Polina Kaloyanova, MD, PA
Board Certified Endocrinology, Diabetes and Metabolism
Board Certified Internal Medicine

Medical City – Dallas
7777 Forest Lane
Building C, Suite 206
Dallas, TX 75230
Tel: 972 566 7272
Fax: 972 566 7202

PATIENT REGISTRATION FORM

Patient Information (please print and provide your ID at check-in)

Patient's Name (Last) _____ (First) _____ (Middle Initial) ____

Marital Status □ Married □ Single □ Divorced □ Widowed □ Legally Separated □ Other _____

Is the patient of Hispanic or Latino origin or descent? □ Yes □ No

What is patient's primary language? □ English □ Spanish □ Other _____

What is patient's race? □ White □ Black or African American □ Hispanic □ American Indian or Alaska Native
□ Asian □ Native Hawaiian □ Other Pacific Islander □ Other Race _____

Social Security Number _____ - _____ - _____ □ Female □ Male Date of Birth _____ / ___ / _____

Street Address _____ Apartment # _____

City _____ State _____ ZIP _____

Email _____

Phone Numbers Work _____ Home _____ Mobile _____

Authorization for Messages (please read and initials)

I hereby authorize physicians and staff of Polina Kaloyanova, M.D., P.A. to leave messages regarding my health, treatment, laboratory results and any healthcare matters on my home, mobile and work voice mailbox.

Patient (or Responsible Party) Initials: _____

Employment Status □ Employed □ Student □ Retired □ Self-Employed □ Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Emergency Phone # 1 _____

Relationship to Patient _____ Emergency Phone # 2 _____

Referring Provider Name _____ Provider's Number _____

Pharmacy Name _____ Pharmacy Phone _____

Eye Doctor Name _____ Eye Doctor Phone _____

Responsible Party Information □ Self (please skip this section)

Responsible Party Name (Last) _____ (First) _____ (Middle Initial) ____

Social Security Number _____ - ___ - _____ □ Female □ Male Date of Birth _____ / _____ / _____

Phone Numbers Work _____ Home _____ Mobile _____

Address _____

City _____ State _____ ZIP _____

Primary Insurance Information (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Insured Employer Name _____

Subscriber ID (Policy Number) _____ Group ID _____

Insured Date of Birth ____ / ____ / ____ Insured's Social Security Number _____ - _____ - _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient (or Responsible Party) Signature **Date**

PATIENT CONSENT FORM

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Polina Kaloyanova, M.D., P.A.** may include consent at satellite offices under common ownership.

I, the undersigned, authorize Polina Kaloyanova, M.D., P.A. to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Polina Kaloyanova, M.D., P.A.

I acknowledge that I have been given the Polina Kaloyanova, M.D., P.A. Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initials: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature **Date**

ASSIGNMENT OF BENEFITS

I hereby assign to Polina Kaloyanova, M.D., P.A. any insurance or other third-party benefits available for health care services provided to me. I understand that Polina Kaloyanova, M.D., P.A. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Polina Kaloyanova, M.D., P.A., I agree to forward to Polina Kaloyanova, M.D., P.A. all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Polina Kaloyanova, M.D., P.A. Practice to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Polina Kaloyanova, M.D., P.A. Practice to release all medical information to my referring physician and my primary (family) physician. I authorize Polina Kaloyanova, M.D., P.A. Practice to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Polina Kaloyanova, M.D., P.A. Practice.

I agree that these provisions will remain in effect until I provide written revocation to Polina Kaloyanova, M.D., P.A. Practice.

_____ _____

Patient (or Responsible Party) Signature **Date**

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CONSENT TO RELEASE INFORMATION

I hereby authorize Polina Kaloyanova, M.D., P.A. to receive copies of the following medical information from the institution listed below. I acknowledge that I have received information regarding my rights to privacy as set forth by the H.I.P.A.A.

Institution Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Information Requested:

- ☐ All Protected Health Information
- ☐ Progress Notes
- ☐ Consult Record
- ☐ Laboratory
- ☐ Nursing Notes
- ☐ Demographics
- ☐ Special Test/Therapy
- ☐ History and Physical
- ☐ Physician Orders
- ☐ Operative Report
- ☐ Imaging/Radiology
- ☐ Medication Records
- ☐ Rehabilitation services
- ☐ Itemized Bill/Claims
- ☐ Others: _____

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health services such as pre-employment, testing, life insurance exams, or drugs screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Patient Name: _____

Social Security Number: _____ DOB: _____

_____ _____

Patient (or Responsible Party) Signature **Date**

E-PRESCRIBING INFORMATION AND PATIENT CONSENT

What is E-prescribing and Why Does Polina Kaloyanova, MD, PA E-Prescribe?

E-Prescriptions, or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Polina Kaloyanova, MD, PA participates in E-prescribing because we care about your health and wellbeing and E-prescribing has multiple safety benefits.

How does E-Prescribing Work?

Instead of writing out your prescription on a piece of paper, your doctor enters it directly into the computer. Your prescription travels from your doctor's computer to the pharmacy's computer. E prescriptions are sent electronically through a private, secure, and closed network, so your prescription information is not sent over the open Internet or as email. Your e-prescription arrives at the pharmacy's computer faster and may help to save you time. The e-prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept e-prescriptions, your provider can print your prescriptions for you.

Privacy

The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared only for the purpose of providing you with clinical care. E-prescriptions meet this requirement.

PATIENT CONSENT FOR E-PRESCRIBING AND PRESCRIPTION MEDICATION HISTORY

I, _____ agree that Polina Kaloyanova, MD, PA may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient (or Responsible Party) Signature **Date**

BILLING, CHARGES AND FEES

(Please Read and Sign)

I agree that I'm responsible for all co-payment, co-insurance, deductible and outstanding balance at the time of service.

Patient (or Responsible Party) Initials: _____

I agree that I'm responsible for all charges insurance carrier denies or does not cover.

Patient (or Responsible Party) Initials: _____

I agree that Polina Kaloyanova, M.D., P.A. Practice will not bill secondary and/or tertiary insurance carriers and I'm responsible for all charges not covered by my primary insurance carrier.

Patient (or Responsible Party) Initials: _____

I agree that outstanding balances not paid promptly are subject to third party collections and/or legal procedures.

Patient (or Responsible Party) Initials: _____

I agree that if insurance carrier has not responded to a claim within sixty days, Polina Kaloyanova, M.D., P.A. Practice reserves the right to formally transfer all associated liability for the claim to me.

Patient (or Responsible Party) Initials: _____

I agree that additional fees as Return Check Fee, Document Preparation Fee, Medical Record Release Fee, Missed Appointment Fee, Late Appointment Cancelation Fee, etc. may apply.

Patient (or Responsible Party) Initials: _____

_____

Patient (or Responsible Party) Name

_____ _____

Patient (or Responsible Party) Signature **Date**

WELCOME TO OUR PRACTICE!

You, the patient, are the most important person in our office. We are committed to providing you with the best possible medical care. Excellence is our goal. We have worked to provide a full range of services and have highly trained and knowledgeable staff. Please do not hesitate to ask us any questions about your health plan or medical care.

Office Hours

Phones: Telephones are answered M-F 9:00 AM – 5:00 PM.
Office Hours: Monday through Friday 9:00 AM to 5:00 PM.

Emergencies: For all life-threatening situations call 911. If you have an urgent problem, please call our office for instructions. After hours, our answering service will inform you of how to reach a physician on call.

Test Results: For all test results call 972-566-7272.

Prescriptions: All prescriptions and refill requests should be requested during normal office hours. Please have your pharmacy call the office at 972-566-7272 for renewal of medication.

Appointments

For an appointment please call 972-566-7272.

- Please call in advance for routine office visits. Make follow-up appointments as you leave. We make every effort to stay on schedule, although emergencies arise. If we are seriously delayed, we attempt to notify patients beforehand.
- As a courtesy to other patients and staff, please call the office as soon as possible if you are unable to keep your appointment or are going to be late. If you do not show for an appointment, or reschedule an appointment within 48 hours prior to your appointment an additional charge of $40.00 will appear in your account.

Financial Policy

- Unless arrangements have been made in advance, co-payments, co-insurance, and any outstanding balances are expected at the time of service. Patients may be financially responsible for payment of all services even if their insurance company does not pay. Patient accounts not paid promptly are subject to third party collections and or legal procedures.
- If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company.
- Any check returned from the bank will result in an additional $30.00 charge that will appear on your account.
- If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor. Failure to promptly resolve this balance may result in third part collection and/or legal procedures being taken. Please keep a close watch for carrier payment and contact the insurance carrier or a clinic patient account representative 972-566-7272 in the event a claim is not resolved within 60 days from date of service.
- We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact a patient accounts representative at 972-566-7272. Please always notify our office of any change in name, address, phone or insurance information.

Insurance

- Prior to your appointment, please check your insurance information so you will be informed about referrals, cop-payments, and any deductible required at the time of visit. We also accept Visa and MasterCard.
- For your first visit, please bring your insurance card and arrive early to complete the necessary patient information forms.
- We accept Medicare as well as most insurers, however, please review all insurance information with our staff prior to services being rendered.
- Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to you carrier.

What Do We Need From You?

- To inform the Medical Practice staff of any pertinent changes insurance, employment, demographic information or relationships with other care/service givers.
- To arrive on time for scheduled appointments and cancel when necessary, with a phone call.
- To provide payment for services requested and delivered by the Medical Practice not covered by insurance within 90 days.
- To notify the Medical Practice of any change in his/her health status.
- Feel free to ask questions if directions or procedures are not understood

What Should You Expect From Us?

- To be treated with respect, dignity and be informed of his/her care needs to make appropriate decisions.
- Help plan his/her care and make changes to it.
- Expect that teaching materials will be provided in a manner he/she can understand.
- To be informed of the Medical Practice billing process.
- To have his/her records kept confidential except when consent has been give.
- To expect services to be professional, timely and appropriate.
- To communicate his/her complaints to the Medical Practice Manager and expect to receive follow-up without negative repercussions or changes in service.
- To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.

THANK YOU!

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NOTICE OF PRIVACY PRACTICES

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

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with Polina Kaloyanova, M.D., P.A. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Polina Kaloyanova, M.D., P.A. is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice please contact our Privacy Manager at 972-566-7272.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

For Payment - Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable

product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery 0request or other lawful process.

To Law Enforcement - We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity - Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits or (3) to foreign military authority if you are a member of that foreign military services.

For Workers' Compensation - Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

When an Inmate - We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use and disclosure of protected health information.

You have tine right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request disclosure accountability - This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.