GARY A. TIGGES, M.D.
Internal Medicine

PATIENT MEDICAL HISTORY

NAME ____ AGE _______ OCCUPATION ________________________________

CHIEF COMPLAINT ____

FAMILY HISTORY

Has any relative had	YES	NO
Cancer of breasts, female organs, colon, melanoma	( )	( )
Tuberculosis (in the last 5 years)	( )	( )
Diabetes	( )	( )
High blood pressure	( )	( )
Kidney trouble (Other than kidney stones)	( )	( )
Heart disease	( )	( )
Anesthesia complication	( )	( )

PERSONAL HISTORY

___________ Weight ___________ Height

Exercise: Do you exercise at least 20 minutes, 3 times a week? YES ( ) NO ( )

Alcoholic Beverages: __Never __ Occasionally __ Moderately __ Daily

Do you smoke: YES ( ) NO ( )

If yes, # of packs per day ___________

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 trouble	( )	( )
Tuberculosis	( )	( )	Venereal disease	( )	( )
High blood pressure	( )	( )	Varicose veins or Phlebitis	( )	( )
Heart disease or murmur	( )	( )	Bleeding disorders	( )	( )
Diabetes	( )	( )	Seizures, loss of consciousness	( )	( )
Depression	( )	( )	Visual disturbance	( )	( )
Thyroid disorder	( )	( )	Treatment for nervous disorder	( )	( )
Ulcer or Stomach problems	( )	( )	Cancer	( )	( )
Hepatitis, jaundice	( )	( )	Blood transfusions	( )	( )
Hospitalization for psychiatric reasons	( )	( )	Alcohol Abuse	( )	( )
Other ______________________			Drug Abuse	( )	( )

Please explain "YES" answers: ____

____

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 10 years (only age 50 and over)? YES ( ), on this date________ NO ( )

Have you had any other immunizations in the past? ____

OTHER

Last Dental Exam _________________________ Dentist Name _____________________________________

Last Eye Exam ___________________________ Eye Doctor Name __________________________________

SURGERIES (Include dates)

____

DRUG ALLERGIES

____

MEDICATIONS: Please list all medication your are currently taking (include dosage):

____

____

____

DATE: _____________________ PATIENT SIGNATURE: ____

Form PIMAGT3

GARY A. TIGGES, M.D.

Board Certified In Internal Medicine

PATIENT INFORMATION

NAME ______________________________ BIRTH DATE ______________ AGE ______

ADDRESS ______________________________ CITY ______________ ZIP ______

SSN ______________ SEX ____ MARITAL STATUS ______ HOME PHONE ______________

WORK PHONE ______________ CELL PHONE ______________ PAGER ______________

EMPLOYER ______________________________ FAX # ______________

ADDRESS ______________________________ CITY ______________ ZIP ______

WHO REFERRED YOU? ______________________________

EMERGENCY INFORMATION

SPOUSE ______________________________ SPOUSE WORK PHONE ______________

RELATIVE ______________________________ RELATIVE HOME PHONE ______________

FRIEND ______________________________ FRIEND HOME PHONE ______________

PRIMARY INSURANCE INFORMATION

____PRIVATE PAY (Cash) ___ PPO ___ HMO ___ MEDICARE ___ OTHER

INSURANCE COMPANY ______________________________

ADDRESS______________________________ CITY ______________ ZIP ______

INSURED'S NAME ______________________________ BIRTH DATE ______________

INSURED'S SSN ______________________________ GROUP # ______________

INSURED'S EMPLOYER ______________________________

HOW LONG AT ABOVE EMPLOYER ______________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ______________________________

ADDRESS ______________________________CITY ______________ ZIP ______

INSURED'S NAME ______________________________

INSURED'S SSN ______________________________ GROUP # ______________

INSURED'S 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. GARY A. TIGGES AND I UNDERSTAND THAT THIS IS AUTOMATIC IN CASE OF HOSPITALIZATION. THIS ASSIGNMENT OF BENEFITS WILL REMAIN EFFECTIVE UNTIL REVOKED BY ME IN WRITING.

PATIENT'S SIGNATURE ______________________________ DATE ______________

GARY A. TIGGES, M.D., P.A.

Internal Medicine

PAYMENT POLICY

1. We will file insurance for our PPO, HMO and other managed care patients. However, all managed care copayment 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 Gary A. Tigges, M.D. is in your managed care network. There will be a $15.00 fee added to your account if the copay/ coinsurance is 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. If there is no secondary insurance, patient will be billed for any remaining balance.

3. There will be a twenty-five dollar ($25) fee assessed for any returned check. 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 forms of cash, money order, or credit card.

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 to those account balances for processing. 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). It is ultimately the patient's responsibility to make sure the doctor received payment for service rendered.

6. We will file insurance for our HMO/EPO/POS patients. However, you must have assigned the doctor you are seeing in this office 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. Tigges 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. Tigges, 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. 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. Tigges was not listed as my Primary Care Physician at the time of service, I will assume full responsibility of the charges incurred for that visit, and will pay in full.

8. If any patient is owed a refund all claims must be processed and paid in full before overpayment is refunded.

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. Patient's 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 of 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 or treatment, and to obtain reimbursement.

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

Patient's Signature ____ Date ____________________

FORM # PIMAGT5

Gary A. Tigges, M.D., P.A.
Internal Medicine
6300 West Parker Rd.
Suite 220
Plano, Texas 75093
(972) 981-8215

CANCELLATION / NO SHOW POLICY

Patients who do not cancel or reschedule their appointment at least 24 business hours prior to their scheduled visit may be charged a fee of **$25.00**. Also, this fee applies to any patients that do not show up for their scheduled appointment. The office will make reasonable attempts to confirm appointments one to two days in advance of the appointment date.

It remains the patient's responsibility to keep or reschedule appointments in compliance with the above policy. *Exceptions will be made for medical or family emergencies.* Please note that insurance companies cannot be billed for missed sessions.

I have read, understand, and agree to comply with the above policy.

____ ________________
Patient Signature Date

____
Signature of Parent/Guardian (for Patients under the age of 17)