860 Airport Fwy, #525
Hurst, TX 76054
Office: 817-522-1530 | Fax: **888-831-3531**
E-mail: **newpatients@pssdfw.com**

New Patient Demographics

Please contact our office if you do not hear from us within 24 hours of submitting this paperwork.

Patient Information (Please Print Clearly)

Last Name_____First Name _____Middle Initial__Nickname_____

Community Name _____Room #_____

Address_____

City_____State _____Zip Code _____

Home Phone _____Cell _____E-Mail_____

Date of Birth _____SS#_____ Gender (Circle One) Male / Female

***Who should we contact before/after appointments, if needed?** _____

Phone Number _____Relationship to Patient _____

Race:
___American Indian or Alaskan Native
___Asian
___Black or African American
___Native Hawaiian or Other Pacific Islander
___White
___ Unknown/Other _____Declined to state

Ethnicity:
____Hispanic or Latino
____Not Hispanic or Latino
____Unknown
____Other
____Decline to state

Preferred Language:
____Chinese ____Russian
____English ____French
____Portuguese ___Spanish
____Italian ____Japanese
____Russian
____Decline to state

Vaccines:
Flu vaccine received **THIS YEAR?** _____ If not current year, when last? _____
Pneumonia vaccine received? _____
Shingles vaccine received? _____
Covid-19 vaccine received? _____Manufacturer: Moderna or Pfizer Vac #1 ____ Vac #2 ____
Booster #1 ____ Booster #2____ Booster #3____

Are you currently receiving Home Health or Hospice care? If yes, which agency? _____

Where are you moving from (Home, Rehab, Out of State, etc. Why new doctor? _____

Insurance Information

Please e-mail or fax copies of both the front and back of primary and secondary insurance cards.

Medicare #_____Provider Services Phone # (Usually on Back of Card) _____

Secondary Insurance_____ ID #_____Provider Services Phone #_____

If VA, please provide Veteran name_____Veteran SS#_____

Patient Name _____ Date of Birth _____

To Whom Should Bills Be Sent? Circle One: Patient / Other

If Other, Please Provide:

Full Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Relationship to Patient _____

Emergency Contact _____ Phone _____

E-mail _____ Relationship to Patient _____

Is there a Medical Power of Attorney? Please provide documents. Name: _____

Personal/Social History

Married / Divorced / Widowed / Single (circle one) Children _____

Previous Occupation _____

History of smoking: Yes / No If yes, are you still smoking? _____ When did you quit? _____

Do you currently drink alcohol? Yes / No If yes, how much/how often? _____

History of Alcohol or Drug Dependence or abuse? Yes / No If yes, explain. _____

Food or Drug Allergies: Yes / No If yes, please list and describe reaction:

_____

_____

_____

Family History (Mother / Father / Brother / Sister)

___Hypertension, heart disease, heart attack
___Diabetes
___Cancer: throat, lung, brain, other: _____
___ COPD
___Alzheimer's Disease
___Other _____
____ Aortic aneurysm
____ Parkinson's Disease

Functional Limitations

Needs assistance with:
___ dressing
___ bathing
___ medication management
___ toileting / incontinence care
___ feeding: special diet _____
___ uses cane
___ uses wheelchair ___ uses power wheelchair
___ uses walker ___ uses motor scooter

Height: _____

Weight: _____

Hospitalizations in past year: _____

Falls in the past month: _____

When sending in new patient forms, please include copies of any legal documents including:
Medical Power of Attorney, Financial Power of Attorney, DNR, along with anything else that should be included in our medical chart.

Patient Name _____ Date of Birth _____

Medication and Pharmacy Information

Name of Pharmacy _____

Address _____

Phone Number _____ Fax _____

Please attach/include a current list of all medications being taken.
(Facility medication list preferred)
Be sure to indicate dosage and frequency of the medications.

Past and Current Medical History

____ Allergies (Hay Fever)
____ Anemia
____ Anxiety
____ Asthma
____ Atrial Fibrillation
____ Back Pain
____ Blood Clot in Leg/Lung
____ Broken Hip
____ Congestive Heart Failure
____ COPD/Emphysema
____ COVID-19
____ Decubitus Ulcer
____ Cancer (type)
____ Dementia / Alzheimer's
____ Dementia / Lewy Body
____ Diabetes - on Insulin
____ Diabetes - on Oral Medication
____ Difficulty Swallowing
____ Edema
____ Falls
____ Heart Attack
____ High Cholesterol
____ Hypertension
____ Hypothyroidism
____ Kidney Disease
____ Depression
____ Osteoarthritis (old age arthritis)
____ Osteoporosis
____ Parkinson's
____ Pneumonia
____ Restless Leg Syndrome
____ Rheumatoid Arthritis
____ Seizures
____ Sleep Apnea
____ Stomach Ulcer
____ Stroke
____ Urinary Incontinence
____ Urinary Retention/Catheter
____ Urinary Tract Infections

_____

____ Other (please list):

_____

_____

Surgical History (please list type and year)

____ Cataracts
____ Heart Surgery
____ Gall Bladder
____ Other: _____
____ Hysterectomy
____ Lung Surgery
____ Breast Surgery
____ Tonsillectomy
____ Total Hip or Knee Replacement
____ Pacemaker / ICD

_____

_____

_____

Any concerns you wish to discuss? _____

_____

_____

Authorization and Agreement for Services

Patient Name_____ **Patient Date of Birth** _____

Consent to Treat: I hereby authorize employees and agents, including physicians, psychiatrists, podiatrists, nurse practitioners, physician's assistants, and nurses of Physician Senior Services, PLLC to render routine medical care as they deem necessary to the patient indicated on this form. This can include ordering labs, imaging, and coordination of prescriptions with a pharmacy. I also authorize Physician Senior Services to perform coordination of my care which can include Chronic Care Management (CCM), Care Plan Oversight (CPO) or Advanced Primary Care Management (APCM). The duration of this consent is indefinite and continues until revoked in writing.

Financial Responsibility: I hereby authorize payment of medical benefits for services rendered to Physician Senior Services. This can include services provided by Physician Senior Services, or by entities that are utilized in my care (ex: x-ray, lab services, etc.). I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct and request payment be made on my behalf. I further understand that although my Medicare/insurance coverage has been verified, there is no guarantee they will reimburse Physician Senior Services for services rendered and I am financially responsible for any unpaid balance.

Release of Information: I understand as part of the provision of healthcare services, Physician Senior Services creates and maintains health records and other information describing, but not limited to, my health information, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I hereby authorize Physician Senior Services to release written, verbal, or electronic information, when the information is required for treatment, payment, business operations, surveyors, or government representatives. I understand by signing this form, I consent to the use and disclosure of protected health information.

Privacy Notice Acknowledgment: I have been provided with a Notice of Privacy Practices providing a more complete description of the uses and disclosures of certain health information in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand I have the right to review the notice prior to signing this consent. I understand Physician Senior Services 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 I have the right to object to the use of my health information for directory purposes and I have the right to request restrictions as to how my health information may be used. By signing this form, I acknowledge each of the above paragraphs, including Consent to Treat, Financial Responsibility, Release of Information, and Privacy Notice Acknowledgement. The duration of this authorization is indefinite and continues until revoked in writing.

Patient or Responsible Party (Printed Name)	Responsible Party Relationship to Patient
Patient or Responsible Party (Signature)	Date

Medical Record Release Form

Patient Name_____ **Patient Date of Birth** _____

Social Security Number _____ Telephone Number _____

Address_____

City_____ State _____ Zip Code _____

Please release to:

Physician Senior Services, PLLC
860 Airport Fwy, #525
Hurst, TX 76054

Office: 817-522-1530
Fax: 817-523-8667
Email: office@pssdfw.com

Please release all records including, but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I hereby authorize the release of medical records as provided above.

Patient or Responsible Party Printed Name

Responsible Party Relationship to Patient

Patient or Responsible Party Signature

Date

PHYSICIAN SENIOR SERVICES

Name	Title / Email	Telephone	Fax
Main Office	office@pssdfw.com	817-522-1530	1-817-523-8667
New Patient Intake	newpatients@pssdfw.com	817-522-1530	1-888-831-3531

Providers	
Kim Higgins, DO, FAAFP, HPM, HMDC	Owner / Physician
Christy Jones, MSN, APRN, FNP-C	Nurse Practitioner
Aaron Cain, MSN, APRN, AGNP-C	Nurse Practitioner
Darian Bradford, MSN, APRN, FNP-C	Nurse Practitioner

Administrative		
Brian Stover, LVN	Practice Administrator brian@pssdfw.com	Practice operations, customer service, staff management, facility relations, third party/vendor relations
Barbara Hoover	Insurance/Credentialing barbara@pssdfw.com	Billing/Insurance, patient and insurance payments, credentialing
Susan Rios	Admin. Service Coordinator I susan@pssdfw.com	New patients, insurance verification, scheduling new appointments, physician referrals, patient charts, 485s
Chad Thomas	Admin. Service Coordinator II chad@pssdfw.com	Office based administrative tasks
Niki Stover	Admin. Service Coordinator III niki@pssdfw.com	Home Health Documentation (485's), office-based admin.

Clinical Support		
Kerri Walker, LVN	Clinical Support Nurse kerri@pssdfw.com	Clinical & operations support
Christine Casey-Strock, NRCMA	Medical Assistant christine@pssdfw.com	Provider relations/communications, orders, refills, etc.
Gracie Parsons, CCMA	Medical Assistant gracie@pssdfw.com	Provider relations/communications, orders, refills, etc.

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Patient Disclosure Authorization Form

Patient Name_____ **Patient Date of Birth** _____

I authorize disclosure of my protected health information to the below specified persons only.

(These are the only people that we can/will discuss or share your health information with, outside of other partners in your healthcare.)

Please list anyone that you want to keep informed of your care; spouse/children/partner/caregiver, etc.

Person(s) or entity(ies) to whom Physician Senior Services may give my information:

Name/Phone/Relation: _____

Name/Phone/Relation: _____

Name/Phone/Relation: _____

Name/Phone/Relation: _____

Name/Phone/Relation: _____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to Physician Senior Services, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- Physician Senior Services will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Patient Signature _____ Date _____

Patient Guardian/Power of Attorney Signature _____ Date _____

If not signed by patient; Guardianship or Power of Attorney documentation must be provided to Physician Senior Services before this authorization is effective.

860 Airport Fwy, #525
Hurst, TX 76054
Office: 817-522-1530
Fax: 1-817-523-8667

Frequently Asked Questions

How do I become a Physician Senior Services patient?
To become a patient of our practice, please **fill out completely and sign** our new patient packet, which includes: *New Patient Demographics* (three pages), *Authorization and Agreement for Services*, *Medical Record Release Form*, and *Patient Disclosure Authorization Form*. All forms need to be mailed, faxed, or e-mailed to our office. Someone from our office will call you when we receive your paperwork. We will then verify your insurance and call you back to schedule your first appointment.

How do I schedule appointments?
Our office will schedule appointments for you approximately every four weeks, depending on your medical needs. If you need an appointment because of an acute issue, then call our office and we will help you decide if a Provider or home health visit is needed.

What are Physician Senior Services office hours?
Our office staff is available to take your calls between 9:00am – 12:00 noon and 1:00 pm – 4:00pm. If you call during off hours, you may leave a message on our office voicemail or speak with our after-hours message service and someone will return your call. *The after-hours message service is for **urgent** calls that cannot wait until the next business day*.

When can I expect a return call after I leave a message?
Our office staff strive to return calls on the same day they are received. If a call comes in after 2:00 pm, it may be returned on the next business day. Providers may ask a staff member to return your call, depending on the nature of the call and their availability.

Can a Provider see me the same day I call with a problem?
Unfortunately, in most instances a Provider will not be able to see you on the same day you call with a problem. Our Providers have full schedules at many facilities. Our office nurse in most instances can listen to your symptoms and contact your Provider for a solution. The nurse can schedule a visit with your Home Health nurse, order X-rays, labs, or medications based on guidance from your Provider.

Are Physician Senior Services providers available 24 hours a day?
No. We have an after-hours message service that take your call and forward your message to our on call provider. The provider will review the message and order meds or tests as necessary. If it is not an emergency, then they will resolve your issue on the next business day.

I cannot make it to my loved one's appointments, can a Provider call me after every visit?
Your loved one's provider is not able to call you after every visit; however, either the provider or someone from our office will contact you for medication changes or if an acute issue arises. Upon request, we can send you a copy of the provider's visit notes.

When will I hear about X-rays or lab work?
Normal lab work will be discussed at your next appointment. If there are any positive results you will be contacted by our office nurse or your Provider. Appropriate action will be taken to resolve your problem. Medications will be ordered or you will be provided with a referral to a specialist, if necessary.

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Physician Senior Services
Prescription Refill Request Policy

1. All medication refill requests will be completed within 72 hours from the time we receive the request.
2. Please **submit your request to your pharmacy** at least a week in advance of when your prescription is empty. If there are no refills left, the pharmacy will contact our office to request additional refills.
3. Refills are processed Monday through Friday; a refill received on a weekend (Friday after 2:30 pm – Monday at 9:00 am) will not be processed until Monday afternoon.
4. Medication requests for new patients who have not been seen by a PSS provider are NOT guaranteed. The provider must review the patient's history to determine if a medication can be filled prior to an initial visit.
5. All medication requests can be faxed to **1-817-523-8667** or e-mailed to **office@pssdfw.com.**
6. For questions please call our office at **817-522-1530**.

Thanks,

Dr. Kim Higgins & PSS Staff

PHYSICIAN
SENIOR SERVICES

INTAKE – NEW PATIENTS / ORDERS

For NEW PATIENTS, please send the following information to our office:

1) **PSS New Patient Packet**
2) **Facility Face Sheet and Insurance Information (please include copy of front and back of all patient insurance cards)**
3) **Patient's Current Medication List**
4) **Patient's DNR/POA or MPOA/Guardianship papers**

Please ONLY send information pertaining to NEW PATIENTS to:

FAX **888-831-3531**

EMAIL newpatients@pssdfw.com

OR susan@pssdfw.com

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ALL ORDERS AND OTHER COMMUNICATIONS SHOULD BE SENT TO:

FAX **1-817-523-8667**

EMAIL office@pssdfw.com

Thank You! ☺

PHYSICIAN
SENIOR SERVICES

860 Airport Fwy, #525
Hurst, TX 76054
Office: 817.522.1530
Fax: 1-817-523-8667

Re: Medicare Annual Wellness Visit

Beginning January 1, 2011, Medicare began covering an "Annual Wellness Visit." The Annual Wellness Visit is not the same thing as your yearly physical exam with your doctor. Medicare is very specific about what your "Annual Wellness Visit" includes and excludes. One of my nurses will see you for this visit in your community home every year.

At your Annual Wellness Visit, my nurse talks with you (and community nurse and caregivers, as some are unable to answer these questions) about your medical history and makes a personalized care plan to keep you healthy. This visit does NOT include a hands-on exam and you will NOT be charged for the Annual Wellness Visit, as it is ***entirely*** paid for by Medicare.

Information needed during your Annual Wellness Visit includes:

- The names of all of your doctors and their specialties (cardiologist, neurologist, urologist, etc.)
- Do you have a Medical Power of Attorney, Advance Directive or a DNR (do not resuscitate)? If yes, please provide a copy at your Wellness Visit.
- Current Medication List (will obtain from community nurse) - we will do a medication reconciliation to ensure all orders/prescriptions are current.

(Most of these things we can get from the community or your Provider's notes)

We appreciate the trust you put in us to care for your health needs, and look forward to serving you.

Sincerely,

Kim Higgins, DO

860 Airport Fwy, #525
Hurst, TX 76054
Office: 817-522-1530| Fax: 888-831-3531
E-mail: office@pssdfw.com

Privacy Officer: **Effective Date:**

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.