Med*Thin 7777 Forest Ln. Suite A331 Dallas, TX 75230

New patient information and office policies

Please bring these to your first visit:

1. Medications
2. Insurance card(s) and driver's license
3. Recent medical records
4. Recent laboratory results and EKG
5. Plan to be in our office about 45 min for the first visit.

If your insurance has a co-pay, you will need to pay your co-pay at the time of your visit.

CANCELLATION POLICY: If you need to cancel or re-schedule an appointment, please call at least 24-48 hours in advance. This allows us to make your appointment available to another patient. **We regret that we have to charge a $50 no-show fee if we do not receive 24 hours advanced notice.**

ZERO TOLERANCE POLICY : All of our staff are to be treated with dignity and respect and will not tolerate swearing or use of harmful language, threats or threatening behavior, any form of physical violence, verbal abuse, racial abuse and sexual harassment, persistent or unrealistic demands.
Any form of physical/verbal abuse and/or threatening behavior will result in the immediate removal of a patient from our practice.

If you have any questions, please don't hesitate to call us at 972-566-2734.
We look forward to serving you.

Valerie Liao, MD

Med*Thin 7777 Forest Ln. Suite A331 Dallas, TX 75230

Name: _____Date of Birth: _____

Gender: _____ Social Sec Number: _____

Address: _____

_____

Email address: _____

Cell phone: _____ Home phone: _____

May we leave voice messages on your phone? _____ yes _____ no

Race: _____

Employer: _____

Who may we thank for referring you?

_____

My primary care physician is: _____ Phone number: _____

Marital status: _____ Partner name: _____

Emergency contact name: _____

Phone number of *emergency contact*: _____

Name of person authorized to obtain my medical information: _____

Pharmacy name: _____

Pharmacy Address or phone number: _____

*In order for your prescriptions to be sent electronically to your pharmacy, we need your authorization. Our electronic medical record system can query your pharmacy to obtain up to date information regarding your prescriptions. Because this is privileged and confidential health information, we require your explicit consent to do this.

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Insurance Information

We will scan your insurance card(s) and driver's license into our system. We will file your insurance claim for you.

Primary Insurance company: _____

Subscriber name:_____ DOB: _____

ID number: _____ Group number: _____

Provider service phone number (on back of card): _____

Secondary Insurance company:_____

Subscriber name:_____ DOB: _____

ID number: _____ Group number: _____

Provider service phone number (on back of card): _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This office is committed to compliance with all Federal and State laws that pertain to the privacy and security rules in the Health Insurance Portability and Accountability Act (HIPAA). ln keeping with HIPAA compliance, this office has a Notice of Privacy Practices that is available for review at any time to help our patients increase their understanding of how their private health information is stored, used and shared and to notify them of their patient rights under HIPAA.

Valerie L. Liao MD, P.A. may furnish information to insurance carriers for reimbursement purposes and to referring physicians that are involved in the continuing care of the patient.

lf you have any questions regarding our HIPAA policies, please feel free to contact our office manager. You may also discuss the questions with Dr. Liao.

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Credit Card Authorization Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Cardholder Name (as shown on card): _____

Card Number: _____

CVV Code: _____

Expiration Date (mm/yy): _____/_____

Cardholder ZIP Code (from credit card billing address): _____

I authorize MedThin to charge my credit card above for agreed upon purchases INCLUDING Cancelled appointments, $50 no-show fees (for appointments cancelled with less than 24 hour notice), co-pays, deductibles, balance on office visits, goods and services received. I understand that my information will be saved to file for future transactions on my account.

Cardholder Signature: _____

Date: _____

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I certify that I have read the Med*Thin forms including the:
Office policies, PHI/HIPAA information, Cancellation policy, Zero tolerance policy, PCP waiver, Insurance authorization, Pharmacy consent, and Consent to Treat.

I agree to the terms and conditions set forth in these forms. My signature indicates agreement with all of the following statements:

1. **CONSENT TO TREAT:** I authorize the doctor to perform such examinations, treatments, lab tests, and to administer such medications as, in her/his opinion, are necessary or advisable for myself. I acknowledge that the doctor does not treat anyone under the age of 18 years old.
2. **PHARMACY AUTHORIZATION:** I hereby authorize my confidential pharmacy and prescription information to be released to Valerie L. Liao MD, P.A.
3. **INSURANCE AUTHORIZATION:** I authorize the release of any medical information necessary to process any claims and request payment of insurance proceeds, including any major medical benefits, to Valerie L. Liao MD, PA. This will also serve as authorization for this office to obtain insurance information from Medicare or any other insurance company regarding any claims submitted on my behalf. I understand that I am financially responsible for all charges whether paid by my insurance or not. A copy of these signatures are as valid as the original.
4. **AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION:** By signing this form, I authorize Valerie L. Liao MD, P.A. to use and disclose protected health information (PHI). Your doctor will receive your medical information.
5. **HIPAA:** I HAVE READ AND UNDERSTAND THE PRIVACY PRACTICES OF VALERIE L. LIAO MD, P.A. I understand how to request a copy of my protected health information.
6. **Cancellation and Zero Tolerance Policy**: I agree to abide by these policies as outlined on page 1. I authorize my credit card to be charged for the $50 no-show fee each time that I cancel without 24 hour notice.
7. **PCP WAIVER:** I understand that Dr. Liao will NOT be my primary care physician.

Signature: _____ Date: _____

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Primary Care Physician Waiver

I understand that Dr. Valerie Liao is an Internal Medicine physician and Diplomate of the American Board of Obesity Medicine, who provides Obesity Medicine "subspecialty" services. Dr. Liao will NOT be assuming the role of my Primary Care Physician. She will only provide care that is directly related to excess weight and disease states related to excess weight. Additional medical issues which may be discovered during the course of my evaluation will be referred back to my Primary Care Physician for further workup and treatment. During the time that I am under Dr. Valerie Liao's care, I will continue to have regular appointments with my Primary Care Physician. I will NOT attempt to transfer my primary care to Dr. Liao.

I understand that obesity increases the risk of certain cancers, and I agree to return to my Primary Care Physician for routine cancer screening, which may include:

- Breast cancer screening, pelvic exam and pap smear
- Testicular and prostate cancer screening
- Colorectal cancer screening

I understand that I will need to continue to receive standard preventive medical care, including immunizations, as determined by my Primary Care Physician.

I acknowledge that Dr. Valerie Liao will communicate my medical information to my Primary Care Physician. A copy of this form will be sent to my Primary Care Physician.

My Primary Care Physician is:

_____

Phone number:

_____

Signature of patient: _____Date:_____

Printed name: _____DOB:_____

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MEDICAL RECORD AUTHORIZATION: I hereby authorize my confidential health information to be released to / from Valerie L. Liao MD.

Patient name: _____

Date of Birth: _____

Physician or Facility to provide records:

All _____

Records to be released: _____

___ Last progress notes ___ Lab results ___ Radiology results

___ ALL available records

___ Other: _____

Signature: _____

Date of Signature: _____