL URINATION	KIDNEY STONES BLOOD OR PROTEIN IN URINE	SLOW URINATION PROSTATE PROBLEM		
OTHER	SKIN PROBLEMS	ALLERGIES	ANEMIA	BLOOD DISEASE	
GYN - FOR WOMEN ONLY					
AGE MENSTRUATION STARTED _____	PERIOD EVERY _____ DAYS	FLOW LASTS _____ DAYS	LAST MENSTRUAL DATE _____	DATE OF LAST PAP SMEAR _____	
MENSTRAUL PROBLEMS	HEAVY PERIOD HOT FLASHES	IRREGULAR INFERTILITY	PAINFUL SEXUAL DIFFICULTY	INFREQUENT BREAST LUMP	SPOTTING BREAST DISCHARGE
NUMBER OF PREGNANCIES _____	NUMBER OF MISCARRIAGES _____	PLEASE LIST ANY BIRTH CONTROL METHODS USED _____			

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE

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STATEMENT OF OFFICE POLICIES

Thank you for choosing the office of Dr. Jeffrey A. George for your healthcare needs. We provide the highest standard of patient care in a convenient and cost-effective manner. Dr. George is board certified in family medicine, and has been in practice in McKinney since 2003. We take your healthcare seriously and look forward to working with you to improve and maintain your health.

Please sign the attached Acknowledgment of Receipt of Office Policies Form and return it to the receptionist. You may keep this copy of Office Policies for your records.

APPOINTMENTS

Normal office hours are 8:00 am to 12 pm and 1:45 pm to 5:00 pm Monday through Friday. Dr. George is out of the office on Wednesday afternoons. October through March, the office is also open from 9:00 am until 11:00 am on Saturdays for acute care only. Office visits are scheduled by appointment only. We accommodate as many "same-day appointments" as possible. However, we do not accept walk-ins.

Dr. George and his staff make every attempt to stay on schedule and see you in a timely manner. However, due to unforeseen patient emergencies, we sometimes have delays. Be assured that Dr. George will spend the necessary time and attention at every visit to ensure your high quality care. Dr. George will always address the primary reason for your appointment, but you may be required to make additional appointments to address additional concerns.

If Dr. George is unavailable due to scheduling, vacation, or absence, every attempt will be made for you to see Dr. Brinkman or Dr. DeShazo, or certain concerns may be addressed by nursing staff. Dr. Timothy Brinkman and Dr. Shannon DeShazo are both board certified family physicians and share office space and on-call responsibilities with Dr. George.

FEES, PAYMENT & INSURANCE

Dr. George's fees are comparable to other local physicians. Charges are determined by the type of service and treatment provided. ***Payment for office visits as well as any laboratory testing or procedures is expected at the time of service.*** Insured patients are responsible for their percentage, deductible and/or co-pay at time of visit. We accept cash, check, Visa, MasterCard, Discover, and American Express. There is a \$25.00 fee for any returned check.

Dr. George is contracted with many insurance companies. This simply means that he has agreed to provide healthcare services at a negotiated rate, and that Dr. George's office will file the insurance claim for you. ***It is YOUR responsibility to provide accurate, updated information, so that we may file a correct and accurate claim. For this reason, you are required to present your insurance card at the time of every visit, and complete a new patient information form on an annual basis.*** Failure to do so can delay payment by your insurance company. You must promptly provide your insurance company with any information they request to process pending claims. Do not ignore a letter from your insurance company or from our office. If payment is not received from your insurance company within 60 days of the claim, you are responsible for the balance.

As the patient, you are ultimately responsible for payment of services provided to you by Dr. George. Please contact us immediately if you have any questions or if financial hardships arise that will not allow you to pay your full balance.

CANCELLATION POLICY

We prefer that you contact our office at least 24 hours prior to your scheduled appointment if you must cancel or reschedule. If you fail to contact our office at least 1 hour prior to your scheduled appointment time, it will be considered a missed appointment. Patients may be dismissed from the practice for repeated missed appointments.

LABORATORY AND TEST RESULTS

Our office will notify you of the results of all tests ordered by Dr. George. ***Dr. George will review your results and report to you by phone or mail, addressing urgent results first. Test results will take up to 14 days, unless you are otherwise instructed by the doctor or nurse.*** IF YOU HAVE NOT RECEIVED YOUR TEST RESULTS ON THE 14th DAY AFTER YOUR TEST, YOU SHOULD THEN CONTACT OUR OFFICE FOR YOUR RESULTS.

REFERRALS

If your insurance plan requires that you obtain a referral in order to see a specialist, please call our office at least one week prior to your scheduled appointment, so that we can process your referral. In some instances, an office visit with Dr. George may be required so that he may ascertain the nature of the problem and communicate it to the specialist. We advise that you contact the specialist's office at least 24 hours prior to your appointment to ensure that the referral has been completed. ***It is your responsibility to verify that the specialist is a participant with your insurance plan and he/she has received your referral.***

PHONE MESSAGES & PRESCRIPTION REFILLS

Dr. George and his staff address messages and refill requests as quickly as possible. Messages are returned the same day, usually at the end of the morning or end of the afternoon. If you have an urgent health concern that requires a more prompt response, please indicate this to the receptionist.

To refill a prescription: Call your pharmacy and request that they fax a refill request to our office.

Prescriptions are refilled during normal office hours, and most refills will be completed within 24 hours, so call your pharmacy after 24 hours to check the status of your prescription. PLEASE GIVE US AT LEAST 72 HOURS ADVANCE NOTICE ON ANY CHRONIC MEDICATIONS TO AVOID INTERRUPTIONS IN YOUR MEDICATIONS. There are occasions when Dr. George is out of the office, or unforeseen delays may occur, which may slow this process.

Under no circumstances will prescriptions be refilled after-hours by the on-call physician. Our office policy strictly prohibits calling in narcotic pain medications other than during normal office hours.

AFTER HOURS URGENT CARE

A physician is available by phone at all times for urgent healthcare questions. Dr. George shares this responsibility with Dr. Brinkman and Dr. DeShazo. You may contact the on-call physician by calling the office number 972-548-1717, and leaving a message. Follow the recorded telephone instructions. ***THE ON-CALL PHYSICIAN IS AVAILABLE FOR URGENT QUESTIONS ONLY.*** In the case of a true medical emergency, please go to the nearest emergency room or dial 911 for assistance. Other non-urgent issues, including prescription refills and questions regarding chronic medical problems should be addressed during normal office hours. ***You MUST leave a phone number that accepts blocked and anonymous calls.*** If you do not, the doctor will be unable to return your call.

PRIOR AUTHORIZATIONS

Certain testing procedures and/or medications require prior authorization by insurance companies. ***You are responsible for ensuring that the authorization has occurred prior to your test.***

MEDICAL RECORDS

You may obtain a single copy of your medical records for your personal use free of charge one time only. Any additional copies will be completed when payment of \$25 is received by the party requesting the records. Insurance companies and other non-physician organizations may obtain your records with a signed consent for their release and a pre-paid fee. We furnish records to licensed physicians without charge.

ADDITIONAL FEES & CHARGES

Additional charges (not covered by your insurance company) may be assessed for special requests made outside of the time of your office visit. These may include but are not limited to written prescriptions, long distance toll charges, referrals outside of office visit, authorizations for radiological procedures or medications, postage fees, or completion of insurance, disability, or personal forms. Alternatively, you may schedule a separate appointment to address these needs, and any fees would be covered within your office visit charges.

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ACKNOWLEDGMENT OF RECEIPT OF OFFICE POLICIES

I acknowledge that I received and reviewed a copy of the office policies for the office of Jeffrey A. George, M.D.

Signature

Date

Name Printed

Phone Number

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AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ DOB: _____

Phone #: _____ SS #: _____

Address: _____

I authorize records: (please select one)

To be released **TO** Jeffrey A. George, M.D. from _____

Address: _____

Phone: _____ Fax: _____

To be released **FROM** Jeffrey A. George, M.D. to _____

Address: _____

Phone: _____ Fax: _____

I request release of the ***complete health record(s)*** for ***all dates of service*** unless specified here: _____

The purpose of this disclosure is for ***treatment/payment/healthcare operations*** unless specified here: _____

This authorization gives Jeffrey A. George, M.D. permission to request your medical records from any health care provider that you have received treatment from as specified above for the duration that you have a direct treatment relationship with Jeffrey A. George, M.D. Jeffrey A. George, M.D. is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws & regulations. **This includes any and all alcohol &/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless otherwise specified above.** Jeffrey A. George, M.D. is released and discharged from any liability, and the undersigned will hold Jeffrey A. George, M.D. harmless for complying with this information. I understand that I am not required to sign this authorization. I understand that I may revoke this authorization at any time by presenting my written revocation to Jeffrey A. George, M.D., 4510 Medical Center Drive, Suite 210, McKinney, TX 75069. I understand that the revocation will not apply to information that has already been used or released under this authorization. I understand that physician's office has the right under Texas state law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

Signature of Patient or Legal Representative

Printed Name of Patient or Legal Representative

Relationship to patient or Legal Representative

Date

Witness

Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Laws & regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.*