**Steven M Pounders, MD, PLLC**
**3500 Oak Lawn, Suite 600**
**Dallas, TX 75219-4373**

**PATIENT INFORMATION UPDATE** ***PATIENT #***_____

Name:_____

Address:_____

City:_____State:_____Zip:_____

Social Security Number: __ __ __ - __ __ - __ __ __ __ Date of Birth: __ __ / __ __ / __ __ __ __

Phone Numbers OK to leave message?

Primary: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ Cell/Home/Work yes no

Secondary: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ Cell/Home/Work yes no

Email: _____ yes no

**DEMOGRAPHICS**

Race:_____ Ethnicity:_____ Preferred Language:_____

**INSURANCE**
Insurance Company:_____

Policy/Member ID#:_____ Group Number:_____

Are you the PRIMARY policy holder? yes no
*If YES, you may skip the next section…if NO, please fill out the next section.*

**POLICY HOLDER INFORMATION**

Name:_____

Address:_____

City:_____State:_____Zip:_____

Social Security Number: __ __ __ - __ __ - __ __ __ __ Date of Birth: __ __ / __ __/ __ __ __ __

**EMERGENCY CONTACT INFORMATION** *Please give the name of someone to contact in case of an emergency.*

Name/Relation:_____

Address:_____ Phone:_____

Name/Relation:_____

Address:_____ Phone:_____

I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to Steven M. Pounders, MD, PLLC for services rendererd. If insurance denies payment, I agree to be personally and fully responsible for payment. I also authorize the release of medical records to any specialist(s) for any referring treatment/consult**. I also understand that I may be charged a fee for missed appointments and cancellations with less than 24 hours notice; $50 for follow-ups and office visits, and $75.00 for a physical/wellness visit or procedure.**
**I also may be charged a $35.00 fee for all insurance/disability related paperwork or physicians statements. Any additional costs involved in collecting an outstanding balance will be the sole responsibility of the patient.**

Patient Signature:_____Date:_____

***PATIENT #*_____**

# STEVEN M. POUNDERS, MD, PLLC
# CONSENT TO USE AND DISCLOSE PROTECTED HEALH INFORMATION

**HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**
Your protected health information will be used by **Steven M. Pounders, MD, PLLC** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

**THE NOTICE OF PRIVACY PRACTICES**
**Steven M. Pounders, MD, PLLC** is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. ***PLEASE REVIEW IT CAREFULLY.***

**YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION**
You may request a restriction on the use of disclosure of your protected health information. However, **Steven M. Pounders, MD, PLLC** may or may not agree to your request to restrict the use of disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or the Office Manager if you would like additional information or clarification.

It is a violation of federal privacy standards if **Steven M. Pounders, MD, PLLC** agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or the Office Manager at the location and contact information listed on the back of the brochure.

**YOU MAY REVOKE THIS CONSENT AT ANY TIME**
You may revoke this consent at anytime; however, **Steven M. Pounders, MD, PLLC** requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect the use and disclosure of your information before the date of your request.

**CHANGES TO PRIVACY PRACTICES**
**Steven M. Pounders, MD, PLLC** reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. **Steven M. Pounders, MD, PLLC** will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

**SIGNATURE**
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to **Steven M. Pounders, MD, PLLC** to use and disclose my health information in accordance with this consent and the notice provided.

_____ _____ _____
Name of Patient *(please print)* Signature of Patient/Date

_____ _____ _____
Patient Representative *(please print)* Signature of Representative/Date

_____
Relationship of Patient Representative to Patient

***PATIENT #*_____**

**STEVEN M. POUNDERS, MD, PLLC**

# Authorization of Use and Disclosure of Protected Health Information

**Appointment Reminders:** The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by e-mail that you have provided to the practice. Prior to your visit, our automated system also calls your phone and gives you a non-specific message that may be left on your answering machine. If you don't approve of these methods and would like alternative reminder methods (i.e., text) please indicate those methods in the space provided.

How would you like to be contacted regarding appointments, treatment, and or other information pertinent to your healthcare for your healthcare provided at Steven M. Pounders, M.D., P.L.L.C.? You will automatically be notified by email of appointments. *(Check all that apply)*

____ Mobile Telephone ____ Home Telephone ____ Work Telephone ____ Text

Other:_____

If you have an answering machine or voice mail, may we leave messages regarding health management, treatment, and or other information pertinent to your healthcare and/or payment for your healthcare provided at Steven M. Pounders, M.D., P.L.L.C.? *(Check one)*

____ YES ____ No ____ N/A Phone Number:_____

If "NO", how else may we contact you regarding this information?

_____

Please list any other restrictions regarding messages or reminders about your healthcare:

_____

**Other Uses and Disclosures:** Disclosure of your health information or its use of any purpose other than those listed in the "Consent to use and disclose protected health information" page of your new patient packet, requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

____ I would like the following restrictions regarding the use and disclosure of my health information:

_____

_____

_____

_____

_____

***PATIENT #*_____**

**STEVEN M. POUNDERS, MD, PLLC**

# Authorization of Use and Disclosure of Protected Health Information (Cont.)

**Persons Authorized to Receive Information:**

Health Information Steven M. Pounders, M.D., P.L.L.C. collects or receives about you may be disclosed to the following persons:

_____

Name of person / Relation / Organization

_____

Name of person / Relation / Organization

**Use and Disclosure of Information:**

_____ I authorize the person(s) listed above to receive ALL health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at STEVEN M. POUNDERS, M.D., P.L.L.C.

_____ I authorize the person(s) listed above to receive only selected health information (i.e. appointment times, etc.), which Include: _____

_____

I do NOT authorize disclosure of my Health information to the following:

_____

**Expiration Date of Authorization:**

This authorization is effecting through one year of the date signed unless revoked or terminated by the patient or patient's personal representative.

**Right to Terminate or Revoke Authorization:**

You may revoke or terminate this authorization by submitting a written revocation to Steven M. Pounders, M.D., P.L.L.C. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

**Potential for Re-disclosure:**

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

***PATIENT #*** _____

**STEVEN M. POUNDERS, MD, PLLC**

## Authorization of Use and Disclosure of Protected Health Information (Cont.)

**Signature:**

_____

Name of Patient (PRINT or TYPE)

_____

Signature of Patient Date

_____

Signature of Patient Representative (if patient cannot sign for self)

_____

Relationship of Patient Representative to Patient

***PATIENT #*** _____

**Steven M Pounders, MD, PLLC**
**3500 Oak Lawn, Suite 600**
**Dallas, TX 75219-4373**

## INSURANCE BILLING, INSURANCE RIGHTS & INSURANCE DISCLOSURE INFORMATION

I, the patient, have made a contact through my employer with an insurance company to provide for third party reimbursement for medical care. As the patient, I am responsible for understanding, fulfilling, and having full knowledge of my insurance benefits, limitations, and restrictions.

I further understand and accept responsibility for complying with all such stated restrictions, limitations and provisions of my individual insurance policy. A failure on my part to comply with my obligations could result in a reduction or denial of my insurance benefits.

As a member of a PPO or a Managed Care Plan, I understand that my insurance company has set forth a system of guidelines to be utilized for reimbursement. By not meeting the guidelines deemed to be my responsibility I may severely limit or restrict my benefits. If I am seen today for a problem and do not have the appropriate referral number, all treatments for said problems could be severely limited or reduced. I accept the responsibility to make sure that I have met my criteria for my insurance company with my individual plan.

I further understand that I may have lab work/blood work that may be covered under my plan. However, this lab work/blood work may not be as inclusive as Steven M. Pounders, MD usually prefers. Blood tests such as HIV Viral Load and Essential Metabolic Analysis are two tests my insurance company may or may not cover under my plan.

**It is my responsibility to understand my policy and if charges are not covered, I will be responsible for them.**

**I also understand that any additional costs involved in collecting an outstanding balance not covered by insurance will be the sole responsibility of the patient, including but not limited to:**
**$30 for NSF/returned check, $35 no-show fee, necessary attorney or collection agency fees, and/or interest.**

_____
Patient Name *(please print)*

_____
Patient Signature

_____
Date

***PATIENT #*** _____

***Last Name:*** _____ ***Date of Birth:*** __ __ / __ __ / __ __ __ __

Current Employer/Position: _____

Previous Employer/Position: _____

Marital Status: *(circle one)* Single Married Partnered Divorced Widowed Separated

**CIRCLE ANY DISEASES THAT YOUR BLOOD RELATIVES ARE KNOWN TO HAVE**:

High Blood Pressure Cancer Heart Attack Diabetes Kidney Disease

Stroke Lung Disease Neurological Disease Blood Disorder Other _____

| **FAMILY HISTORY** | Medical Problem | Current Age or Age at Death |
|---|---|---|
| Mother | | |
| Father | | |
| Brothers | | |
| Sisters | | |
| Grandmother (mother's side) | | |
| Grandfather (mother's side) | | |
| Grandmother (father's side) | | |
| Grandfather (father's side) | | |
| Children | | |

**ALLERGIES**

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

***PATIENT #*_____**

***Last Name:*_____** ***Date of Birth:* __ __ / __ __ / __ __ __ __**

**CURRENT MEDICAL PROBLEMS or SYMPTOMS**

_____ _____
_____ _____
_____ _____
_____ _____

**PAST MEDICAL PROBLEMS *(please indicate dates*)**

_____ _____
_____ _____
_____ _____
_____ _____

**INURIES or ACCIDENTS (*please indicate dates)***

_____ _____
_____ _____
_____ _____
_____ _____

**OPERATIONS *(please indicate dates)***

_____ _____
_____ _____
_____ _____
_____ _____

**SMOKING HISTORY**

**NON**smoker **PREVIOUS** smoker
**CURRENT** smoker less than one pack a day more than pack a day

**ALCOHOL HISTORY**

**NON**drinker **SOCIAL** drinker **MODERATE** drinker

**HEAVY** drinker drinks per week_____

***PATIENT #*_____**

***Last Name:*_____** ***Date of Birth:* __ __ / __ __/ __ __ __ __**

**WEIGHT:** *(list usual weight in pounds)*_____ **HEIGHT**:_____feet_____inches

**EXERCISE HISTORY:** *(circle one)*

NONE OCCASIONALLY FREQUENT

**DIETARY HISTORY:** *(circle one)*

Regular Diet *(no restrictions)* Low Salt Low Cholesterol

Diabetic Vegetarian No Red Meat Weight Reduction

Other

**CURRENT MEDICATIONS *(include over the counter medicines)***

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

****Name of Current Pharmacy or Pharmacy most convenient to you:**

**Pharmacy Name: _____**
**Phone: _____**
**Address: _____**

**GYNECOLOGICAL HISTORY *(women only)***

Date of last menstrual period __ __ / __ __ / __ __ __ __ Number of pregnancies _____

Number of Deliveries _____ Last PAP smear __ __ / __ __ / __ __ __ __

Last mammogram __ __ / __ __ / __ __ __ __ Do you examine your breast regularly? yes no

***PATIENT #_____***

***Last Name:_____*** ***Date of Birth: __ __ / __ __/ __ __ __ __***

## HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING?

***(circle all that apply)***

Weight Loss
Weight Gain
Loss of Appetite
Fever
Night Sweats
Headaches
Visual problems
Hearing Loss
Ringing in Ears
Nosebleeds
Hoarseness
Difficulty Chewing
Difficulty Swallowing
Thyroid problems
Pneumonia
Asthma
Bronchitis
Coughing up Blood
Shortness of Breath
Palpitations
Change of Bowel Habits
Blood in Stool
Abdominal Pain
Nausea or Vomiting
Skin Rash

Frequent Urination
Burning During Urination
Blood in Urine
Kidney Stones
Impotence
Hot Flashes
Hernias
Hemorrhoids
Muscle Aches
Joint Pains
Excessive Fatigue
Intolerance to Cold
Intolerance to Heat
Swelling of the Feet
Fainting
Loss of Balance
Difficulty with Speech
Paralysis
Weakness
Insomnia
Lack of Sexual Drive
Vaginal Discharge
Irregular Periods
Painful Menstrual Periods

***PATIENT #*_____**

***Last Name:*_____** ***Date of Birth:* __ __ / __ __/ __ __ __ __**

**VACCINATION/IMMUNIZATION HISTORY:**

Date of last Tetanus Shot: ___ ___ / ___ ___ / ___ ___ ___ ___

**Have you had any of the following?**

| | | | |
|---|---|---|---|
| **Influenza (flu shot)** | **yes** | **no** | **date_____** |
| **Twin Rx** | **yes** | **no** | **date_____** |
| **Hepatitis A** | **yes** | **no** | **date_____** |
| **Hepatitis B** | **yes** | **no** | **date_____** |
| **Pneumovax** | **yes** | **no** | **date_____** |
| **MMR (measles, mumps, rubella)** | **yes** | **no** | **date_____** |
| **TB/PPD Skin Testing** | **yes** | **no** | **date_____** |
| **Pneumococcal Vaccine** | **yes** | **no** | **date_____** |
| **Haemophilus Influenza Vaccine** | **yes** | **no** | **date_____** |

Please list additional Vaccinations/Immunizations

_____ _____
_____ _____
_____ _____
_____ _____

***PATIENT #*_____**

**Steven M Pounders, MD, PLLC**
**3500 Oak Lawn, Suite 600**
**Dallas, TX 75219-4373**
**214-520-8833 Fax 214-520-2956**

## REQUEST FOR RELEASE OF MEDICAL RECORDS

***PATIENT RECORDS AND INFORMATION PERTAINING TO:***

Patient Name:_____

Address:_____

City:_____State:_____Zip:_____

Social Security Number: __ __ __ - __ __ - __ __ __ __ Date of Birth: __ __ / __ __ / __ __ __ __

Phone Number: __ __ __ - __ __ __ - __ __ __ __

***I AUTHORIZE***:
Name of Disclosing Doctor/Party:_____

Address:_____

City:_____State:_____Zip:_____

Phone Number: __ __ __ - __ __ __ - __ __ __ __ Fax Number: __ __ __ - __ __ __ - __ __ __ __

***to dispose to:***

**Steven M Pounders, MD, PLLC**
**3500 Oak Lawn, Suite 600**
**Dallas, TX 75219-4373**
**214-520-8833 FAX 214-520-2956**

I, _____requesting and authorizing that any and all medical information pertaining to my diagnosis and treatment be released to Steven M. Pounders, MD, PLLC to include Laboratory, EKG, Stress Tests, Echoes, Nuclear Studies, Hospital Admission and Discharge Summaries, Medical Treatment and Treatment Progress, or information (including information regulated by 42 USC Section 290dd3 (alcohol) and 290ee3 (drug abuse) and mental information regulated by TEX,CIV,STAT.ANN, Article 5561H, 5547-87, Texas Rule of Evidence, Rule 510, and Article 4419(b)-1, VTCS (HIV). The releases of my records are so that I may continue to receive medical care. I understand that my medical records (including alcohol, drug abuse, and mental status information and HIV test results) are protected by Federal Regulation and/or State Law. I also understand that I may revoke this consent at any time, except for action which was taken based on it, by sending written notification to the practice's Privacy Contact at 3500 Oak Lawn, Suite 600, Dallas TX 75219. The office of Steven Pounders, MD, PLLC will condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This consent will expire in 90 days.

_____ _____
Signature of Patient, Parent, Guardian, or Legal Representative Date

***This information is confidential pursuant to Federal and State Law and is protected from further disclosure without the specific written consent of the above individual(s).***

**Steven M Pounders, MD, PLLC**
**3500 Oak Lawn, Suite 600 Dallas, TX 75219-4373**
***(Corner of Oak Lawn and Lemmon Ave)***
*Office* **214-520-8833** *Fax* **214-520-2956**

# PATIENT FREQUENTLY ASKED QUESTIONS

## *Office Hours:*

| | | |
|---|---|---|
| Monday, Tuesday, Wednesday | 8:00am - 5:00pm | (lunch 12pm-1pm) |
| Thursday | 10:00am - 7:00pm | (lunch 3pm-4pm) |
| Friday | 8:00am - 3:00pm | (lunch 12pm-1pm) |

## *Telephone Options:*

**Option 1 –** Healthcare Providers or Medical Representatives
**Option 2 –** General Information (Fax, Address, Etc)
**Option 3 –** Scheduling
**Option 4 –** Insurance and Billing
**Option 5 –** Your Providers and Medical Assistants
- **Sub-Option 1 –** Dr. Pounders' Medical Assistant Andrea (direct ext 218)
- **Sub-Option 2 –** Dr. Nyland's Medical Assistant C.C. (direct ext 205)
- **Sub-Option 3 –** Trew's Medical Assistant Chris (direct ext 217)
- **Sub-Option 4 –** Cameron's Medical Assistant Clint (direct ext 207)
- **Sub-Option 5** – Chad's Medical Assistant Kelly (direct ext 206)

**Option 6 –** Laboratory Technicians
**Option 7 –** Chronic Care Management (direct ext 212)
**Option 8 –** All Other Inquiries

## *Referrals/Precerts/Prior-Auths/Diagnostic Testing:*

**There is a 48 hour turnaround time for all Referral/Precerts.** Our medical staff will call or fax a request to the insurance company to obtain a referral number. If you are given a referral list, you should call to make your own appointment, which will generally be 2-3 weeks from the date of your call. As your appointment with the specialist nears, if you have not heard from our office regarding your referral/precert number, please dial Option 5 to reach the appropriate medical assistant and obtain this information. Most specialty doctors' offices do not see you unless you have the required referral/precert number. Diagnostic tests are generally set within 24 hours by our staff.

## *Prescription Refills:*

***Please call your pharmacy FIRST*** for refills and allow two to three full business days/48-72 hours to process. Mail order renewal prescriptions may take up to three (3) full business days. **Make refill arrangements prior to running out of your medications.** Controlled substance prescriptions refills can be done over the phone as long as your follow up appointments are scheduled with your provider. Please dial Option 5 to contact your provider's medical assistant for refill requests.

## *Blood Draws/Lab Test Information/Results:*

Generally, your blood is drawn and testing completed one to two weeks prior to next your scheduled office visit in order to review the results with you one-on-one. All lab appointments are scheduled and tests are ordered by the provider. Lab blood draws are conducted ***by appointment only*** each day. Please direct any questions concerning lab bills to Option 4. To have your lab orders sent out to a patient service center, please select Option 6, and leave the center's information with the laboratory technician. **HIV test results are never given over the phone; you must schedule an office visit to retrieve these results.**

## *Allied Health Professionals:*

In order to better facilitate your health care and allow more flexible scheduling of appointments, this office utilizes Physician Assistants (PA) and Nurse Practioners (NP); this Allied Health Professional is well trained in the delivery of medical care, including preventative care, and reports directly to Dr. Pounders and Dr. Nyland. D. Trew Deckerd, PA-C, Cameron Wyatt, FNP-C, and Chad Crager FNP-C are certified nationally and licensed by the State of Texas. ***You have a choice to see any provider at any time.***

***Same day cancellation of your appointment and/or no show will incur a fee of $50.00 for follow-ups and office visits and $75.00 for physical/wellness visits and procedures. NSF/Returned check fee is $35.00.***

*Dr. Steven M. Pounders has hospital privileges at Baylor University Medical Center, Presbyterian Hospital of Dallas, and UT Southwestern.*