# Welcome to Argyle Health Services

We are so happy you have chosen Argyle Health Services to be your primary care provider. Please fill out the enclosed new patient packet completely and sign.

Scheduling appointments: Call our office at 214-518-5016 to schedule your appointment or our office will call you the day before a scheduled appointment to confirm. Please note that if you do not confirm your appointment within 24 hours, your appointment may be canceled.

We normally schedule follow up appointments approximately every 4 weeks depending on your medical needs. For acute issues, please call our office and we will get you scheduled as soon as possible, based on your needs. We try to do same day appointments if medical need dictates, so please do not hesitate to call.

**Office Hours:** Monday through Friday 9:00 am to 5:00 pm. If you call during business hours and leave a message our staff will return your call by no later than the following business day. If a message is left after hours, we will return the call the following business day for non-urgent matters.

**X-rays and Labs:** Normal lab work and x-rays will be discussed at your next scheduled visit. For abnormal labs or abnormal findings, our office will contact you directly for medication changes or directions for appropriate action to resolve your issue.

**Prescription Refills:** For all prescription refills, please call your pharmacy at least 5 days in advance of your medication running out. If there are no refills left, the pharmacy will contact our office to request additional refills. Please ensure the pharmacy has our correct office number and fax number, to ensure a quicker refill process.

**Billing: For all Insurance Patients Please list Dr. Crystal B. Kronenberger, as PCP**

Please Notify your Insurance Provider that you have changed Primary Care Providers to Dr. Crystal B. Kronenberger, MD so that she is listed as your current PCP.
1490 Commons Circle # 200, Argyle,Texas 76226 Phone 214.518.5016

Dr. Crystal B. Kronenberger is the delegating physician over Nurse Practitioners Tracy Cook, Kimberly Kammerer, Amber Snider and Megan Sloan.
Again, thank you for choosing Argyle Health Services.

Office phone: 214-518-5016
Fax:844-713-8346

Argyle Health Services

# New Patient Data Sheet

Name: _____Phone :_____

Date of Birth: _____ Email: _____

Address: _____City,State, Zip_____

Sex: **M** ☐ or **F** ☐ Social Security _____ _

Race: _____ Ethnicity: _____

Medicare : _____ Secondary: _____+_____ ID#:_____

Insurance Plan: _____ Policy#_____ Group# _____

Primary Insurance Card Holder_____ DOB: _____

**Emergency Contacts:**

Name: _____ Email:_____

Address:_____

Phone Number:_____ Cell:_____

**Service Providers:**

Specialist: Name:_____ Type:_____

Phone Number:_____ Fax:_____

Specialist: Name:_____ Type:_____

Phone Number:_____ Fax:_____

Pharmacy:_____ Phone Number:_____

Hospital of Choice:_____

Resident has Living Will: **Y** ☐ or **N** ☐ Medical Power of Attorney: **Y** ☐ or **N** ☐

Do Not Resuscitate: **Y** ☐ or **N** ☐ Please provide copies of all if applicable

Argyle Health Services

Name _____ Date _____

New Patients

Last Doctor: _____

Address: _____

City, State, Zip: _____

Phone : _____

Date Last Appointment _____ Last EKG date _____

Date Last Chest Xray _____ Last Physical _____

Allergies: (Name of Allergan & Type of Reaction)

_____

_____

_____

_____

Medication : (List **all** including over the counter or others no prescribed for you – you may use the back of this form)

Drug Name Strength/Dose How Often Apx. Date Started

Current Medical Problems:

Problem: Doctor: Current Status:

Previous Hospitalizations

Hostpital: Doctor: Reason:

# Consent and Financial Policy

**Patient Name: _____ Date of Birth: _____**

Thank you for choosing AHS as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payment due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

**Please initial in each space below**

**_____ AUTHORIZATION TO MAIL, CALL, OR E-MAIL: NAME_____PHONE #_____**

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize an Argyle Health Services, PLLC representative or my practitioner to mail, call, or e-mail me/ or above mentioned with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the Argyle Health Services PLLC to that effect in writing.

_____**LAB/ X-RAY/ DIAGNOSTIC SERVICES:** I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam, or physical , lab testing, X-Ray, EKG, and any other screening services or diagnostic testing ordered by the practitioner's staff. I understand that I may receive a separate bill for these services.

_____**CONSENT TO TREATMENT:** I hereby consent to evaluation, testing, and treatment as directed by my Argyle Health Services PLLC or his/her designee.

_____**FINANCIAL:** I understand that if my account is not paid in full within 90 days of a statement, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current. **Person Financially Responsible (Guarantor)** if other than patient.

Name: _____ DOB: _____ Relationship to patient: _____

_____**FINANCIAL:** Argyle Health Services will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Argyle Health Services if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT US UP TO ME TO KNOW MY INSURANCE BENEFITS.

_____**FINANCIAL:** I understand that some primary insurances pay only a certain percentage of the visit and the secondary cost is either covered by my secondary insurance or if I do not have a secondary insurance the remaining balance is my responsibility. Also, my insurance may require me to pay a copay when services are rendered.

Copay_____ Costs not covered by primary insurance, excluding deductible: _____

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending practitioner.

**Signature of Responsible Party: _____ Date: _____**

**Assignment of Benefits: We require insured patients to complete assignment of benefits authorizing insurance to remit payment to practitioner's office.**

**I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled private insurance and any other health plans to Argyle Health Services PLLC. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges were or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure payment.**

**Signature of Responsible Party: _____ Date: _____**

Argyle Health Services

Welcome to your personalized Chronic Care Management program& Remote Patient Monitoring

With your enrollment in these programs, we will take a significant step together towards better managing your care and ensuring you receive the highest quality of care available. You will have access to a Chronic Care Manager (CCM) before, during and after normal business hours and weekends. With this program, you will be more engaged with the entire Argyle Health Services team. Our CCM will be in constant communication with your Provider to ensure that there is not a gap in care.

**Chronic Care Manager (CCM) Consent Form**

To better your overall care with us, please follow the tips below:

- Make a list of any questions you may have regarding your care, dietary needs, or lifestyle challenges.
- Please inform our team, right away, if you are admitted to the hospital, visit an Urgent Care Facility or an ER. Contact
- our team with any prescription medications that you need refilled or have not filled.
- We will call to check up on you in between visits and ask that you inform us of any new problems or concerns that may arise.
- The number to reach us at for all health care questions and medication refills is: 214-518-5016 Ext 1
- This program is 100% covered by your insurance and you will never have to pay out of pocket for this, excluding any deductibles. If you receive a bill please contact 214-518-5016

☐ Chronic Care Management

**Remote Patient Monitoring (RPM) Consent Form**

I understand that:

- I am the only person who should be using the remote monitoring equipment as instructed. I will not use the device for reasons other than my own personal health monitoring. I understand that I can only participate in this program with one Medical Provider at a time.
- I will not tamper with the equipment. I understand that I am responsible for any fees associated with misuse of the equipment.
- I understand the devices are the Property of Argyle Health Service and are only designed for the RPM program.

☐ I acknowledge that I received Glucometer Serial # :_____

☐ I acknowledge that I received Blood Pressure Monitor Serial # :_____

☐ I acknowledge that I received Scale Serial # :_____

- The device is meant to collect Readings and transfer those readings to an online website. It is NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7. Call 911 for immediate medical emergencies.
- I am aware my daily readings will be transmitted from the monitor to a website located at www.myhealthconnected.net in a safe and secure manner. I can withdraw my consent to participate in this program, and revoke service at any time by returning the BP Monitor/Cuff, Scale or Glucometer device. Argyle Med Spa & ThoroughCare will securely and confidentially store my collected data, and record and store my readings into my Electronic Medical Record monthly.
- I will do my best to take my Readings every day. I am aware that a Remote Patient Monitoring Qualified Health Professional will only view my readings every 30 days, and that this program is NOT a 24/7 Monitoring Service. I will be contacted every 30 days, by phone, to review and discuss my results and progress.

I, have read and understood the information (Print your name) _____ and consent to participate in the Remote Patient Monitoring program as stated above. I am aware that this consent is valid as long as I'm in possession of the RPM equipment/device. I understand that these devices are the property of Argyle Health Services and if I choose the cancel services I will need to return all devices listed above.

_____

Signature of Patient or Authorized Person (Relationship of Authorized Person) Date: (mm/dd/yyyy)

This program covered by your insurance and you will never have to pay out of pocket for this, excluding any deductibles. If you receive a bill please contact our Billing and Scheduling department.

P: 214.518.5016 Fax: 844.713.8346

# HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION.**

**PLEASE READ IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for purposes required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information (PHI)**

Your protected health information may be used and disclosed by your practitioner, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills to support the operation of the practitioner’s practice and any other use required by law.

**Treatment** We will use and disclose your protected health information to provide coordinate or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you OR you protected health information may be provided to a practitioner to whom you have been referred to ensure that the practitioner has necessary information to diagnose or treat you.

**Payment** Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

**Healthcare Operations** We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician’s practice. These activities include, but are **NOT** limited to:

- **Quality Control**
- **Licensing**
- **Employee Reviews**
- **Training of medical students**

We may use or disclose our protected health information in the following situation without your authorization. These situations include, as Required by Law, Public Health Issues, Communicable Disease Health Oversight, Abuse, or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity, and National Security, Workers Compensation, Inmates, Required Uses, and Disclosures. Under Law, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization, or opportunity to object unless required by law.

**You may revoke this authorization** at any time in writing, except to the extent that your practitioner or the practitioner’s practice has taken an action in relation to the use or disclosure indicated in the authorization.

Argyle Health Services

**Your rights**

The following is a statement of your rights with respect to your Protected Health Information:

**You have the right to inspect and copy your Protected Health Information** Under federal law, however, you may not inspect or copy the following records- psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

**You have the right to request a restriction of you Protected Health Information** This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations. You may, also, request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restrictions and whom they apply.

Your practitioner is not required to agree to a restriction that you may request. If practitioner believes your restriction is unreasonable and it is in your best interest to permit, use, disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the right to request and received confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically or by fax.

**You may have the right to have your practitioner amend your Protected Health Information** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of you Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**- You may complain to the U.S. Department of Health and Human Services. 200 Independence Ave. S.W. Room 509F HHH Building, Washington D.C. 20201. If you believe your privacy rights have been violated by us you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on February 1, 2016.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

**ACKNOWLEDGEMENT**

**Signature below is only acknowledgment that you have received this Notice of our Privacy Practices**

**Print Name:** _____

**Signature:** _____

**Date:** _____

Argyle Health Services

1490 Commons Circle #200
Argyle, TX 76226
Phone: (214) 518-5016
Fax: (844) 713-8346

# Authorization and Request for Release of Medical Information

**Patient Name:** _____
**Last 4 of SSN:** _____
**Date of Birth:** _____

**RELEASE RECORDS ___TO ___FROM**
Argyle Health Services, PLLC
1490 Commons Circle #200, Argyle TX 76226
Phone: (214)518-5016

**RELEASE RECORDS TO FROM**
_____
_____
_____

Request is made and permission is granted to release the following:

_ Admission History and Physical
_ Alcohol or Substance Abuse Records
_ Discharge Summary
_ EKG / Echo / Stress Results
_ Entire Health Record
_ Eye Exam Results
_ Imaging Results
_____ Lab Results
_____ Mammogram Results
_____ Mental Health Records / Notes
_____ Office Visit Notes
_____ Operative / Procedure Reports
_____ Pathology / Biopsy Reports
_____ Treatment of AIDS or HIV records

**Dates of service to include date from**_____ **to** _____

**The purpose of this request is for the following reason(s)**
_ at the request of the individual
_ for continuity of medical management
_ transfer of care to another provider or leaving the area.

**This authorization shall expire on the earlier of 6 months from the date signed, or on (Date)**_____**.**

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Argyle Health Services, PLLC Attention Medical Release Correspondent, at the above address.

I hereby authorize Argyle Health Services(AHS) to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

**Patient Name:** _____
**Patient Signature:** _____ **Date:** _
**Phone:** _____

Legal Representative: _____ Date: _
Relationship: _____

Witnessed by: _____ Date: _

Argyle Health Services

# Credit Card Authorization Form

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

| Credit Card Information |
| --- |
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX<br>☐ Other _____ |
| Cardholder Name (as shown on card): _____ |
| Card Number: _____ CVV:_____ |
| Expiration Date (mm/yy): _____ |
| Cardholder ZIP Code (from credit card billing address): _____ |

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date