Bruckerhoff Internal Medicine Associates

Denise K. Bruckerhoff, D.O.

NEW PATIENT PROCESSING

Please bring the following items with you to your first appointment:

_____Drivers License or other government photo ID

_____Insurance cards (primary, secondary, and tertiary – if applicable)

_____List of all medications, insulin, inhalers & over the counter medications, supplements or vitamins. (Must include doseages)

_____Vaccination Record

Please complete the attached forms and bring them with you to your first appointment. You can also fax or email them to our office prior to your appointment.

Fax: 817-755-8499 Email: bima@bimadr.com

_____PATIENT DATA FORM

_____FINANCIAL RESPONSIBILITY

_____MEDICAL RECORDS RELEASE

_____PATIENT CARE COMMUNICATION

_____PRESCRIPTION HISTORY CONSENT

_____REVIEW OF POLICIES

_____CONSENT TO EMAIL AND OR TEXT MESSAGES

_____CONSENT TO AI

_____HIPAA FORM & EMERGENCY CONTACT

If you have questions regarding new patient processing, please call Bruckerhoff Internal Medicine Associates at 817-755-1005.

We look forward to seeing you.

Visit our website at www.bimadr.com for more information and to set up your patient portal.

1900 Matlock Road, Bldg 6, Ste 604
Mansfield, TX 76063
Phone: 817-755-1005 Fax: 817-755-8499 Email: bima@bimadr.com
www.bimadr.com

BRUCKERHOFF INTERNAL MEDICINE ASSOCIATES

Please complete all fields.

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____State:_____Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ____Male ____Female SS#: _____

Marital Status: _Single_Married_Divorced_Widowed Occupation:_____

Previous PCP name/Location: _____

Patient Referred By: _____ Spouse's Name: _____

Spouse's Date of Birth: _____ Main Contact #: _____

Local Pharmacy: _____ City: _____ Phone #: _____

Intersection: _____

Mail Order Pharmacy:_____Phone Number:_____

Preferred Pharmacy: ☐ Local ☐ Mail

Primary Insurance: _____

Secondary Insurance: _____

Tertiary Insurance: _____

_

HIPAA Release Form

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

I hereby give my permission to Bruckerhoff Internal Medicine Associates to disclose and discuss information related to my medical condition(s) to/with the following persons. Choose one (1) Emergency Contact.

Name: _____ Emergency Contact: ◯ YES ◯ NO

Relationship: _____ Ph#:_____

Name: _____ Emergency Contact: ◯ YES ◯ NO

Relationship: _____ Ph#: _____

Name: _____ Emergency Contact: ◯ YES ◯ NO

Relationship: _____Ph#: _____

Name: _____ Emergency Contact: ◯ YES ◯ NO

Relationship: _____Ph#: _____

Name: _____ Emergency Contact: ◯ YES ◯ NO

Relationship: _____Ph#: _____

_____ I do not wish to give consent for any person to have access to any information regarding my medical condition(s).

This authorization shall remain in effect unless otherwise revoked in writing, I understand that requests for medical information from persons not listed above will require a specific written authorization prior to disclosure of any records.

Signature of Patient or Legal Representative: _____

Printed Name: _____

Relationship: _____

Today's Date: _____

Medical History

Name:		Date of Birth:	

Allergies: (Include Medications, Foods, X-ray Dyes or write N/A if No Known Allergies)

Name of Allergy	Type of Reaction

Current Medications: (Include prescriptions, over the counter, herbal supplements & vitamins)

Name	Dose	How often taken:

Hospitalizations (Overnight Admissions Only)

Reason for Stay	Date	Hospital Name & City

Surgeries

Type of Surgery	Date	Hospital Name & City

OB/Gyn History (Women Only)

Number of Pregnancies	Number of Deliveries	Date of Last Menstrual Cycle

Tobacco History

Are you an active cigarette Smoker? YES NO Have you ever been a cigarrette smoker? YES NO

Packs a Day	Number of Years	Date that I quit smoking:
	Years	

Alcohol & Drug History

Have you ever been diagnosed with alcoholism? YES NO

Do you currently drink alcohol regularly? YES NO

Drinks per Week	Number of Years	Date that I quit drinking alcohol:
	Years	

Have you ever used intravenous drugs? YES NO

Family History

Is there a family history of:	Yes	No	Who is affected? (Relation to you)
Heart Attack			
Diabetes			
Prostate Cancer			
Kidney Cancer			
Kidney Stones			
Other:			

Recent Tests & Health Maintenance Screenings

Test or Screening Name:	Month & Year of Last Exam	Hospital or Facility Name & City
Bone Density		
Colonoscopy		
Diabetic Foot Exam		
Eye Exam		
Mammogram		
Pap Smear		
Physical		
Medicare Wellness Exam		
PSA		
Tdap/Tetanus Shot		
Flu Shot		
RSV Vaccine		
Covid 19 Vaccination:		
1st Dose		
2nd Dose		
Booster #1		
Booster #2		
Booster #3		
Booster #4		
Booster #5		
Pneumona Vaccine:		
Prevnar 13		
Pneumovax 23		
Prevnar 20		
Prevnar 21		
Shingles Vaccine:		
Shingles Dose #1		
Shingles Dose #2		

Medical History

List all medical problems you have ever been diagnosed or treated for.

Diabetes			History of Transmplant	
Hypertension			Cataracts	
Cholesterol			Glaucoma	
Obesity			Macular Degeneration	
Coronary Heart Disease			Blindness	
CHF			Hearing Loss	
A-Fib			Anxiety	
COPD/Emphysema			Depression	
Asthma			PTSD	
OSA			H/O Abuse	
HypoThyroid			Dementia	
HyperThyroid			Arthritis	
Other Thyroid			Osteoarthritis	
Cancer			Rheumatoid Arthritis	
History of Chemo			Psoriasis	
History of Radiation			Lupus	
Anemia			Fibromyalgia	
Blood Clots			Other Arthritis	
Fatty Liver			Gait Abnormality	
Hepatitis			Loss of Balance	
Other Liver			Falls	
Chronic Kidney			Osteopenia	
Kidney Stones			Osteoporosis	
Enlarged Prostrate			History of Benzodiazepine Use Over 1 Year	
UTI			History of Opiod Use over 1 Year	
Incontinence			Abnormal Mammogram	
Other Kidney			Abnormal Pap Smear	
Indigestion/Reflux			History of Colon Polyps	

Other Diagnosis or Treatment: (Please Explain)

_____

_____

_____

_____

_____

Specialists: (List all specialists including Optometrist & Ophthalmologist)

Name	**Location & Phone Number**

Bruckerhoff Internal Medicine Associates
Denise Bruckerhoff, D.O.
1900 Matlock Road, Building 6, Suite 604, Mansfield, TX 76063
P: 817-755-1005
www.bimadr.com

Below you will find the definition of a Preventive Care Visit (Well Visit), Office Visit, and Medicare Annual Wellness Visit (MAWV).

_____(Initial) PREVENTIVE VISIT

A Preventive Visit is a yearly, *prevention-focused appointment* intended to prevent illnesses and detect health concerns early, before symptoms are noticeable.

- Insurance often only pays for a Basic Wellness Exam.
- Procedures are covered at various rates and you will be billed for any portion not covered by your insurance.
- ACUTE ISSUES ARE NOT INCLUDED IN THIS VISIT. If discussed, an additional office visit charge may be charged.

_____(Initial) MEDICARE ANNUAL WELLNESS VISIT

Annual preventative screening visit that **does not include** a physical, labs, EKG, or other diagnostic testing and is required by Medicare once a year.

- This is a preventative visit.
- Insurance often only pays for a Basic Wellness Exam.
- Procedures are covered at various rates and you will be billed for any portion not covered by your insurance.
- ACUTE ISSUES ARE NOT INCLUDED IN THIS VISIT. If discussed, an additional office visit charge may be charged.

_____(Initial) OFFICE VISIT

An Office Visit is a *problem-focused appointment* designed to discuss new or existing health problems or symptoms.

- To address these specific health concerns, your provider may order tests, prescribe medication, refer you to a specialist or provide advice and education.
- Problems will be prioritized, and you may be asked to schedule additional follow-up appointments for multiple concerns.
- **Office Visits are subject to standard insurance co-pay, co-insurance or deductible.**

_____(Initial) LABS

We do not guarantee your labs will be covered by your insurance. If they are not entirely covered, you may receive a bill from the lab for any out-of-pocket expense.

By signing this form, you agree that you have read this and understand the terms listed above. If you have any questions, please address them with the staff prior to your visit. You may be asked to reschedule your preventative visit or offered a follow-up visit.

_____ _____

Patient Signature **Date**

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

Bruckerhoff Internal Medicine Associates Phone 817-755-1005 / Fax 817-755-8499

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

1900 Matlock Drive, Building 6, Suite 604, Mansfield TX 76063

Address (Street, City, State and ZIP)

FROM:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

Address (Street, City, State and ZIP) F ax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient

Bruckerhoff Internal Medicine Associates

Financial Policies

Welcome to our practice and thank you for choosing Bruckerhoff Internal Medicine Associates to care for you and/or your loved ones. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Due to patient questions regarding patient and insurance responsibilities for services rendered, we have developed this financial policy. Our billing office is located in Dallas and can be reached at 214-775-9013 if you need assistance.

INSURANCE:
We participate in most insurance plans. Please bring your up-to-date insurance card with you to each visit. It is your responsibility to make sure that our providers are on your specific plan and in-network for you. If you are insured by a plan we accept, but do not have an up-to-date insurance card, payment in full is required until we can verify your insurance coverage. If you are not insured by a plan we do business with, payment is required in full at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

PROOF OF INSURANCE:
We must obtain a copy of your driver's license and a current valid insurance card to provide proof of insurance. If your health insurance changes, please notify us before your visit so we can make the appropriate changes. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim. We reserve the right to reschedule your appointment if insurance is unable to be verified. We never guarantee insurance coverage for in office, laboratory testing , or referred care. You are always welcome to take lab orders to outside labs for an estimated lab cost prior to being drawn.

CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES:
All co-payments, co-insurance, deductibles and patient balances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. We accept cash, check, Visa, MasterCard and Discover.

CLAIM SUBMISSION:
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any reason, our office cannot be responsible for that bill. It is your responsibility as the patient to pay the denied amounts in full. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed

to you. It is your responsibility to know if our providers are in-network for your insurance plan and what your specific insurance plan's benefits are.

NON-COVERED SERVICES:
Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. Concerns dealing with mental health issues such as anxiety, depression, attention deficit disorder, and stress-related problems, etc. might not be covered by your insurance. If you are seeing our doctor for any of these problems, you may want to contact you insurance company to see if they are covered if seen by any physician other than an approved mental health provider. As with all non-covered services, you will be expected to pay in full whatever the insurance companies do not reimburse. We never guarantee insurance coverage for in office, laboratory testing , or referred care. You are always welcome to take lab orders to outside labs for an estimated lab cost prior to being drawn.

NONPAYMENT:
If your account is over 90 days past due, you will receive a letter stating that the balance should be paid in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. Should this occur, you will be notified by certified mail and will have 30 days to find a new physician.

PHONE CALLS:
By providing contact information, I authorize Bruckerhoff Internal Medicine Associates, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

MISSED APPOINTMENTS:
If you cannot keep your appointment, you will need to reschedule your appointment 24 hours in advance. This will allow us to schedule another patient in that time slot. If any appointment is no-showed, cancelled with less than 24 hours notice or rescheduled due to late arrival, a minimum $50.00 charge will be billed to your account. This charge is not payable by your insurance company and is due prior to scheduling you next appointment. The amount of this fee may change without notice. If multiple appointments are missed and we identify a problem with you keeping appointments, we will not continue to provide care for you at this office and you will be terminated from the practice.

FORMS:
There is a $25 charge for the completion of all forms. Since insurance companies do not cover this service, this charge is your responsibility. Payment is due at the time the forms or requests are dropped off at the clinic.

Bruckerhoff Internal Medicine Associates

Patient Name:_____ DOB:_____

Consent to Treat

I hereby authorize employees and agents (including physicians, physician assistants, and nurse practitioners) of this medical office to render routine medical care to me, the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) I hereby authorize employees and agents of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, medical care will not be provided except in a case of emergency.

Financial Responsibility

I hereby authorize payments from Medicare or other insurance companies of medical benefits directly to Bruckerhoff Internal Medicine Associates and/or the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I appoint Bruckerhoff Internal Medicine Associates to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Bruckerhoff Internal Medicine Associates. I further understand that should by account become delinquent, I shall pay the reasonable fees or collection expenses, if any. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier. The duration of this authorization is indefinite and continues until revoked in writing.

Release of Information

Authorization is hereby granted to release of information contained in my medical record as may be necessary for medical treatment or to process and complete my insurance claims. I understand that this release of information may include information regarding communicable diseases such as, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The duration of this authorization is indefinite and continues until revoked in writing.

Financial Policies

I have read and received a copy of the financial policies for Bruckerhoff Internal Medicine Associates.

Acknowledgement of Receipt of the Notice of Health Information Practices for Bruckerhoff Internal Medicine Associates

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Bruckerhoff Internal Medicine Associates and associated physicians are committed to securing the privacy of your health information. We have made available to you a copy of the notice which provides information about how its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Bruckerhoff Internal Medicine Associates' Notice of Health Information Practices.

I have read all of the above and agree to these terms.

_____ _____

Signature of Patient/ Legal Guardian (if patient is a minor) Date

Bruckerhoff Internal Medicine Associates
1900 Matlock Road, Building 6, Suite 604
Mansfield, TX 76063

AUTHORIZATION TO RETRIEVE MEDICATION RECORDS

I_____authorize Bruckerhoff Internal Medicine Associates to retrieve my complete medication profile from my insurance, pharmacy, or other third party source. I understand this information will be kept confidential and used only to aid in my ongoing treatment.

I understand this authorization will remain in effect until/unless I revoke it in writing.

_____
Signature of Patient (or Authorized Representative)

_____
Date

Consent Form for Artificial Intelligence/ Scribe

I hereby give my consent to Bruckerhoff Internal Medicine Associates (Healthcare Provider) to create and maintain medical charts detailing my health history and treatment which may require the use of artificial intelligence or a remote scribe service. This may require the visit to be recorded on a HIPPA compliant platform.

Patient's Name: _____

Signature: _____

Date: _____

Medical Record Requests

To obtain a copy of your medical record, please allow 10 business days from the date of receipt of your **written** request. Fees for medical records are due prior to records being released. If files are too large to be faxed or emailed, a paper copy can be obtained at the Paper Copy Rate below.

Electronic Records faxed or emailed to patient:

0-500 Pages: $25.00

501+ Pages: $50.00

Paper Copy of Medical Records provided to patient:

0-20 Pages: $25.00

21+ Pages: $0.50/page

These fees are in accordance with the allowable charges set forth by the Texas Medical Board.

_____ _____

Patient Printed Name Date of Birth

_____ _____

Signature Date