Lomibao
RHEUMATOLOGY & WELLNESS CARE

Patient Information

Last_____ First_____ M_____

DOB_____/_____/_____ Sex circle one: Female Male SS#_____-_____-_____

Cell Phone_____ Home Phone ☐ check here if same as cell_____

Email_____

Address_____
Street City State Zip

Emergency/Alternate Contact

Last_____ First_____ M_____

Relation_____ Phone_____ Email_____

Employer ☐ check here if not employed

Name_____ Phone_____

Address_____
Street City State Zip

Primary Insurance

Name_____ Phone_____

Group_____ ID_____

Address_____
Street City State Zip

Primary Insured ☐ check here if same as patient

Last_____ First_____ M_____

DOB_____/_____/_____ Relationship to Patient_____

Phone_____ Email_____

Address_____
Street City State Zip

Secondary Insurance ☐ check here if none

Name_____ Phone_____

Group_____ ID_____

Address_____
Street City State Zip

7700 Lakeview Pkwy Suite 300A
Rowlett, TX 75088
Phone: 469-825-4010
Fax: 469-825-4020

Last_____ First_____ DOB_____/_____/_____

Secondary Insured ☐ check here if same as patient ☐ check here if same as primary insured

Last_____ First_____ M_____

DOB_____/_____/_____ Relationship to Patient_____

Phone_____ Email_____

Address_____
Street City State Zip

Referring Provider

Last_____ First_____

Phone_____ Fax_____

Address_____
Street City State Zip

Primary Care Provider ☐ check here if same as referring provider

Last_____ First_____

Phone_____ Fax_____

Address_____
Street City State Zip

Pharmacy - Local

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Pharmacy - Mail Order ☐ check here if none

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Demographics - Please circle one of each of the following:

Marital Status	Race	Ethnicity	Language
Annulled	American Indian/Alaskan Native	Declined to specify	English
Divorced	Asian	Hispanic or Latino	Other
Domestic Partner	Black or African-American	Not Hispanic or Latino	Spanish
Legally Separated	Declined to specify	Other	
Married	Multiracial more than one race		
Single	Native Hawaiian or Other Pacific Islander		
Widowed	White		

Last_____ First_____ DOB_____/_____/_____

Patient Preference Regarding Communication of Personal Health Information

I hereby grant permission for Lomibao Rheumatology & Wellness Care, PLLC to disclose and discuss any information related to my medical condition(s) with the following individual(s), if requested by said individual(s):

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

☐ I do not wish to grant permission for any individual(s) to have access to any information regarding my medical condition(s).

Last_____ First_____ DOB_____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received, reviewed, and understand the HIPAA Notice of Privacy Practices ("HIPAA Notice") on behalf of the Lomibao Rheumatology & Wellness Care, PLLC. I acknowledge that the HIPAA Notice describes Lomibao Rheumatology & Wellness Care, PLLC's policies and procedures regarding the use and disclosure of my protected health information created, received, transmitted, and maintained by the Lomibao Rheumatology & Wellness Care, PLLC.

In addition, by signing below, I acknowledge and agree to authorize the Lomibao Rheumatology & Wellness Care, PLLC to communicate the Notice via e-mail and my health information through the use of phone, voicemail, e-mail, text message, electronic communications, telehealth technology, and personal communication as well as including electronic communication for announcements, newsletters, or other similar purposes as permitted under applicable law.

_____ _____

Patient Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF

Financial Policy, Billing Procedures, Card on File Policy

Appointment Confirmation Policies

Forms & Medical Records Copies Policies

Medication Refill & Controlled Substance/Psychoactive Drugs Policies

Texas Medical Board Notice

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the above Policies and Notices of Lomibao Rheumatology & Wellness Care, PLLC.

_____ _____

Patient Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF Emergency Room Disclaimer

For medical urgent situations and emergencies we advise you to go to the nearest emergency room or to call 911. There is no overnight, weekend, holiday call coverage, and there is no call coverage whenever the office is closed for other reasons. PLEASE REPORT TO THE NEAREST EMERGENCY ROOM.

_____ _____

Patient Signature **Date**

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Last_____ First_____ DOB_____/_____/_____

Consent to Receive Medical Care

I hereby authorize Lomibao Rheumatology & Wellness Care, PLLC and any employee working under direction of the physician to provide medical care for me. This medical care may include services and supplies related to my health and may include but not limited to preventive, diagnostic, therapeutic, rehabilitative, maintenance, counseling, assessment or review of physical or mental status/function of the body. This consent includes contact and discussion with other health care professionals for care and treatment.

_____ _____

Patient Signature **Date**

Consent for Telemedicine

1. I hereby authorize Lomibao Rheumatology & Wellness Care, PLLC to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition(s).

2. I understand that it is my responsibility to set up and learn how to use the telehealth system *prior* to my scheduled appointment time.

3. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

4. I accept that the professionals intend to offer the telehealth sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

5. I understand that my current insurance may not cover the fees for telehealth practices and I may be responsible for any fee that my insurance company does not cover for this service.

_____ _____

Patient Signature **Date**

☐ check here if declines telemedicine

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Last_____ First_____ DOB_____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF COVID-19 Risk Patient Informed Consent

By signing below, I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment visit, and I give express consent for my Lomibao Rheumatology & Wellness Care, PLLC provider and staff at this location to proceed with treating me. I am hereby informed that this notice is downloadable on the company website and will be posted to my online portal.

I represent that I have been practicing all current CDC guidelines with respect to “social distancing,” and, to my knowledge, I neither have symptoms of COVID-19, have COVID-19, nor have I been in contact with a person who has tested positive for, or who is suspected to be positive for, COVID-19.

By signing below, I hereby acknowledge and represent that I have: (i) been informed by Lomibao Rheumatology & Wellness Care, PLLC of its desire to protect its patients, staff, and the community at large; and (ii) been given the option to defer my treatment to a later date.

_____ _____

Patient Signature **Date**

CDC Notice COVID-19 Screening

1. Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?	**YES**	**NO**
2. Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
3. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
4. Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

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Last_____ First_____ DOB_____/_____/_____

Patient/Guarantor Responsibilities, Insurance Disclaimer, Private Pay Disclaimer

I (print name of patient/guarantor) _____ understand that if my insurance does not pay for my office visit or any other services performed for any reason, I remain fully responsible to pay for any or all of the services provided.

Initial here:

_____ It is the patient/guarantor's responsibility to determine if the provider/practice is IN or OUT of network with the patient's insurance. Patient/guarantor is still responsible to pay for all services rendered even if discovered out of network after services rendered.

_____ It is the patient/guarantor's responsibility to update our office every time their insurance coverage changes, lapses, or terminates, prior to any services rendered. Patient/guarantor is still responsible to pay for services rendered even if discovered out of network due to change in insurance coverage, after services rendered.

_____ It is the patient/guarantor's responsibility to determine if their insurance requires referral from their PCP, and ensure it is received by this office, prior to every visit. Patient/guarantor understands that they will be subject to No Show Fee if appointment is cancelled with notice less than 1 (one) full business day due to failure of the office having PCP referral.

_____ It is the patient/guarantor's responsibility to come prepared to pay in full for services rendered (if private pay), or pay in full for their portion of services (if using insurance), on the day of the appointment at the time of service.

_____ The patient/guarantor understands that the practice does not offer payment plans as payment in full is due at the time of service, and unpaid bills are reported to collections agency. If the patient/guarantor's account is transferred to collections, any and all fees assessed by the agency will be added to their balance. Any patient with unpaid bills forfeits any further services until all outstanding balances are paid in full. Any patient sent to collections forfeits any future appointments.

_____ The patient/guarantor understands that failure to provide twenty-four (24) hours or one (1) full business weekday advanced notice of cancellation/rescheduling by phone, will result in an automatic No Show Fee charged to the card on file.

_____ The patient/guarantor understands that private pay fees or any fees separate from insurance are subject to change without notice.

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the above Patient/Guarantor Responsibilities, Insurance Disclaimer, Private Pay Disclaimer of Lomibao Rheumatology & Wellness Care, PLLC.

_____ _____

Patient Signature **Date**

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Last_____ First_____ DOB_____/_____/_____

Clinical History Intake

How did you hear about us?

What is your Reason for Referral?

What is the History of your Present Illness? (ie. onset, location, duration, characteristics, aggravating or alleviating factors, treatments attempted)

Please log into the **Patient Portal** (**http://www.nextmd.com**) to:

1. Enter your past clinical histories (ie. medical, surgical, family, social)
2. Fill out the multi-dimensional health assessment questionnaire (MDHAQ)

If you do not yet have a username and password, call the office at 469-825-4010 to receive an email with Patient Portal account set up information.

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Last_____ First_____ DOB_____/_____/_____

Medications - please list both prescription & over-the-counter ☐ check here if not taking any medications

Name	Dose	Frequency	When started taking

Allergies - tell us what type of reaction happens Others:

☐ check here if no known drug allergies

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Insulin
- ☐ Penicillin
- ☐ Sulfa

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Review of Systems - Please circle if you are ***currently*** experiencing any of the following.
If you are not experiencing any of these, please circle None in each category.

Constitutional	Cardiovascular	Metabolic/endocrine	Skin
None	None	None	None
Chills	Chest pain	Cold intolerance	Discoid rash
Fatigue	Palpitations	Hair loss	Nail changes
Night sweats	Raynaud's	Heat intolerance	Extreme sun sensitivity
Weight gain			Psoriasis
Weight loss	Gastrointestinal	Neurological	
	None	None	Musculoskeletal
HEENT	Abdominal pain	Confusion	None
None	Bloody stools	Extremity numbness	Height loss
Vision loss	Constipation	Headache	Joint pain
Blurred vision	Diarrhea	Memory loss	Joint swelling
Dental decay	Difficulty swallowing	Seizures	Joint tenderness
Dry mouth	Heartburn	Fainting	Low back pain
Dry eyes	Nausea	Stroke	Morning stiffness
Nose bleeds	Vomiting		Muscle cramping
Hearing loss		Psychiatric	Muscle weakness
Nasal sores	Genitourinary	None	Neck pain
Oral ulcers	None	Anxiety	
Red eye	Painful urination	Depression	Hematologic/lymph
Sinusitis	Bloody urine	Emotionally labile	None
	Urinary frequency	Hallucinations	Easy bleeding
Respiratory		Insomnia	Easy bruising
None			Blood clots
Cough		Immunologic	
Bloody cough		None	
Pleurisy		Allergic rhinitis	
Shortness of breath		Frequent infections	
		Food allergies	

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