DAVID BREHM, M.D.
BREHM MEDICAL CENTER
6190 LBJ FWY SUITE 800 | DALLAS, TX 75240 | 972.851.0055 | FAX 972.851.0066

PATIENT MEDICAL HISTORY

NAME _____ AGE _____ OCCUPATION_____

CHIEF COMPLAINT _____

PERSONAL HISTORY

Weight _____ Height _____
Exercise: Do you exercise at least 20 minutes, 3 times a week? YES ( ) NO ( )
Alcoholic Beverages: _____ Drinks/Week _____ Drinks/Month
Do you smoke: YES ( ) NO ( )
If yes, # of packs per day _____ & # of years _____
If you have quit, how long has it been? _____
Have you used, previously used or had problems with:
___ Marijuana ___Heroin ___Cocaine ___Other recreational drugs

MEDICAL HISTORY:

Have you ever had	YES	NO		YES	NO
Asthma or breathing problems	( )	( )	Colon trouble or bowel disorder	( )	( )
Anemia (longer than 3 months)	( )	( )	Kidney Disease	( )	( )
Tuberculosis	( )	( )	Depression	( )	( )
High blood pressure	( )	( )	Anxiety	( )	( )
Heart disease	( )	( )	Bleeding disorders	( )	( )
Diabetes	( )	( )	Seizures, loss of consciousness	( )	( )
Acid reflux	( )	( )	Visual disturbance	( )	( )
Thyroid disorder	( )	( )	Cancer	( )	( )
Sexually transmitted diseases	( )	( )	Blood transfusions	( )	( )
Hepatitis, jaundice	( )	( )	Alcohol Abuse	( )	( )
Other	( )	( )	Drug Abuse	( )	( )

Please explain "YES" answers: _____
_____

DRUG ALLERGIES: _____
MEDICATIONS: Please list all medication you are currently taking (include dosage): _____
_____

IMMUNIZATIONS

Have you had a tetanus shot in the last 10 years? YES ( ), on this date _____ NO ( )
Have you had a pneumonia shot in the last 5 years? YES ( ), on this date _____ NO ( )
Have you had a Gardisil vaccine series? YES ( ), on this date _____ NO ( )
Have you had a Zostavax (shingles vaccine)? YES ( ), on this date _____ NO ( )
Have you had a Hepatitis A vaccine series? YES ( ), on this date _____ NO ( )
Have you had a Hepatitis B vaccine series? YES ( ), on this date _____ NO ( )

SURGERIES (include dates) _____

OTHER

Last Dental Exam _____ Dentist Name _____
Last Eye Exam _____ Eye Doctor Name _____

FAMILY HISTORY

Has any relative had	YES paternal or maternal?	NO		YES paternal or maternal?	NO
Lung cancer	( ) _____	( )	Tuberculosis (in the last 5 yrs.)	( ) _____	( )
Prostate cancer	( ) _____	( )	Diabetes	( ) _____	( )
Colon cancer	( ) _____	( )	High blood pressure	( ) _____	( )
Breast Cancer	( ) _____	( )	Kidney disease	( ) _____	( )
Any other type of cancer	( ) _____	( )	Heart disease	( ) _____	( )
Depression	( ) _____	( )	Thyroid disorders	( ) _____	( )
Bipolar disorder	( ) _____	( )	Other _____	( ) _____	( )

PATIENT'S SIGNATURE _____ DATE _____

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PATIENT INFORMATION

Name _____Date of Birth: _____/_____/_____ Age _____

Address _____City_____ State_____ Zip_____

SSN _____-____-_____ SEX □M or □F Marital Status: □Single □Married □Divorced □Widowed

HomePhone (____) ____-_____ Cell Phone(____)____-_____ Work Phone(____)_____X_____

Who Referred You Here?_____

Employer Name _____

Preferred Contact Method?
□Phone □Patient Portal

Preferred Reminder Method?
□Home Phone □Work Phone
□Cell Phone □Patient Portal

Ethnic Group:
□ Decline
□ Hispanic or Latino
□Not Hispanic or Latino

Race:
□Decline
□American Indian or Alaska Native
□Asian
□Black or African American
□Native Hawaiian or Other Pacific Islander
□White
□Other Race

Primary Language: _____

EMERGENCY CONTACT INFORMATION

Spouse Name: _____ Phone Number _____

Relative Name: _____ Phone Number _____

Friend Name: _____ Phone Number _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURED'S NAME_____DOB: _____INSURED'S SSN _____

INSURANCE IDENTIFICATION: _____GROUP #_____

INSURED'S EMPLOYER_____HOW LONG AT ABOVE EMPLOYER_____

PATIENT / RESPONSIBLE PARTY'S AUTHORIZATION

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO PROCESS CLAIM. I REQUEST THAT PAYMENT OF MEDICAL BENEFITS BE MADE TO DR. DAVID BREHM AND I UNDERSTAND THAT THIS IS AUTOMATIC IN CASE OF HOSPITALIZATION. THIS ASSSIGNMENT OF BENEFITS WILL REMAIN EFFECTIVE UNTIL REVOKED BY ME IN WRITING.

PATIENT'S SIGNATURE _____ DATE_____

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PAYMENT POLICY

1. We will file insurance for our PPO, HMO and other managed care patients. However, all managed care co-payment and/or deductible and/or coinsurance amounts are due at the time services are rendered. Any disallowed/uncovered amounts are due from the patient. It is your responsibility to make sure that David Brehm, M.D. is in your managed care network. There will be a $15.00 fee added to your account if the co-payment and/or deductible and/or coinsurance are not paid at the time of service.

2. We accept assignment and will file insurance for our Medicare patients. However, any calendar year deductible amounts (to the extent of the visit amount) are due at the time of the service. We will also file secondary insurance after payment from Medicare is received. If there is no secondary insurance, the patient will be required to pay their deductible and/or coinsurance at the time services are rendered.

3. There will be a thirty dollar ($30) fee assessed for any returned checks. This fee is assessed regardless of whether the check is redeposited because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount. Payments will be expected in the form of cash, money order, or credit card. If payment is not received by the due date indicated on the bill, then your information will be turned over to the Collin County District Attorney. After receiving a returned check we will no longer accept checks as a form of payment on your visits for up to five years.

4. Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. We will attempt to verify coverage, although that is not a guarantee of payment until your insurance has processed the claim.

5. For all accounts that must be sent to a collection agency, a $50.00 fee will be added for processing. For all account balances in excess of 90 days past due, a late fee of $50.00 will be added (even if the payment delay is due to the insurance company). It is ultimately the patient's responsibility to make sure the doctor received payment for services rendered.

6. We will file insurance for our HMO/EPO/POS patients. However, you must have assigned Dr. David Brehm to be your Primary Care Physician (PCP) prior to your appointment. The assignment of the PCP must be effective the day of your appointment. If you have not assigned Dr. Brehm to be your PCP, you agree to be responsible to pay the entire balance of your visit. If you have not changed your PCP to Dr. Brehm because you are not sure if you want to assign him yet, you must assume full responsibility for the balance of that visit. Payment will be due at the time services are rendered; no exceptions will be made.

7. If any patient is owed a refund, all claims must be processed and paid in full before an overpayment is refunded. All refund amounts less than $50.00 will be left as a credit on your account, unless refund is requested by you.

8. Patients have up to 24 hours from their appointment time, to cancel or reschedule their appointment in order to avoid a late cancellation fee of **$45.00**. Patients that have an appointment scheduled on a Monday must cancel or reschedule their appointment by 12:00pm the previous business day. This fee also applies to any patients who arrive 30+ minutes late. If you schedule an appointment that will be less than 24 hours away you forfeit the ability to cancel/reschedule/no show without being charged the $45 since we accommodated your request.

PRECERTIFICATION/REFERRAL AUTHORIZATION

1. Precertification of Hospital – we must be notified within twenty-four (24) hours of any hospital admit so that we may precertify your hospital visit/stay. Failure to do this may result in reduction of benefits. We will not be responsible for any reduction of benefits if this is not done.

2. Referrals – due to tremendous referral requests, we must be notified at least five (5) days prior to your appointment in order to obtain a referral to a specialty care provider. Patients who see specialty care providers first and then call after the fact to request a referral number run the risk of reduction of benefits because most insurance companies do not backdate referrals. We will not be responsible for any reduction benefits for any "after the fact" referral requests.

3. When referred, it is the patient's responsibility to verify that the physician or facility is in their insurance network.

AUTHORIZATION

I authorize release of medical records to determine liability for payments for treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to David Brehm, M.D., P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of the instrument will have the same validity as the original.

_____ _____

Patient Name (PRINTED) Date of Birth

_____ _____

Patient/Guardian Signature Date

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NOTICE OF PRIVACY PRACTICES
PATIENT CONSENT FORM

I hereby give consent for Brehm Medical Center, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO). (The Notice of Privacy Practices provided by Brehm Medical Center, P.A. describes such uses and disclosures more completely).

You have the right to request that we restrict how protected health information about you is used or disclosed, however we are not required to agree to this restriction, but if we do, we shall honor that agreement. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you can obtain a revised copy during your next office visit.

With this consent, Brehm Medical Center, P.A. may mail, email, and/or call the telephone numbers that I have provided on my Patient Information page and leave a detailed message on voicemail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

On a routine basis this office is able to release the following: (Please check one or both)

☐ Billing Information/Records ☐ Medical Information/Records

To be discussed with: _____
Contact name relation phone #
(Example: spouse, parent, partner, friend, family member, etc.)

By signing this form, you consent to Brehm Medical Center's use and disclosure of protected health information to carry out TPO. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If I do not sign this consent, or later revoke it, Brehm Medical Center, P.A. may decline to provide treatment to me.

_____ _____
Printed Name of Patient or Legal Representative Date of Birth

_____ _____
Patient/Guardian/Legal Representative Signature Date
*Valid for 24 months from date of signature.

Relationship to Patient (if other than patient): _____

Witness: _____ _____
Printed Name Witness Signature

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FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for Brehm Medical Center to access my pharmacy benefits data electronically through RxHub. This consent will enable Brehm Medical Center to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

Patient Name (PRINTED) Date of Birth

_____ _____

Patient/Guardian Signature Date

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MID-LEVEL PRACTITIONER CONSENT FOR TREATMENT

Brehm Medical Center has on staff mid-level practitioners, for example physician assistant and/or nurse practitioner, to assist in the delivery of medical care.

A mid-level practitioner is not a doctor. A nurse practitioner is a registered professional nurse who has received advanced graduate education and clinical training. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, mid-level practitioners can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

Mid-Level Practitioners may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

A mid-level practitioner can serve as a patient's primary health care provider and is able to provide the coordination and management of care required in various health care delivery models, such as medical home, accountable care organizations, transitional care, etc.

I have read the above, and hereby consent to the services of a mid-level practitioner for my health care needs.

I understand that at any time I can refuse to see the mid-level practitioner and make an appointment to see a physician.

_____ _____
Patient Name (PRINTED) Date of Birth

_____ _____
Patient/Guardian Signature Date