Lisa E. Medwedeff, M.D. • Gracie Martinez, APRN FNP-C

Legacy Medical Village • 5425 West Spring Creek Parkway • Suite 210 • Plano, TX 75024

Phone (972) 608-3333 • Fax (972) 473-7333 • www.villageimg.com

CONTACT INFORMATION

Date: ____/____/____

First Name:_____ Last Name: _____

Address:_____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

_____

Best Contact Number:_____( ) Home ( ) Work ( ) Cell

Second Best Number:_____( ) Home ( ) Work ( ) Cell

Email: _____

Do You Use Mail Order For Rx?

YES NO

Please Provide PHARMACY

Name: _____

Location: _____

Phone: _____

Please provide two Emergency Contacts:

Name:_____ Phone: _____

Name:_____ Phone: _____

Date of Birth: ____/____/____ **AGE:** (_____) **Social Security Number:** _____-_____-_____

Marital: ( ) Single ( ) Married ( ) Divorced ( ) Domestic Partner

Gender: ( ) Male ( ) Female

Race: ( ) Caucasian ( ) African American ( ) Hispanic ( ) Oriental ( ) American Indian ( ) Arabic ( ) Other

Employment Status: ( ) Student ( ) Employed ( ) Looking ( ) Full-Time In Home ( ) Retired

Employer: _____ **Position:** _____

How did you hear about Dr. Medwedeff – Dr. Wills? _____

Name of Insurance Company: _____

Subscriber ID:_____ **Group No:** _____

Primary Insured:( ) Self ( ) Spouse:_____( ) Parent: _____

Birth Date of Primary Insured: _____

I authorize Village IMG to disclose all or part of my patient records to my insurance company or other medical associations such as physicians, labs, or clinics, as such information may be necessary for the completion of insurance claims.

I understand and agree that after 45 days of non-payment by my insurance for any reason, I become fully and immediately responsible for all charges incurred during my office and/or hospital visit(s). I agree that unpaid claims after 90 days from the date of service may be sent to a collection attorney if I fail to pay, and will likely have a negative effect on my credit standing.

I authorize payment from insurance to be made directly to Village IMG (assignment of insurance benefits). I waive this assignment if my insurance fails to pay within 45 days from the date of service as a breach of contract.

Signature:_____ **Date:** _____

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PATIENT INFORMATION AND NOTIFICATION

I would like to ask you to take a few minutes to read over the policies and procedures we have chosen to operate Village IMG. Please help us by understanding there are many unique considerations and aspects of the solo primary care medical practice. We need to implement guidelines in order to continue to provide quality patient care and protect the ability to continue as a solo practice. By working together, we can establish strong patient relationships that can remain autonomous while meeting patients' needs with the highest degree of excellence. Without some basic standards of operation, we will certainly be taken under by a healthcare system that is working against us. By reading and signing below, you are stating that you have been provided and understand our office policies and procedures put in place to ensure our ability to provide the best levels of service and care for our patients.

Thank you in advance for your understanding and cooperation.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping patient information private is important to us. Our policy is to only disclose patient information (billing and medical condition), to the patient or legal guardian. This includes a spouse or adult child who you might want Village IMG to discuss medical findings with or involve in your treatment plan. If there are additional people whom you would like to have access to this information, please fill out the form provided in this packet.

WRITTEN CORRESPONDENCE

We can only provide written correspondence in three ways: via the patient portal, US Mail, or in person. We cannot provide statements, test results, or other medical information through e-mail.

INSURANCE

Even though this information is stored in our computer system, insurance changes frequently and we need to be absolutely sure we have your latest coverage updated and that we file correctly. Please be prepared to show us your insurance information on each visit.

Healthcare Insurance can be confusing. Keep in mind the following:

We are only contracted with select insurance plans. Contact your insurance carrier to confirm Dr. Medwedeff or Dr. Wills is a "preferred provider" or "in network."
We will contact your insurance carrier for benefits; however, it is your responsibility to know your benefits and coverage.
We will submit your insurance claims on your behalf.
After filing with your insurance there are several possible outcomes:
The claim will be paid and you will receive a statement for the portion your contract allows but does not pay in full.
All or part of the claim may be applied to your deductible and you will be responsible for the balance.
They may deny the claim. If this happens: You will need to contact your insurance carrier (not our office) for the denial reason and what, if anything, can be done to get the claim paid. Once you do this, let us know, and we will resubmit the claim. If it is still denied, you will be responsible for all allowed charges.

Texas law now requires commercial insurance carriers to pay medical claims within 45 days. If they do not, it will then be your responsibility to pay the professional services in full. Should we receive a subsequent payment from your insurance carrier, we will provide a refund by check or a refund your credit card.

SCHEDULING

Excellent medical care takes time to diagnose and treat. Sometimes our schedule is delayed when patients require more attention than originally anticipated. We ask for your patience in waiting, realizing that you will receive the same high level of care.

ANNUAL PHYSICALS / GYN EXAMS

If you advise that you're coming in for a physical or a Gynecological (GYN) exam, we will bill the office visit and lab as "routine wellness". If your plan does not cover these services, you will have to pay in full. If you require services beyond "routine wellness" at the same time, an additional office visit charge will be added.

LATE ARRIVALS/NO SHOW

The first appointment in the morning and afternoon are reserved for individuals who have tight schedules and need to be seen promptly. We have a zero tolerance for late arrivals for these choice times.
All appointments need to be rescheduled if you're running more than 15 minutes late unless we have had a cancellation and can accommodate your visit into our schedule.
Patients more than 20 minutes late will be considered a no-show and an appropriate charge will be assessed.
If you "no show" for three appointments, written notice will be sent to you terminating you as a patient.

CANCELLATIONS

Please provide us with 24 hours advance notice if you need to reschedule an appointment. This can be done via phone or patient portal. Failure to do so will incur the following charges based on the amount of time previously reserved:

- 15 – 25 minute appointments $25.00
- Physical/GYN exam $50.00
- Procedure visit such as minor surgery or diagnostic testing $75.00

LAB

Our electronic health records (EHR) are interfaced with Clinical Pathology Laboratory (CPL) and Quest. For this reason, these are our preferred laboratories.

PATIENT PORTAL

You have partial access to your medical records via the secure patient portal. You can review all documented diagnosis, medications, medication allergies, and most test results. Messages can be sent and will be addressed within 48 hours (during regular business hours.) All non-emergency communication should take place via the patient portal as opposed to email or phone calls

STATEMENTS

Statements are due upon receipt.
Late fees (1.5% total due) may be added if payment has not been received within 30 days from the date of the statement.
Payments due for more than 90 days are subject to collection.
Payments may be made at any time via phone with Visa or MasterCard.

ADDITIONAL ITEMS:

Health forms to be completed (outside of office visits) will have a charge of $25.00 per page.
Letters requested of Dr. Medwedeff will be charged based on complexity and time, starting at $40.00.
Copies of medical records are charged according to the Texas Medical Examiners fee schedule which is $25 for the first 20 pages and $0.50 per page thereafter.
Letters mailed at patient's request are $1.00.

I have read and understand the above policy and procedure:

_____
Patient Signature

_____
Today's Date

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PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services that Village IMG creates and maintains health records describing among other things my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging medical review, legal services, auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I have listed below the names of others that may have access to my personal health information. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral, or electronic format, are confidential and cannot be disclosed for reasons outside of treatmen payment, or healthcare operations without prior written authorization, except as otherwise provided by the law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

PRIVACY DISCLOSURE OF MEDICAL INFORMATION
(circle YES or NO)

I approve the receipt of a FAX with medical information: YES or NO

I approve the receipt of an E-MAIL with medical information: YES or NO

I approve the receipt of a TEXT MESSAGE with medical information: YES or NO

I approve the receipt of a VOICEMAIL with medical information: YES or NO

_____ _____
Printed Name of Patient Date of Birth

_____ _____
Patient Signature Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient Name Date of Birth

I, the above mentioned, release the following medical information:

_____ All medical records

_____ All billing records

Information can be released and sent to the following people authorized to receive information:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I, the above mentioned, release Village Internal Medicine Group, and the staff, from any liability concerning my medical records.

_____ _____
Patient Signature Date

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INTERNAL MEDICINE GROUP

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Today's Date: _____.

Name: _____ **Date of Birth:** _____.

Occupation/Profession: _____.

Marital Status: _____.

__ Single __ Married __ Widowed __ Divorce __ Separated __ Engaged __ Domestic partner

Tabacco History:

__ Current Smoker __ Former Smoker __ Social Smoker __ Never Smoked

Smoked _____ packs/day for _____ years.

I quit smoking _____ years ago. If yes, what method? _____.

Cigars: __ Yes __ No

Chewing Tabacco: __ Yes __ No

E-Cig: __ Yes __ No

Alcohol:

__ None __ Rarely __ Occasional __ Everyday __ Socially

Number of drinks _____ day/week/month/year.

Current Medication (Please include prescription, over the counter, and vitamins)

Name	Dose	Date Started	Condition treating

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Allergies

Drug	Reaction

Self and family history

Mark the columns that apply	None	Self	Father	Mother	Brother	Syster	Son	Daughter
Congestive heart failure								
Arrhythmia								
Diabetes								
High cholesterol								
Thyroid								
COPD (chronic lung disease)								
Asthma								
High blood pressure								
Stroke								
Kidney disease								
Arthritis								
Osteoporosis								
Osteopenia								
Obesity								
Liver disease								
Kidney disease								
Cataract								
Depression								
Anxiety								
Bipolar disorder								
Schizophrenia								
Dementia								
Cancer								

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Surgical History

Date	Surgery

Hospitalization

Date	Reason

Immunizations	Date	Notes
COVID		
Tdap (Tetanus-Diphtheria-Pertussis)		
Pneumo 23 (Pneumonia)		
Prevnar 13		
Influenza/Flu		
Shingrix (Shingles)		
Hep A		
Hep B		
PPD		
Varicella		
HPV		

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Preventive medicine	Date	Results	Performed by:
Physical Exam			
Medicare Wellness (>65)			
Full labs			
Mammogram (If applicable)			
Pap Smear/HPV (If applicable)			
Bone Density (If applicable)			
PSA (If applicable)			
Colonoscopy/FOBT			
Last eye exam/Retinopathy			
Nephropathy/Urine Microalb/Cr ratio			
DM Foot Exam			
Neuropathy			
Last Fall			

Physicians or Health Care Providers

Specialty	Physician name	Date last seen
Cardiologist		
Pulmonologist		
Eye doctor		
Endocrinologist		
Physical therapist		
Gynecologist		
Dermatologist		
Ear, nose, and throat		

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Patient's Name: _____ Today's Date: _____

General Sense of well-being: __ Good __ Poor Energy level: __ Good __ Poor __ Fever __ Chills __ Night Sweats __ Weight Loss __ Weight Gain __ Change in Sleep __ Insomnia	**Gastrointestinal** __ Changes in Appetite __ Trouble chewing or swallowing __ Heartburn/Reflux __ Nausea __ Indigestion __ Vomiting __ Diarrhea __ Constipation __ Hemorrhoids __ Increased Gas/Bloating __ Change in Bowel Movements __ Bloody/Black Stools __ Chalky Stools __ Mucous in Stools __ Abdominal pain __ Yellowish Eyes/Skin
Skin __ Dry skin __ Discoloration __ Acne __ Moles __ Lumps __ Rashes __ Eczema __ Psoriasis __ Hives	**Genitourinary** __ Urinary Burning __ Excessive Night Urination (# times/night __) __ Difficulty Starting/Stopping Stream __ Decreased Urinary Stream __ Leakage __ Genital Lesions __ Discharge __ Sexual Dysfunction
Eyes __ Irritation __ Pain __ Swelling __ Redness __ Double Vision __ Blurred Vision __ Spots __ Blank areas	**Endocrine** __ Heat/Cold Intolerance __ Excessive Thirst __ Excessive Urination __ Excessive Dry/Oily Skin __ Excessive Hair Growth/Loss
Ears __ Pain __ Hearing problems __ Hearing Aids Ringing __ Drainage	**Hematology** __ Easy Bruising __ Prolong Bleeding
Nose __ Allergies __ Sinus pain __ Nasal discharge __ Bleeding __ Deviated septum __ Decreased sense of smell __ Polyps	**Peripheral Vascular** __ Leg Swelling __ Leg pain when walking __ Cold Feet __ Varicose Veins __ Leg Cramping
Throat/Mouth __ Fever Blisters __ Canker Sores __ Tongue Problems __ Dentures __ Snoring __ Sore throat __ Swollen Glands __ Dry Mouth	**Neurology** __ Headaches (# per month __) __ Confusion __ Seizures __ Dizziness __ Tremor __ Numbness/Tingling __ Gait Abnormality __ Balance Difficulty __ Fainting __ Memory Loss
Pulmonary __ Wheezing __ Shortness of Breath __ Phlegm __ Cough __ Coughing up Blood __ Pain with Inspiration __ Emphysema __ Pneumonia __ Bronchitis	**Musculo/Skeletal** __ Joint Pain __ Joint Swelling __ Joint Tenderness __ Weakness __ Ache __ Stiffness __ Decreased range of motion __ Injury Shoulder/Arm/Hip/Knee/Ankle
Heart __ Chest Pain __ Palpitations (racing heart) __ Irregular Heartbeats __ Heart Murmur __ Hypotension __ Leg Swelling __ Difficulty lying flat __ Decreased ability to exercise	**Mental Health** __ Sadness __ Feeling anxious __ Chemical Dependence/Abuse __ Forgetful __ Cognitive Changes __ Depressed Mood

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Patient's Name: _____ **Today's Date:** _____.

For the following questions please answer with this scale:

	Poor	Fair	Good	Very Good	Excellent
Overall, describe your health.					
Overall, describe your quality of life.					
Overall, describe your mental health, taking into consideration your mood and cognitive ability.					

For the following questions please answer Yes or No.

	Yes	No
Have you experienced urinary incontinence within the past 6 months?		
Have you fallen within the past 12 months?		
Do you have any issues with hearing or are you perceived to have hearing issues?		
Does your eyesight hinder your ability to read, watch television, drive, or perform any other day-to-day tasks?		

In your home have the following safety measures been taken?

	Yes	No
Secured loose rugs and/or carpets		
Functioning carbon monoxide detector		
Functioning smoke alarm		
Well-lit walking areas		
Sturdy stair rails		
Anti-slip floors in shower/bathtub or grab bars in bathroom		

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Please describe your ambulation/mobility status (Please list any use of mobility assistive devices i.e., cane, walker, wheelchair, mobility scooter):

_____

Mode of transportation:

___I drive myself___Someone else drives me___I use public transportation, Uber, Lyft, etc.,

What is the typical serving of vegetable and/or fruits you consume daily?

___ >5 servings ___ 3-5 servings ___ 1-2 servings ___None

	Yes	No
Do you have an Advance Directive (power of attorney and living will)?		
If yes, do you have your Advance Directive in your records with us?		

Patient Name:_____ **Date:**_____

Patient ID #_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	Independence (1 Point) **NO** supervision, direction or personal assistance.	Dependence (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

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