Office Hours By Appointment

Penelope Aikin Jackson, M.D.
Lake Granbury Internal Medicine & Pediatrics, PA
Dual Board Certified Internal Medicine & Pediatrics

2005 Rockview Drive
Granbury, TX 76049
Telephone: 817-579-1005
Fax: 817-579-1093

We provide comprehensive medical care for the entire family.

PATIENT REGISTRATION

PLEASE PRINT *DO NOT PRINT IN THE AREA ABOVE

PATIENT INFORMATION

FIRST NAME: MIDDLE INITIAL:	LAST NAME:	SEX: ☐ MALE ☐ FEMALE
DATE OF BIRTH:	SOCIAL SECURITY:	EMAIL:
HOME ADDRESS: APT. #	CITY: STATE:	ZIP CODE:
HOME PHONE #:	MOBILE #:	WORK #:
EMPLOYER / SCHOOL: FULL TIME ____ PART TIME ____ RETIRED ____ STUDENT ____	EMPLOYER ADDRESS:	PATIENT PREFERRED COMMUNICATION: ☐ HOME PHONE ☐ MOBILE PHONE ☐ PATIENT PORTAL ☐ MAIL TO HOME ADDRESS OF FILE
OCCUPATION: MARITAL STATUS: SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED ____	RACE: ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ AMERICAN INDIAN / ALASKAN NATIVE ☐ BLACK / AFRICAN AMERICAN	ETHNICITY: ☐ HISPANIC / LATINO ☐ NON-HISPANIC / LATINO PRIMARY LANGUAGE:

AUTHORIZED PHONE NUMBER TO LEAVE A MESSAGE: (_____) ____________ PATIENT/PARENT/GUARDIAN SIGNATURE: ____________

EMERGENCY CONTACT INFORMATION

PRIMARY CONTACT:	RELATIONSHIP TO PATIENT:	HOME PHONE:	WORK / OTHER PHONE:

IF PATIENT IS A MINOR, PLEASE PROVIDE US WITH THE INFORMATION BELOW:

MOTHER (LEGAL GUARDIAN): ____________ DATE OF BIRTH: ____________ MOBILE #: ____________

FATHER (LEGAL GUARDIAN): ____________ DATE OF BIRTH: ____________ MOBILE #: ____________

GUARANTOR / RESPONSIBLE PARTY INFORMATION

FIRST NAME:	LAST NAME:	MIDDLE INITIAL:
DATE OF BIRTH:	SOCIAL SECURITY:	SEX:
HOME ADDRESS: APT. #	CITY: STATE:	ZIP CODE:
HOME PHONE #:	MOBILE:	WORK #:
EMPLOYER / SCHOOL: OCCUPATION: FULL TIME ____ PART TIME ____ RETIRED ____ STUDENT ____	EMPLOYER ADDRESS:	RELATIONSHIP TO PATIENT: SELF ____ SPOUSE ____ PARENT ____ OTHER ____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY:	GROUP NAME OR NUMBER:	INSURANCE / MEMBER ID NUMBER:
RELATIONSHIP TO POLICY HOLDER: SELF ____ SPOUSE ____ CHILD ____ OTHER ____	POLICY HOLDER LAST NAME: SEX: DATE OF BIRTH:	FIRST NAME: INITIAL: PHONE:
ADDRESS:	CITY:	STATE: ZIP CODE:

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY:	GROUP NAME OR NUMBER:	INSURANCE / MEMBER ID NUMBER:
RELATIONSHIP TO POLICY HOLDER: SELF ____ SPOUSE ____ CHILD ____ OTHER ____	POLICY HOLDER LAST NAME: SEX: DATE OF BIRTH:	FIRST NAME: INITIAL: PHONE:
ADDRESS:	CITY:	STATE: ZIP CODE:

HOW DID YOU HEAR ABOUT US? ____________

Medical History

General Information

Name: ______________________________ DOB: __ __ / __ __ / __ __ __ __ Age: __________

Social Security Number: __ __ __ / __ __ / __ __ __ __ Sex: ☐ M ☐ F Date (today): __ __/__ __/__ __ __ __

Language(s) spoken: ☐ English ☐ Spanish ☐ Polish ☐ Other: ______________________________

Medical History

Check all current and past problems.

Allergies/hay fever
Anemia
Anxiety problem
Arthritis
Asthma/wheezing
Back pain
Bleeding disorder
Blood transfusion
Bone/joint injuries
Cancer
Chicken pox
Convulsions/seizures
Dementia/memory loss

Dental/oral disease
Diabetes
Depression
Ear/hearing problems
Eating disorder
Eye/vision problems
Foot problems
Gall bladder disease/stones
Gastritis/ulcer
Gout
Headaches/migraine
Heart disease
Heart rhythm problem

Hemorrhoids
Hepatitis
Hernia
Herpes
High blood pressure
High cholesterol
HIV/AIDS
Kidney disease/stones
Liver disease
Lung disease
Menstrual problems
Mental illness
Osteoporosis
Overweight/obesity

Pneumonia
Prostate disorder
Sexual problems
Sexually transmitted disease
Skin disease/sores
Sleep problems
Stomach/digestive disease
Stroke
Thyroid disease
Tuberculosis (or positive TB test)
Urinary problem

Please give details of any items checked, or add information about other problems if they are not listed:

____

____

____

____

Surgical History

List the date and type of any past surgeries.

Date	Surgery	Date	Surgery

Medications

List your medications, prescription or non-prescription, including the dose and how often you take them. Please include all types of medicine, including pills, injections, creams and eye drops.

Medication	Dose and Frequency	Medication	Dose and Frequency

Are you taking or using anything else for your health or to treat symptoms (such as vitamins, herbs or weight loss products)? If so, please list them: ______________________

Allergies and Reactions

List any substances that have caused a bad reaction, and write the reaction.
Please include prescription or non-prescription medicines, foods, plants or other materials.

Substance	Reaction	Substance	Reaction

Personal History and Habits

Your answers will be kept confidential.

General

Are you employed? ☐Yes ☐No If yes, what occupation?: ______________________
Are you? ☐Single ☐Married ☐Divorced ☐Widowed
Are you sexually active? ☐Yes ☐No
Do you have children? ☐Yes ☐No If so, how old are they? ______________________
Who lives with you in your home? ______________________
At home, do you need help getting around, dressing, bathing, using the bathroom, or eating? ☐Yes ☐No
If yes, what do you need help with? ______________________
Do you exercise? ☐Yes ☐No If yes, what activities and how often? ______________________
When was your last dental exam? ______________ Do you wear dentures? ☐Yes ☐No
When was you last vision exam? ______________ Do you wear glasses or contact lenses? ☐Yes ☐No
Have you recently or do you often travel outside the U.S.? ☐Yes ☐No If so, where? ______________

Substances

Do you use tobacco? ☐Yes ☐No
If no, have you ever used tobacco? ☐Yes ☐No
If yes, what type:
☐ Cigarettes How much and for how long: ______________
☐ Cigars How much and for how long: ______________
☐ Chewing tobacco How much and for how long: ______________

In the past year, have you ever drunk or used drugs more than you meant to? ☐Yes ☐No
In the past year, have you ever thought you should cut down on your drinking or drug use? ☐Yes ☐No
Do you ever get annoyed or angry when people talk to you about your drinking/drug use? ☐Yes ☐No
Do you ever feel guilty about your drinking/drug use? ☐Yes ☐No
Have you ever had an "eye-opener" (morning drink) to get started first thing in the morning? ☐Yes ☐No
How many alcohol-containing drinks do you have in a typical week? (one drink is 12 oz. beer, 5 oz. wine, or 1 shot of liquor)
☐0 ☐1-7 ☐8-10 ☐11-13 ☐14-20 ☐21-30 ☐31-40 ☐41 or more

Safety

Have you had any falls within the past 6 months? ☐Yes ☐No
Do you use a cane, walker or other device to help you get around? ☐Yes ☐No
Do you feel unsafe or threatened in any way (at home, work or otherwise)? ☐Yes ☐No
Have you ever been the victim of violence or abuse (including sexual abuse)? ☐Yes ☐No
Have you been hit, kicked or otherwise hurt by someone in the past year? ☐Yes ☐No
Do you feel unsafe in your current relationship? ☐Yes ☐No
Have you been forced to have sex? ☐Yes ☐No
Do you or other family members keep gun(s) in the home? ☐Yes ☐No
Do you wear a seatbelt when you drive? ☐No ☐Yes ☐Sometimes
Do you have smoke detector(s) in your home? ☐No ☐Yes ☐Don't know

Nutrition

What is your usual weight? ______________ What is your usual height? ______________
Have you had decreased food intake for more than one week? ☐Yes ☐No
Have you unintentionally gained or lost 10 pounds in the last month? ☐Yes ☐No
Do you have difficulty swallowing? ☐Yes ☐No
Are you on a modified or special diet, or on tube feeding? ☐Yes ☐No
(For **women**): Are you pregnant or breast-feeding? ☐Yes ☐No

Family History

Please write which family member(s) have or had the following:

Condition	Family Member(s)	Condition	Family Member(s)
Alcohol / substance abuse		High cholesterol	
Cancer, type: ______		Psychiatric illness	
Diabetes		Stroke	
Heart disease/attack		Tuberculosis	
High blood pressure		Other: ______	

Obstetric/Gynecologic History (for **women** only)

Age of first period? ______ If you no longer have periods, at what age did they stop? ______
Please list: Total # of pregnancies? ______ Abortions? ______ Miscarriages? ______
Do you plan to get pregnant within the next year? ☐Yes ☐No
Are you using any birth control? ☐Yes ☐No If yes, what type? ______

Cancer Screening

Breast Cancer (for **women** only):
When was your last mammogram (year)? ______ ☐Don't remember ☐Never had one
Have you ever had an abnormal mammogram? ☐Yes ☐No ☐Don't know

Cervical Cancer (for **women** only):
When was your last Pap smear (year)? ______ ☐Don't remember ☐Never had one
Have you ever had an abnormal Pap smear? ☐Yes ☐No ☐Don't know

Colon cancer (for **men and women over age 50**):
Have you ever had a test to see if you had colon cancer? ☐Yes ☐No ☐Don't know

Prostate cancer (for **men** only)
Have you ever had a rectal examination or a "PSA" blood test? ☐Yes ☐No ☐Don't know

Immunizations Have you ever had the following vaccines?:

Tetanus: ☐Yes, Year (most recent): ______ ☐Never ☐Don't know
Flu: ☐Yes, Year (most recent): ______ ☐Never ☐Don't know
Pneumonia: ☐Yes, Year (most recent): ______ ☐Never ☐Don't know

Advance Directives

Do you have a Living Will (instructions about the medical care you want given if you get very sick)? ☐Yes ☐No ☐Don't know

Do you have a Power of Attorney for health care (instructions about who you want to make medical decisions for you if you are not able to make them)? ☐Yes ☐No ☐Don't know

Would you like more information about a Living Will or a Power of Attorney? ☐Yes ☐No

LAKE GRANBURY INTERNAL MEDICINE AND PEDIATRICS, P.A.

2005 ROCKVIEW DRIVE

GRANBURY TEXAS, 76049

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________

Address: ______________________________

Phone Home: ____________ Date of Birth ____________

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information may invalidate this Authorization.

REQUESTING RECORDS FROM	WHERE TO SEND THE RECORDS
Name/Facilty: ____________	Lake Granbury Internal Medicine & Pediatrics, PA
Address: ____________	2005 Rockview Drive
City: ________ State: ________	Granbury, Texas 76049
Phone: ____________	Phone: 817-579-1005
Fax: ____________	Fax: 817-579-1093

Please send records for the following:

____ Discharge summary ____ Consultation ____ Pathology Reports ____ Labs

____ History & Physical ____ Operative notes ____ Imaging/X-Rays ____ Entire Record

____ Other (Specify)______________________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed.

I understand that the requestor may not further use or disclose protected health care information unless another authorization is obtained, or unless law specifically requires disclosure

The law permits the use or disclosure of protected health care information without authorization for the purpose of coordination of a treatment plan, payment for services and or to evaluate the quality of care you receive.

Signature of Patient or Legal representative: ______________________ Date: ____________

Relationship to Patient: ____________ Witness: ______________________ Exp.____________

LAKE GRANBURY INTERNAL MEDICINE AND PEDIATRICS, PA

2005 ROCKVIEW DRIVE

GRANBURY, TEXAS 76049

MEDICATION REFILL POLICY

- Call your pharmacy and let them know what prescription you need refilled.
- It is your responsibility to notify this office in a timely manner when refills are necessary.
- Approval of your refill can take up to three business days and mail order can take up to fourteen (14) days. Please think ahead and don't wait until you are out of medication to call.
- Medication refills will only be addressed during regular office hours. No prescriptions will be refilled on Saturday, Sundays or Holidays.
- Refills can only be authorized on medication prescribed by Dr Jackson. We will not refill medications prescribed by other providers.
- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every three to six months.
- If you have questions regarding your medications please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.
- New symptoms or events require an appointment. Your provider can not diagnose or treat over the phone.

SIGNATURE: ______________________________ DATE: ______________

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT FOR SERVICES RENDERED

All Patients:

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Lake Granbury Internal Medicine and Pediatrics, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I request this authorization also apply to all other insurance.
I agree to be financially responsible for all charges. I have read this information and understand it.

Patient/Responsible Party: ______________________ Date: ______________

Witness: ____

MEDICARE PATIENTS (LIFETIME AUTHORIZATION)

I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other pertinent information or documentation needed for this or a related Medicare claim. I authorize the physician to submit a claim to Medicare on my behalf. I request the payment for services provided be made directly to the physician. I request this authorization also apply to all other insurance. I agree to be financially responsible for all charges. I have read this information and understand it.

Patient/Responsible Party: ______________________ Date: ______________
Witness: ____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

Due to the HIPAA Act, the following information must be filled out.

I authorize Lake Granbury Internal Medicine and Pediatrics, PA to release any of my medical or insurance information necessary to process my medical claims and coordinate/mange my medical care.

With whom may we discuss information about your care, treatment of Diagnosis?

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

MAY WE CALL YOUR NAME OUT LOUD IN OUR LOBBY? YES NO

May we leave a detailed message?

HOME PHONE: ______________________ YES NO

CELL PHONE: ______________________ YES NO

WORK PHONE: ______________________ YES NO

SIGNATURE: ______________________ DATE: ______________________

LAKE GRANBURY INTERNAL MEDICINE AND PEDIATRICS, PA

2005 ROCKVIEW DRIVE

GRANBURY, TEXAS 76049

FINANCIAL POLICY

It is the policy of this practice to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care in a comfortable, personal and cost effective manner.

Payment is expected at the time of service

Payments made to the practice can be made by cash, check and credit or debit card. Patients seen at the practice for their first visit are required to pay their responsible balance in full. All co-insurance and deductible amounts are due at the time of service. We do our best to include all charges at the time of service. Occasionally, charges may be added or modified after your visit.

Insurance billing

Insurance claims are filed as a courtesy to our patients. You are expected to pay your co-insurance and the balance for any non-covered services at the time of service. We expect payment in full within 60 days for services billed to insurance. **It is your responsibility to pay any balance owed** and to follow up with your insurance company for reimbursement. If we receive a payment from your insurance company after your balance has been paid we will issue you a refund. **It is your responsibility** to contact your insurance company if a claim is denied, paid at a lower rate than you expected or if it is not paid in a timely manner. If we have made an error, we will gladly resubmit a corrected claim.

Credit balance/refunds

Patient refunds will not be processed until all active or past due balances are paid in full. Refunds less than $15.00 will not be refunded unless specifically requested by the patient/guarantor or insurance company.

FINANCIAL AGREEMENT

- I have read the policies above and understand them
- I agree to promptly pay all fees and charges for treatments provided to me and/or my family
- All insurance payments for services rendered are assigned to this office
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full
- I understand that I am to pay all charges after insurance pays this office
- I understand that charges may occasionally be added or modified by my clinician
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance
- I authorize this practice to release to my insurance carrier any medical information needed to obtain payment.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days.
- I authorize this practice and its agents, the use of any telephone number including wireless numbers, provided to them, to message or contact me regarding my account

Do not sign this agreement before you read and agree to the conditions set forth above. You may request a copy of this agreement for your records.

Signature: ______________________ **Relationship:** ______________________

Date: ______________________

LAKE GRANBURY INTERNAL MEDICAINE AND PEDIATRICS, PA

2005 ROCKVIEW DRIVE

GRANBURY TEXAS, 76049

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected heath information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses and Disclosures we may make without written authorization.** We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment: We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you: to provide appointment reminders: or to provide information about treatment alternatives or services we offer.

Payment: We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations: We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting our practice.

Other uses and disclosures: We may also use or disclose your information for certain other purposes allowed by 45 CFR 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state and federal law such as reporting abuse, neglect or certain other events.
- As allowed by worker compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as military or correctional institutions.
- For research purposes if certain conditions are satisfied.

- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors or organ procurement organizations as necessary to allow them to carry out their duties.

Disclosures we may make unless you object: Unless you instruct us otherwise. We may disclose your information as described below.

- To a member of your family, relative, friend or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment

Your rights Concerning Your Protected Health Information: You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, mail at you home address and e-mail if you have given your e-mail address. You may request that we contact you by alternate means or at alternative locations. We will accommodate reasonable requests.
- You inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.

Changes to This Notice: We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Privacy Officer: Jamie Riley 817-579-1005 Ext. 5 or at Jamie@lgimp.com

LAKE GRANBURY INTERNAL MEDICINE AND PEDIATRICS, PA

2005 ROCKVIEW DRIVE

GRANBURY, TEXAS

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BIOTE QUESTIONNAIRE FOR WOMEN

NAME: ______________________________ DATE: ________________________

CHECK ALL SYMPTOMS THAT APPLY

SYMPTOMS	MILD	MODERATE	SEVERE		SYMPTOMS	MILD	MODERATE	SEVERE
FATIGUE					BREAST TENDERNESS			
MEMORY LOSS					VAGIAL DRYNESS			
MENTAL CONFUSION					HOT FLASHES			
DECREASED SEX DRIVE					NIGHT SWEATS			
SLEEP PROBLEMS					DRY WRINKLED SKIN			
IRRITABILITY					HAIR LOSS			
HEADACHES					COLD			
DIFFICULTY CLIMAXING					SWELLING			
BLOATING					JOINT PAIN			
WEIGHT GAIN								

ALLERGY SCREEN

CHECK ALL SYMPTOMS THAT APPLY

SYMPTOMS	YES	NO		
DO YOU HAVE SEVERE ASTHMA, HISTORY OF RESPIRATORY DISTRESS OR ANAPHYLAXIS?				
ARE YOU CURRENTLY TAKING BETA BLOCKERS?				
ARE YOU CURRENTLY PREGNANT?				
	NEVER	SOMETIMES	OFTEN	ALWAYS
RUNNY NOSE, SNEEZING OR STUFFY NOSE				
ITCHY, WATERY OR DRY EYES				
HEADACHE OR SINUS PAIN				
POST-NASAL DRIP OR SORE THROAT				
ARE YOU OFTEN TIRED				
DO YOU EVER HAVE HIVES OR RASH				
HIVES OR RASH WITHIN 2 HOURS AFTER EATING				
SWELLING OF TONGUE OR THROAT WITHIN 2 HOURS AFTER EATING				
DIARRHEA, BLOATING, CRAMPS OR VOMITING WITHIN 2 HRS AFTER EATING				
HOW LONG DO YOU GET RELIEF FROM ALLERGY MEDICATION?				