

Wheatland Internal Medicine Clinic

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2701 Prince George Ave., Suite 100

DeSoto, TX 75115



NEW PATIENT REGISTRATION

Patient Information

Patient Name: _____

Date of Birth: _____

Sex: M F Other

Phone: _____ Mobile Home Work

Email: _____

Address: _____

City/State/ZIP: _____

Preferred Pharmacy (name & location): _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Insurance Information

Primary Insurance: _____

Policy/ID #: _____ Group #: _____

Subscriber Name (if not patient): _____

Relationship to Patient: _____

Secondary Insurance: _____

Policy/ID #: _____ Group #: _____

Subscriber Name (if not patient): _____

Copy of insurance card provided

Copy of photo ID provided

Acknowledgment

By receiving care at Wheatland Internal Medicine Clinic, you acknowledge and agree to office policies.

Signature: _____ Date: _____

HIPAA AUTHORIZATION TO DISCLOSE MEDICAL / FINANCIAL INFORMATION

Federal privacy regulations (HIPAA) prohibit the disclosure of protected health information (PHI) without patient authorization. By signing below, you authorize Wheatland Internal Medicine Clinic to disclose information as indicated.

Authorized Individuals

1. Name and phone number: _____

Relationship: _____ Medical Financial Both

2. Name and phone number: _____

Relationship: _____ Medical Financial Both

Expiration of Authorization (check one)

One year from the date of signature On this date: _____

Upon written revocation by the patient

I understand that I may revoke this authorization in writing at any time, except where action has already been taken.

Patient Name: _____

Patient Signature: _____

Date of Birth: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Payment is due **at the time of service**, unless prior arrangements have been made. We accept **checks, money orders, Visa, and MasterCard**.

Office Hours

- **Monday–Thursday:** 8:00 AM – 4:30 PM
- **Friday:** 8:00 AM – 1:00 PM
- Visits are by appointment only

Patients arriving more than **15 minutes late** may be asked to reschedule.

Insurance & Billing

- Copayments, coinsurance, and deductibles are due at the time of service.
 - Patients are responsible for all charges not covered by insurance.
 - Incorrect or expired insurance information will result in patient billing.
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Missed Appointments

- **24-hour notice** required for cancellations.
 - Fees: **\$50** (new patient/physical) | **\$25** (follow-up)
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Administrative Fees

- Forms/letters requiring physician review: **\$35**
 - Medical records: charged per **Texas law**
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Financial Hold

- If there is a balance on your account that is more than 60 days old, your account will be placed on a financial hold. Once the account is on a financial hold, it cannot be

removed until the balance is paid in full or a payment plan is set up for the balance. While the account is on financial hold, no future appointments can be booked.

I have read and agree to the Financial Responsibility Policy of Wheatland Internal Medicine Clinic.

Patient Name: _____

Patient Signature: _____

Date: _____

Patient Consent to Treat & General Consent for Telehealth / Virtual Visits

1. Consent to Treat

I hereby give my voluntary consent to **Wheatland Internal Medicine Clinic** and its physicians, nurse practitioners, physician assistants, and clinical staff to provide medical evaluation, care, treatment, and diagnostic services as deemed necessary or advisable for my health condition.

I understand that: - The practice of medicine is not an exact science and no guarantees or assurances have been made to me regarding the results of treatment. - My care may include examinations, laboratory testing, diagnostic procedures, medications, referrals, and other medically appropriate services. - I have the right to ask questions about my care and to refuse or withdraw consent for treatment at any time, except in emergency situations.

Acknowledgement of Consent to Treat

I acknowledge that I have read and understand the information above and voluntarily consent to receive medical treatment from **Wheatland Internal Medicine Clinic**.

2. Consent & Acknowledgement for Telehealth / Virtual Visits

I consent to participate in telehealth services (also known as virtual visits) provided by **Wheatland Internal Medicine Clinic**, which may include video, phone, or other electronic communications for medical evaluation, diagnosis, treatment, follow-up care, and patient education.

I understand and acknowledge that: - Telehealth involves the use of secure electronic communications when I am not physically present in the clinic. - Telehealth may not be appropriate for all medical conditions and has certain limitations compared to in-person visits. - My provider may determine that an in-person visit is necessary for my care. - Potential risks of telehealth include technical difficulties, interruptions, unauthorized access, or limitations in clinical assessment. - I am responsible for providing accurate and

complete medical information and for ensuring a private environment during telehealth visits whenever possible. - Telehealth services are conducted in compliance with applicable federal and state laws, including CMS and Medicare telehealth requirements, and privacy regulations such as HIPAA. - My health information may be shared electronically with authorized members of my healthcare team for treatment, payment, and healthcare operations.

By signing below, I acknowledge that I have read and understand this telehealth consent and voluntarily agree to receive telehealth services from **Wheatland Internal Medicine Clinic**.

3. Consent & Acknowledgement

By signing below, I acknowledge that: - I have read and understand this Consent to Treat and Telehealth Consent form. - I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. - I voluntarily consent to treatment and telehealth services provided by **Wheatland Internal Medicine Clinic**.

Patient / Legal Representative Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

Clinic Use Only

Provider Name: _____

Date: _____

This consent remains valid until revoked in writing by the patient.

COMMUNICATION AND OFFICE POLICIES

Preferred Communication – Healow Patient Portal

Healow is the fastest and most efficient way to communicate with our office.

Patients are strongly encouraged to use Healow for:

- Secure messages
- Medication refill requests

- Test results
- Referral requests
- General questions

Messages sent through **Healow** receive **faster responses** than phone calls.

Telephone Calls

Our phone is answered **24 hours a day**. After hours, a provider is on call for **urgent medical concerns only**.

Non-emergency calls (appointments, refills, referrals, test results) should be made during office hours:

- **Mon–Thu:** 8:00 AM – 4:30 PM
 - **Fri:** 8:00 AM – 1:00 PM
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Emergencies

For a medical emergency, **call 911 or go to the nearest emergency room**. Please ask the emergency department to contact our office at **(972) 634-8110**.

Test Results

- Test results may take **several days to one week** to return.
 - Routine results are communicated by **phone or Healow**.
 - If we cannot reach you, a portal message or letter will be sent.
 - Results may also be viewed directly in **Healow**.
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Medication Refills

- Refill requests should be made **through your pharmacy**, which will contact our office if needed.

- Requests are processed during business hours and may take up to **48 hours**.
 - Refill requests submitted via **Healow** may be processed more quickly.
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Referrals & Prior Authorizations

- Patients are responsible for notifying the office if insurance authorization is required.
 - Routine referrals and authorizations may take up to **7 business days**.
 - Please request referrals **at least 14 business days** before specialist appointments.
 - Urgent requests are handled as quickly as possible.
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Medical Records

- Written authorization is required for medical record requests.
 - Fees are based on **Texas law**.
 - Please allow **up to 15 business days** for processing.
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Payments & Insurance

- Co-payments and unmet deductibles are due **at the time of service**.
 - We accept **check, money order, Visa, and MasterCard**.
 - Please notify us promptly of any insurance changes.
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Forms & Letters

Forms or letters requiring provider review and signature are subject to a **\$35 fee**, payable before release.

Thank you for choosing Wheatland Internal Medicine Clinic.