

Patient Demographics

NAME (Last, First, MI.): _____ DOB: ____ / ____ / ____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYMENT STATUS: Full-time Part-Time PRN Retired Homemaker Other

EMPLOYER: _____ WORK PHONE: _____

PRIMARY INSURANCE

Plan Name: _____ Member ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

SECONDARY INSURANCE

Plan Name: _____ Member ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

Phone Number: _____

Name: _____ Relationship: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

Phone Number: _____

PHARMACY INFORMATION

Name: _____

ADDRESS / INTERSECTION: _____ CITY, STATE, ZIP: _____

Phone Number: _____ Fax Number: _____

How did you hear about us?

Friend/Family Member Hospital Physician Advertisement Other: _____

If a friend or family member, please list their name so we may thank them: _____

Health and Medical History Form

** Please fill out this form as completely as possible. A thorough patient and family history is pertinent in identification and treatment of many conditions. If you are unsure about some of the information, please ask

Personal History: (Please mark all conditions you are currently diagnosed with, or have been diagnosed with in the past.

Cardiovascular:

- ☐ Arrhythmias
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other: _____

Digestive:

- ☐ IBS (Constipation/Diarrhea)
- ☐ Crohn's or Colitis
- ☐ Diverticulosis
- ☐ Gastroesophageal Reflux
- ☐ Ulcers
- ☐ Other: _____

Endocrine:

- ☐ Diabetes (Type _____)
- ☐ Polycystic Ovarian Syndrome
- ☐ Thyroid Disease
- ☐ Other: _____

Integumentary: (Skin)

- ☐ Acne
- ☐ Cold Sores
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Other: _____

Nervous:

- ☐ Alzheimers / Dementia
- ☐ Headaches / Migraines
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke(s)
- ☐ Other: _____

Lymphatic:

- ☐ Lymphedema
- ☐ Other: _____

Genitourinary:

- ☐ Chronic Kidney Disease
- ☐ Incontinence
- ☐ Kidney / Bladder Stones
- ☐ Enlarged Prostate / BPH
- ☐ Recurrent UTI
- ☐ Other: _____

Respiratory:

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD / Emphysema
- ☐ Pleural Effusion
- ☐ Pneumonia
- ☐ Other: _____

Reproductive:

- ☐ Endometriosis / Fibroids
- ☐ Infertility
- ☐ Low Testosterone
- ☐ Sexually Transmitted Disease
- ☐ Sexual Dysfunction
- ☐ Other: _____

Musculoskeletal:

- ☐ Chronic Back Pain
- ☐ Osteopenia / Osteoporosis
- ☐ Sciatica
- ☐ Other: _____

Surgeries: (Please list all surgeries with year it was performed.)

Hospitalizations: (Please list the cause for each hospitalization with the year it occurred.)

Immunizations: Please list the vaccine and date received.

COVID: _____ (Mod., Pfiz., J&J) Booster(s): _____ (Mod., Pfiz., J&J)
Tetnus: _____ Influenza: _____ Pneumonia: _____ Shingles: _____

Family History: Please list medical conditions of each family member.

**If the person is living, please list age, if deceased, please list age of death and cause if known.

<u>Family Member</u>	<u>Conditions</u>	<u>Age</u>	<u>Deceased</u>	<u>Cause of Death</u>
Mother:			Y / N	
Father:			Y / N	
Maternal Aunts/Uncles:			Y / N	
Paternal Aunts/Uncles:			Y / N	
Maternal Grandmother:			Y / N	
Maternal Grandfather:			Y / N	
Paternal Grandmother:			Y / N	
Paternal Grandfather:			Y / N	

Is there family history of any forms of cancer? (Please list what kind and your relationship.)

Are there any other things you would like us to know about your family history?

Social History:

What is your relationship status?(Circle One) Married Single Divorced Separated Widowed

Do you have any children? If so, please list age, sex, and medical conditions, if any.

Are you employed? If so, where? _____ Work from home? Y / N

Do you do any of the following? If so, please specify whether a past or current user, and for how long.

	Current Use?	Past Use?	If past use, what kind and how long go did you quit?
Cigarettes, cigars, or smoked tobacco:	Y / N	Y / N	
Vape products:	Y / N	Y / N	
Smokeless / Oral Tobacco:	Y / N	Y / N	
Caffiene (coffee, tea, soda, etc.):	Y / N	Y / N	
Alcohol:	Y / N	Y / N	
Drug Use:	Y / N	Y / N	
Marijuana Use:	Y / N	Y / N	

Medication and Allergy List

Please complete medication list prior to visit, as this will be reviewed prior to you seeing the provider.
If there is a medication that you cannot recall the name, dose, or regimen for, please notify the medical assistant
so they may notify the provider. ***Please include all supplements or over the counter medications.

Allergies:

[illegible]



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Updated May 2022

Medical Records Request Form

By signing this form, I authorize the indicated medical provider to release confidential medical records of the patient as indicated below. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____ Date of Birth: _____

Please list the provider/organization name, address, phone number, and fax number.

PLEASE RELEASE THE REQUESTED P.H.I. TO THE FOLLOWING PROVIDER/ENTITY:

***NTX Medical Clinic
1400 Coit Rd. Suite 2502
McKinney, Texas 75071
Ph:972-295-9000
Fax: 972-634-0350
Office@ntxmedical.com***

LAST 3 YRS OFFICE VISITS AND LABS

Please send all records including, but not limited to, Lab Results, Scans/Imaging, Office Notes, Medication lists or other relevant information.

PLEASE DO NOT SEND CD'S

Patient Name (Print): _____ Date: _____

Patient/Guardian Signature: _____ Relationship: _____

DEEPA CHINTALA, M.D., P.A. dba NTX MEDICAL CLINIC
1400 Coit Road #2502, McKinney, Texas 75071 (972) 295-9000



HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____ DOB: _____

I. My Authorization

I authorize NTX Medical Clinic to access and use my current and past medical information as needed to continue my care. In addition, I authorize NTX Medical Clinic to share my medical records with other providers which are involved in my care.

To use or disclose the following health information: (check one) ☐ - All of my health information ☐ - My health information limited to: _____

II. Who to Contact Regarding Your Personal Health Information/Results/Condition

I hereby give my permission to NTX Medical Clinic to disclose and discuss information pertaining to my medical condition(s) to/with the following family members, relatives, or indicated persons.

Name: _____ Ph: _____ Relationship: _____

Name: _____ Ph: _____ Relationship: _____

Name: _____ Ph: _____ Relationship: _____

Name: _____ Ph: _____ Relationship: _____



III. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

Signature of Patient or Legal Representative: _____

Relationship to Patient: _____ **Date:** _____



Financial and Office Policies

Thank you for choosing us as your healthcare providers. We are committed to providing you with quality and affordable healthcare. The following are our financial and office policies. Please read, check the box on the left, sign at the bottom, and return this form to the front office representative.

- **Patient Responsibility:** We participate in many insurance plans. We recommend that you familiarize yourself with your insurance benefits and confirm our participation in your plan. Most misunderstandings about insurance can be avoided if you understand what your policy covers. Please contact your insurance company with any questions regarding your coverage.
- **Insurance Carriers Requiring Referral:** If you are referred to a specialist and your insurance carrier requires a referral number, our office must receive at least 7 days' notice to complete that referral.
- **Proof of Insurance:** All patients must complete their patient information form before seeing the doctor. We must obtain a copy of your valid government-issued identification and a current, valid insurance card. Please bring these items on each visit. Payment in full is required if we are unable to verify your current insurance information.
- **Payments Due at the Time of Service:** Co-pays, deductibles, cash-pay fees, or fees not covered by insurance are due at the time of service.
- **Nonpayment & Returned Checks:** Unpaid accounts will be referred to an outside collection agency and may result in dismissal from the practice. A \$30 fee will be charged for all returned checks.
- **Late Arrivals:** Please arrive 15 minutes before your appointment. If you arrive late, our office may need to reschedule your appointment to a new time or date. Patients who are on time will not be delayed accommodating late arrivals.
- **No-Shows:** Please notify us 24 hours in advance if you must cancel or change your appointment. Failure to do so will result in a \$35 no-show fee that is not covered by your insurance. A third no-show may result in dismissal from the practice.
- **Cancellations:** If you cancel within 24 hours of your scheduled visit, you will be subject to a \$35 cancellation fee applied to your account.
- **After-Hours Call Services:** NTX Medical Clinic provides patients with the security of an “after-hours” line that connects you directly to one of our licensed providers. I understand that this service is an elective and should be used only for urgent needs. The fee for “after-hours” service is \$25 and is not a substitute for emergency care.



- **Referrals:** The providers at NTX Medical Clinic may refer you to providers outside the practice. It is the patient's choice to receive ancillary healthcare services from any ancillary healthcare provider or facility of their choice.
- **Form Completion:** All forms requiring medical review and physician signature—including school, daycare, and camp physicals, prior authorizations, FMLA, disability, or other paperwork—may incur an administrative fee of \$30. Administrative fees may be waived if the patient has a scheduled appointment in conjunction with form completion.
- **Lab Draws:** Labs will not be completed prior to the office visit but will be performed during that visit or on a subsequent day as necessary. Blood Draw / Lab Services on site is provided as a convenience by the third party to the patient. Any bills from the lab are your responsibility and it is not associated with the services provided by the NTX Medical Clinic.
- **Refills:** If you miss or cancel your appointment, refills will not be provided. Refill requests are processed Monday through Friday. If you need a refill, please contact your pharmacy so they may send a digital request. Refills will not be called in or sent after business hours or at weekends.
- **Policy Acknowledgment:** I have read and understand the Financial and Office Policies of NTX Medical Clinic and agree to abide by its guidelines.
- Your insurance policy is a contract between YOU and YOUR insurance company. It is your responsibility to understand your benefits and obtain any necessary referrals. We file claims on your behalf. Any non-payment of claims from your insurance company will be billed to you directly.

Signature: _____ Date: _____

Printed Name: _____



Notice to all Patients:

Appointment Billing Information

OFFICE VISIT: This is a problem-based visit to discuss new or existing medical issues. The exam and questions will focus on the reasons for the visit. This may also include a follow-up on chronic problems (e.g., diabetes, cholesterol, blood pressure). During this visit, your healthcare provider may prescribe medications, order lab tests, perform in-office procedures, and/or make referrals to specialists. Telemedicine visits will be billed to insurance as a visit, with coding to indicate the manner of the visit. A co-pay will be charged at this visit, consistent with standard office visits.

ANNUAL PHYSICAL: This type of visit is preventive and is intended for patients who are asymptomatic and have no complaints but wish to receive a complete physician examination. It includes a thorough review of your general well-being, which may encompass recommendations regarding diet and exercise, age-appropriate immunizations, and screenings.

OFFICE VISIT AND PHYSICAL (BOTH): This refers to a scenario where a physical exam and an office visit occur during the same appointment. For example, if you present for a physical and also have an acute or chronic issue to address, it is considered a combination visit and must be billed differently than either a physical or an office visit alone.

HOW THIS COULD AFFECT ME: Many insurance companies recognize the office visit/physical combination; however, some may still require the patient to pay a co-pay or have additional costs applied to their annual deductible or coinsurance. Physicals are targeted as preventive care and are billed accordingly. Medication refills and/or other ailments, injuries, or illnesses addressed during the physical will be billed in addition to the physical itself. These charges may be passed on to the patient. Please check with your insurance company to confirm your coverage for all types of doctor visits. We understand this can be confusing, so if you have any questions or concerns after reviewing this material, please ask.

Patient Signature: _____ Date: _____

Patient Name (Printed): _____



Billing Consent

Financial and Patient Responsibilities

I understand that my insurance and subsequent charges will be billed by DEEPA CHINTALA, M.D., P.A., doing business as NTX Medical Clinic. I agree to cooperate in the reimbursement process for the medical care and services provided. I understand that I am responsible for any amounts not covered by my insurance provider(s), including, but not limited to, any applicable co-payments, co-insurances, and deductibles.

If there are any questions regarding your bill or the billing process, please call (877) 749-9578.

Assignment of Benefits and Insurance Payments

I authorize NTX Medical Clinic to submit insurance claims and any other information necessary to bill my insurance provider(s) on my behalf for the products and services provided by Dr. Deepa Chintala and the staff. I authorize the payment of medical benefits from my insurance provider(s) directly to NTX Medical Clinic for the products and services rendered. I agree to endorse and forward any payments made to me by my insurance provider(s) to NTX Medical Clinic for products and services billed under this agreement.

By signing this consent form, I agree to all the terms and conditions listed above. I certify that I have read this consent form carefully before signing and fully understand its terms. A copy of this consent form will be provided upon request.

Printed Patient Name or Representative

Relationship to Patient

Patient or Guardian Signature

Date

DEEPA CHINTALA, M.D., P.A. dba NTX MEDICAL CLINIC
1400 N. Coit Rd., #2502 McKinney, Texas 75071



Nurse Practitioner Consent to Treat

NTX Medical Clinic is proud to employ a diverse team of medical professionals dedicated to delivering high-quality healthcare. Nurse practitioners, while not physicians, are registered nurses who have completed advanced education and training in healthcare provision. They are certified by an accredited board, ensuring adherence to established healthcare standards.

Under the supervision of a physician, nurse practitioners are authorized to diagnose, treat, and monitor both acute and chronic conditions, as well as provide preventive health maintenance. They operate as autonomous healthcare providers and may practice independently. However, the nurse practitioner will inform the physician about the patient's condition, discuss evaluations and treatment options with the physician, and obtain the physician's approval as needed.

It is important to note that "supervision" does not necessitate the constant physical presence of the supervising physician. Instead, it involves overseeing the activities of the nurse practitioner and accepting responsibility for the medical services rendered

By signing below, I acknowledge that I have read the statement above and consent to receiving healthcare services from a nurse practitioner. I understand that the nurse practitioner will bill under the provider's name, and that no refunds will be issued after services are rendered. I recognize that the schedules of the physician and nurse practitioners may differ, leading to variability in availability. I understand that treatment for my condition may require multiple visits. I also acknowledge that I can refuse to see the nurse practitioner and request an appointment with the physician; however, due to individual scheduling, I may need to reschedule for the earliest available appointment with the physician.

Printed Name

Date

Signature

DEEPA CHINTALA, M.D., P.A. dba NTX MEDICAL CLINIC
1400 N. Coit Rd., #2502 McKinney, Texas 75071



PATIENT PORTAL USER AGREEMENT

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider for the exclusive use of established patients. The Patient Portal is designed to serve as a resource for patients to better manage their health. All users must be established by a previous office visit. We strive to keep all the information in your records correct and complete. By using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services:

- Request appointments
- View your medical records
- Receive educational material
- Send messages to clinical staff

The following limitations also apply:

- No internet-based triage and treatment requests. Diagnosis can only be made, and treatment rendered after the patient is evaluated by the Provider.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room or calling 911 should the emergency be life threatening.
- It may take 72 hours to receive a response to a message sent through the Patient Portal. If you do not receive a response within 72 hours you should contact the office at (972) 295-9000.

This Patient Portal is provided as a courtesy to our patients. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal. The data is HIPAA compliant with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. Please read our HIPAA policy for information on how private health information is used in our office. Once you have signed the Patient Portal User Agreement and have provided our office with a legitimate email address that is secure, you will receive a "Welcome" email to guide you.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given the risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between my provider and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered to my satisfaction.

Signature: _____ Date: _____

Printed Name: _____