

Welcome!

Thank you for choosing us.

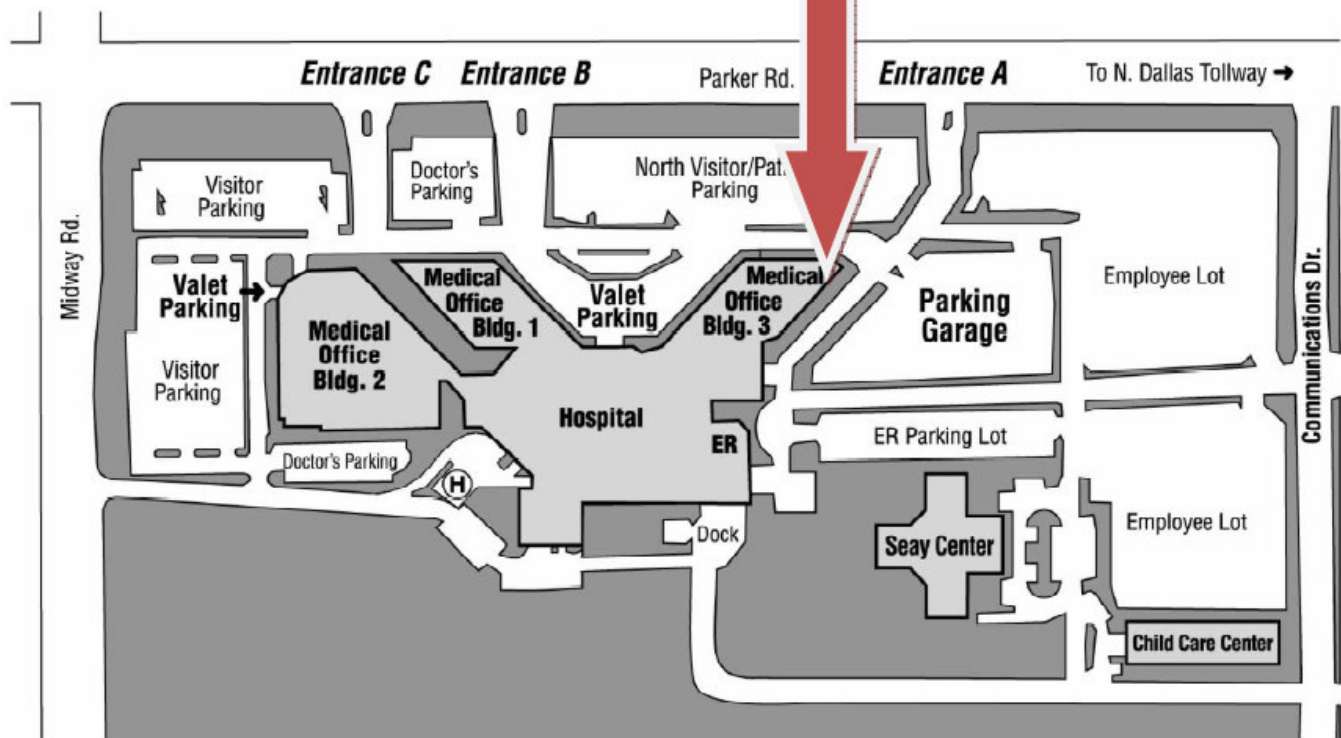
Please print these forms and fill them out prior to your appointment. We would appreciate it if you can arrive 15 minutes prior to your scheduled appointment.

Our new office's address is:

6124 W. Parker Road, Suite #234 (Medical Office Building # 3 – the one attached to the parking garage)  
Plano, Texas 75093

Our phone # is: 972-981-7500

Here is a map of where we are located:



# ***Internal Medicine Associates of Plano, PA***

## **Patient Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SSN#: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ e mail: \_\_\_\_\_  
Alternate e mail: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Work #: \_\_\_\_\_ Fax # (only if secure): \_\_\_\_\_ Occupation: \_\_\_\_\_  
Did someone refer you to us: \_\_\_\_\_

## **Emergency Contact Information:**

Spouse: \_\_\_\_\_ Phone #'s \_\_\_\_\_  
Relative: \_\_\_\_\_ Phone #'s \_\_\_\_\_  
Friend: \_\_\_\_\_ Phone #'s \_\_\_\_\_

## **Primary insurance:**

Name of Insurance: \_\_\_\_\_ Type (HMO/PPO/POS/ect...) \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Group #: \_\_\_\_\_ Effective date: \_\_\_\_\_  
Insured SS#: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Insured Employer: \_\_\_\_\_ How long at the current employer: \_\_\_\_\_

## **Secondary insurance (if applicable):**

Name of Insurance: \_\_\_\_\_ Type (HMO/PPO/POS/ect...) \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Group #: \_\_\_\_\_ Effective date: \_\_\_\_\_  
Insured SS#: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Insured Employer: \_\_\_\_\_ How long at the current employer: \_\_\_\_\_

## **Patient/Responsible Party Authorization:**

I authorize the release of medical information as decided by providers of Internal Medicine Associates of Plano and staff to process my claims. I request that payment of medical benefits be made to Dr. Tirandaz. This assignment of benefits will remain in effect until revoked by me in writing.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

## **Manner of Contact:**

By my signature below I authorize the staff at Internal Medicine Associates of Plano, P.A., to contact me by e mail or through any of the phone numbers listed above and to leave message as they deem necessary regarding my health and test results. I realize that e mail is not secure. This authorization will remain in effect until revoked by me in writing.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

## ***Internal Medicine Associates of Plano, P.A.***

**Arash Tirandaz, M.D., F.A.C.P., P.A.**

**Chandra Brown, M.D., P.A.**

**Mary Hammack, M.D.**

### **PAYMENT POLICY**

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

Patients who do not cancel or reschedule their appointment at least 24 business hours prior to their scheduled visit will be charged a fee of \$25.00. This fee also applies to any patients that do not show up for their scheduled appointment. Excessive no shows and/or late cancellations could be grounds for termination from Internal Medicine Associates of Plano.

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 service. We will only file secondary claims when Medicare is the primary insurance. If there is no secondary insurance then we will bill the patient for any remaining balance unpaid by Medicare.

There will be a twenty-five (\$25.00) fee charged for any returned check. This fee is charged even if the check is re-deposited 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 forms of cash, money order, Visa, MasterCard, American Express, or Discover. 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.

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 this is not a guarantee of payment until your insurance has processed the claim.

For all account balances in excess of 90 days past due, a late fee of \$50.00 will be added to the balance (even if the payment delay is due to the insurance company). The account will be turned over to our collection agency if payment is not received 15 days after notification. It is ultimately the patient's responsibility to make sure that Internal Medicine Associates of Plano received payment for services rendered.

We will file insurance for our HMO, EPO, POS, and Open Access patients. However, you must have assigned the physician you are seeing in this office to be your Primary Care Provider (PCP) *prior* to your first office visit/appointment. The assignment of the PCP must be effective the day services were rendered (or beforehand). If you have not assigned Dr. Tirandaz, Dr. Brown or Dr. Hammack as your PCP, you agree to be responsible to pay the entire balance for your visit. If you would like to meet with the physician prior to choosing him or her as your PCP, you will have to assume full responsibility for the amount of that visit as your insurance will not cover the visit until PCP status has been assigned by you.

I have read this agreement and understand the provisions outlined. I agree to be responsible for any balance present on my account. If my insurance denies payment because Dr. Tirandaz,

Dr. Brown, or Dr. Hammack was not assigned as my PCP at the time of service, I will assume full responsibility of the charges incurred for that visit, and will pay in full.

If any patient is owed a refund, all claims must be processed and paid in full before an overpayment is refunded. Internal Medicine Associates of Plano processes refunds 1 time a month, typically on the 15<sup>th</sup> of the month. All refund amounts less than \$50.00 will be left as a credit on your account, unless refund is requested by you.

### **PRECERTIFICATIONS/REFERRAL AUTHORIZATION**

Precertification of Hospitalization: Internal Medicine Associates of Plano must be notified within 24 hours of any hospital admit so that we may pre-certify 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.

Referrals: Due to the tremendous amount of referral requests, we must be notified at least five (5) business days prior to your appointment with the specialist in order to provide the formal referral necessary for that 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 as most insurance companies do not back date referrals. We will not be responsible for any reduction of benefits due to “after- the- fact” referral request. 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 or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits and procedures to Arash Tirandaz M.D., Chandra Brown M.D., or Mary Hammack M.D and their respective Physician Assistants. This assignment will remain in effect until revoked by me in writing. A photocopy of this document will have the same validity as the original.

Patient Name (please print) \_\_\_\_\_

Patient/Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_