**Sweetwater Medical Associates**
**16651 Southwest Freeway, Suite 100**
**Sugar Land, Texas 77479**
**Office: (281) 494-4900 Fax: (281) 494-4905**

**Jeffery T. Alford, M.D.**
**Dina B. White, M.D.**

# Welcome to Sweetwater Medical Associates, PLLC

We are happy to welcome you to our practice and proud that you chose us to care for your medical needs. We will strive to make each and every visit a satisfying experience. For us to be successful in this endeavor we must ask for your cooperation and understanding in not only supplying us with correct information, but with our office policies as well. We hope that the following information is helpful in guiding you through your years as a part of Sweetwater Medical Associates. We ask that you keep in mind that this letter in no way constitutes a contract between the patient and the physician but serves as an outline for some of our most important policies that must be followed to keep our office open and available to our patients.

## Appointments

We accept patients by appointment. As a courtesy, appointments are usually confirmed the day before via our automated system. **We caution you not to rely on a confirmation from our office to remember your appointment, as you are still responsible for arriving on time or for canceling** when you are unable to make your appointment. Failure to arrive or give a 24-hour notice for a cancelled appointment will cause the patient account to incur a charge of $70 - $100. These fees are subject to change at any time without written notice. We ask that you call to schedule your appointment during regular business hours. Anyone calling after hours may leave this information on the appropriate voice mailbox, the system will guide you through the prompts, and your call will be returned the next business day. Late arrivals may be asked to reschedule. We understand walk-in appointments at times are needed. Our office has Nurse Practitioners that will do their best to provide you with the same quality care. Therefore, walk-in appointments have been added to our practice. There may be a wait, but rest assured we will do our best to provide you with the same quality care.

Physicals go by many different names. They include, but are not limited to, General Physical, Annual Exam, and Preventive Exam; for women, Well Woman Exams; and in some cases, for men, Well Man Exams. Commercial insurance carriers usually pay for one exam every 365 or more days, while some pay one per calendar year. Medicare does not cover any type of physical/preventive exam. Medicare will cover, one prostate screening a year, and for women, one collection of a PAP smear and one breast exam every two years unless the patient is high-risk, i.e., history of abnormal PAP smears.

## Collection of Pertinent Data

We must collect certain information from patients in order to file their insurance while other information is collected as office policy. This information is protected by the HIPAA regulations and when destroyed, it is done so in a secure manner. Once a year we will ask patients to review their demographic information for updates, which includes, but is not limited to, address, phone number, insurance information, driver's license, and social security number. Some of this information gathered is to help ensure our privacy and keep your insurance safe from forgery.

## Prescription Refills

You must call your prescription refills to your pharmacy allowing us at least 48 hours for processing.

## Hospitalization

When hospitalization becomes necessary, we utilize a hospitalist for the admission and treatment of our patients. Hospitalists are physicians with specific expertise in hospital treatment and evaluation. The hospitalist is an extension of our office and there is 2-way communication between physicians. Please schedule a follow-up appointment after hospitalization in our office.

**Forms and Medical Records**

Forms are subject to charges and these fees may change at any time without written notice. The Medical Assistant working with the physician will be able to inform you of the charges associated with this type of request. Medical records being released to certain persons are also subject to charges that vary depending on the number pages contained in the record. Persons that will be charged for records include but are not limited to: the patient, attorneys and insurance companies for determination of new coverage. For records, please call the main number and follow the prompts.

**Insurance**

While we will make every effort to verify a patient's insurance coverage, the patient needs to understand that verification is never a guarantee of payment. It is the responsibility of the patient to know their policy, what it covers and when they may be responsible for non-covered services. Should the insurance company fail to make payment for any number of reasons, the amount owed will then be billed to the patient and due payable upon receipt.

**<u>We must receive the correct insurance information for that day of service before the physician sees the patient</u>**. Changes to the patient's insurance may and should be called to our verification desk (or front desk) **<u>in advance of your appointment.</u>** This will help avoid any delay or problems with verification, which in turn could delay your appointment time. We are unable to accept insurance applications as proof of insurance. Claims will be filed with one insurance company only and will include submission to a secondary if applicable. If the patient fails to supply the correct information before seeing the physician, then the patient will be responsible for payment at that time and there will be no allowance for insurance adjustments. For these patients and self-pay patients, no itemized receipt will be issued until services are paid for in full. Upon receipt of insurance cards, it is our policy to copy the card and stamp it with the date received. This allows us to know when we are presented with the information. We are unable to retroactively file any insurance claim.

**Billing and Collections**

Once a payment is determined to be the responsibility of the patient, you will receive your first billing, which is due upon receipt. Should you be unable to make payment at that time we ask that you call our business office at 281-494-4900 and meet with a staff member for us to document the situation and to discuss when payment should be expected. If there is no contact with us or payment made to our office a second notice will be issued. Then, if necessary, a third and final notice. If the final notice goes unheeded then the account will be turned over to our collections agency and due process will begin.

Once again, we want to thank you for allowing us to take care of your medical needs and look forward to a long and fruitful relationship. We appreciate your understanding and cooperation of our policies and procedures that are in place to help keep our office running smoothly and efficiently for you, our patient.

Sincerely,

The Physicians and Staff at Sweetwater Medical Associates

**Please note: We reserve the right to refuse service to any person that may choose not to follow our office policies and procedures.**

________________________________________ ____________________________

**Patient Acknowledgement Signature** **Date**

# Acknowledgement and Authority

I consent to treatment as necessary or desirable for the care of the patient named on this form, including, but not restricted to, drugs, medications, lab tests or other studies which may be used by the physician and/or his/her qualified designate.

**I understand and acknowledge that I am solely responsible for providing valid and correct insurance information for any services provided by Sweetwater Medical Associates before services are rendered. I also understand by failing to supply said information that I will be entirely responsible for payment in full.**

Sweetwater Medical Associates, PLLC verifies insurance coverage and files claims as a courtesy to our patients. Upon verification of patient benefits, every insurance company has a disclosure statement stating there is no guarantee of coverage. Therefore, we too cannot guarantee your coverage. It is your responsibility, as the insured, to confirm with your insurance company as to what is covered and what is not covered, under your policy. By signing below, I acknowledge that any charges not covered under my insurance are my sole responsibility.

At the time services are rendered I acknowledge and understand: 1) I am fully responsible for cash payment (if self-pay or auto accident), co-payment, deductible and/or co-insurance of such services and agree to pay my bill ***at the time services are rendered unless other arrangements are made with the financial department in advance.*** 2) That it is my sole responsibility to provide the correct insurance information for the services rendered on any given day for Sweetwater Medical Associates to bill my insurance company. 3) Sweetwater Medical Associates will not bill any insurance provided after services are rendered. 4) Should I fail to provide the correct information at the time services are rendered, I am ultimately responsible for payment in full, before being issued an itemized receipt, and no contractual adjustments will be honored.

I authorize Sweetwater Medical Associates to release information as required to my insurance or third-party payer (including my employer or my employer's worker's compensation carrier) for the purposes of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/or mental issues. I also authorize Sweetwater Medical Associates to bill my insurance or third-party payer and receive payment directly from them for services rendered.

This authorization shall remain valid until such as I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Patient Name:________________________________________ Signed:_____________________________________

Relationship to Patient: ______________________________ Date: ______/______/_______

***Thank you for considering Sweetwater Medical Associates for your primary care needs. Please enter the information below and submit it back to us. If you are a Medicare patient please stop and call our office to schedule an appointment.***

*****New patients, if you requested a new patient appointment on the website, please skip this form and move to the next form.***

**Date**:______/______/______

**Patient Name**:______________________________________ **Date of Birth**:_____/_____/_____

**Male** ☐ **Female** ☐

**Single**: ☐ **Married**: ☐ **Widowed:** ☐ **Divorced**: ☐

**Address**: ________________________________________________________________________________
**(Include apartment number if applicable)**

**Address:**________________________________________________________________________________

**City**:____________________________, **State**:_____________________ **Zip Code**:____________________

**Home No**:______________________ **Cell**:_____________________ **Work**:_____________________

**Emergency Contact Name**:_____________________________________________

**Cell Number**:_______________________ **Relationship to Patient**:__________________

**Primary Insurance/Insured's Information**

**Insurance Name**:___________________________________________________________________________

**Member ID No**:__________________________________ **Group No**:_____________________________

**Primary Insured's Name:**__________________________________________

**Primary Insured's Date of Birth**:_____________________

**Secondary Insurance/Insured's Information**

**Insurance Name:**____________________________________________________________________________

**Member ID No**:__________________________________ **Group No**:________________________________

**Primary Insured's Date of Birth:**________________________

## Sweetwater Medical Associates
## Medical History Questionnaire

**Name**: ________________________________________ **DOB**: ______/______/______ **Date**: ______/______/______

**CURRENT MEDICATIONS:** LIST ALL MEDICATIONS YOU ARE TAKING, BOTH PRESCRIPTION AND NON-PRESCRIPTION. INDICATE STRENGTH AND NUMBER OF PILLS A DAY

1. ________________________________ 2. ________________________________ 3. ________________________________

4. ________________________________ 5. ________________________________ 6. ________________________________

7. ________________________________ 8. ________________________________ 9. ________________________________

**LIST ANY ALLERGIES TO MEDICATIONS: INCLUDE THE EFFECTS THE MEDICATIONS MAY HAVE**.

______________________________________________________________________________________________________

**PAST MEDICAL HISTORY**: LIST ANY CHRONIC MEDICAL PROBLEMS YOU MAY HAVE, I.E. ALLERGIES, ASTHMA, DIABETES, HIGH BLOOD PRESSURE, HEART ATTACHK, LIVER OR KIDNEY PROBLEMS, ETC…

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**PAST SURGICAL HISTORY:** LIST ALL PRIOR SURGERIES AND YOUR AGE WHEN THEY OCCURRED

______________________________________________________________________________________________________

______________________________________________________________________________________________________

WHEN WAS YOUR LAST COLONOSCOPY? ________________________ BONE DENSITY SCAN? _________________________
WHEN WAS YOUR LAST PAP SMEAR? ____________________ WHEN WAS YOUR LAST MAMMOGRAM? __________________
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? _____YES _____NO MAMMOGRAM?_______YES _______NO
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ______YES ______NO

**IMMUNIZATIONS**: WHEN WAS YOUR LAST TETENUS SHOT? ____________________PNEUMONIA SHOT?_____________________

**SOCIAL HISTORY**:
DO YOU SMOKE? _____YES _____NO HOW MANY PACKS PER DAY? _______ WHEN DID YOU START? ____________________

PAST HISTORY OF SMOKING: WHEN DID YOU QUIT? __________________
DO YOU DRINK ALCOHOL? ______YES ______NO WHAT TYPE? _______________ NUMBER PER DAY? ________________

DO YOU USE ILLEGAL DRUGS? _______YES _______NO WHAT TYPE? ___________________________________________________
HAVE YOU EVER USED A NEEDLE TO ADMINISTER ANY ILLEGAL DRUG? _______YES ________NO
DO YOU HAVE A TATOO? ______YES ______NO
WHAT IS YOUR OCCUPATION? ______________________________________________________________________________________
DO YOU EXERCISE? ______YES ______NO HOW OFTEN? ____________________ HOW LONG? ________________________
DO YOU WEAR YOUR SEAT BELTS? ______YES ______NO

**FAMILY HISTORY**: DO ANY FAMILY MEMBERS HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?

HIGH BLOOD PRESSURE FAMILY MEMBER: ______________________________________________________________
CANCER (INCLUDE TYPE) FAMILY MEMBER: ______________________________________________________________
DIABETES FAMILY MEMBER: ______________________________________________________________
HEART ATTACK/DISEASE FAMILY MEMBER: ______________________________________________________________
STROKE FAMILY MEMBER: ______________________________________________________________
ASTHMA/ALLERGIES FAMILY MEMBER: ______________________________________________________________
OTHER FAMILY MEMBER: ______________________________________________________________

# HIPAA Notice of Privacy Practices

**Sweetwater Medical Associates, PLLC**
**16651 Southwest Freeway, Suite 100**
**Sugar Land, Texas 77479**
**(281) 494-4900**

**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.**

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment**: We will 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment**: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations**: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and licensing. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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 use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to 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 Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

________________________________________ ________________________________
Patient Initials Date

# STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Information to be Used or Disclosed**
The information covered by this authorization includes all medical information except what is listed below:

______________________________________________

______________________________________________

______________________________________________

**Persons Authorized to Use or Disclose Information**
Information listed above will be used or disclosed by:

______________________________________________
Name of Person or Organization

______________________________________________
Name of Person or Organization

**Persons to Whom Information May Be Disclosed**
Information described above may be disclosed to:

______________________________________________
Name of Person or Organization

______________________________________________
Name of Person or Organization

**Expiration Date of Authorization**
This authorization will remain in effect until this authorization is revoked or terminated by the patient or the patient's personal representative in writing.

**Right to Terminate or Revoke Authorization**
You may revoke or terminate this authorization by submitting a written revocation to Sweetwater Medical Associates, PLLC. You should contact the Privacy Officer to terminate this authorization.

**Potential for Re-disclosure**
The person or organization to which it is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under the federal privacy regulations.

______________________________________________
**Name of Patient (Print or Type)**

______________________________________________
**Signature of Patient** **Date**

______________________________________________
**Signature of Patient Representative**

______________________________________________
**Relationship of Patient Representative to Patient**

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## HEALTH INFORMATION DISCLOSURE

In a continuing effort to enforce privacy regarding our patients' medical information, we are requesting that you provide a designated telephone number where messages can be left. Our preference is always to speak with you, but we do understand you will not always be available to be contacted. Please list all telephone numbers where we can leave a message and you are able to retrieve it.

Phone #1 ______________________________

Phone #2 ______________________________

Instructions/Comments ________________________________________________________________

Patient Signature: ____________________________________ Date: ____________________________

## PATIENT RESPONSIBILITY

Thank you for allowing Sweetwater Medical Associates to be a part of your medical care. We greatly appreciate being your physicians.

***I understand that when my physician has ordered any lab work or radiological procedures, it is my first responsibility to follow through and have the ordered test performed. I understand that if I have not received a call or letter from this office, or I am unable to retrieve my results from the automated phone system, it is also my responsibility to call the office for my results about four weeks after the tests are performed.***

Secondary to the nature of managed care and their mandate to have your lab tests and radiological tests sent to a different location, it is imperative that we have constant communication with you in order to review results.

Patient Signature: __________________________________________ Date: ______________________

# Lab Results

Effective May 1, 2012

All lab results will now be available through our patient portal. We will no longer make general calls regarding your lab results.

In order to receive labs, you must provide our office with a valid email address. This is required in order to help us Web-enable you so you will be able to access the patient portal through eClinical Works. This is a secure site that you will log into and obtain your results. You will be notified via email, by eClinical Works, of your username and password that will be required for you to log into our secured patient portal. Once you have successfully logged in, you will be able to choose your own username and password. Thereafter, once your lab results are available, you will receive an email notification and will be able to log into the portal and see the results.

Please speak to the Front Desk or Medical Assistant if you have not yet registered.

_______ I understand that I must register to have access to the patient portal in order to receive my lab results.
My email address is: ____________________________________________

_______ I DO NOT have access to the internet or email and will not be able to access the patient portal. I understand that I will need to schedule a follow-up appointment to review my lab results.

Patient Name: ________________________________

Signed: ________________________________ Date:________________