

**KENNETH E. BAIRD, M.D., P.A.**  
**PATIENT INFORMATION**

**Name:** Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ **Race:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Address:** Street \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Phone:** Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Name of Insurance:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ (located on your insurance card)

**HIPAA COMPLIANCE**

Kenneth E. Baird, M.D., P.A. has a legal, ethical and moral obligation to protect your confidentiality. Any information about you will be held strictly confidential.

I, \_\_\_\_\_, hereby authorize Dr. Kenneth Baird and staff to release all medical records/information (including drug screens and HIV test results, and also allows the following family members the authorization for written prescription and sample medication pick up):

Spouse: \_\_\_\_\_

Parent/children: \_\_\_\_\_

I **do** **do not** authorize Dr. Kenneth Baird and staff to leave a message concerning my medical care or laboratory results on my telephone. The phone number that I wished to be contacted at is \_\_\_\_\_.

\_\_\_\_\_  
PATIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS (office staff, optional)

**KENNETH E. BAIRD, M.D., P.A.**  
**PAST MEDICAL/SURGICAL/SOCIAL HISTORY & REVIEW OF SYSTEMS**

PATIENT NAME \_\_\_\_\_

**\*\*Check only those that apply\*\***

**GENERAL**

- Diabetes Mellitus
- High Blood Pressure
- High cholesterol
- Serious infection
- Cancer
- Type \_\_\_\_\_
- Other \_\_\_\_\_

**EYES, EARS, NOSE, THROAT**

- Allergies
- Frequent ear infections
- Frequent sinus infections
- Frequent strep throat
- Vision problems
- Glaucoma
- Hearing problems
- Other \_\_\_\_\_

**CARDIOVASCULAR**

- Coronary artery disease
- Heart attack
- Angina
- Stroke
- High blood pressure
- High cholesterol/triglycerides
- Abnormal heart rhythm
- Blocked arteries
- Where \_\_\_\_\_
- Blood clots in veins
- Congestive heart failure
- Heart valve disease
- Aneurysm
- Where \_\_\_\_\_
- Other \_\_\_\_\_

**RESPIRATORY**

- Asthma
- COPD/emphysema
- Sleep apnea
- Blood clots in lungs
- Other \_\_\_\_\_

**ENDOCRINE**

- Diabetes
- Hypothyroidism
- Hyperthyroidism
- Hyperparathyroidism
- Osteoporosis
- Other \_\_\_\_\_

**SKIN**

- Acne
- Psoriasis
- Eczema
- Other \_\_\_\_\_

**GASTROINTESTINAL**

- Colon polyps
- Irritable bowel syndrome
- Crohn's disease
- Ulcerative colitis
- Hepatitis
- Type \_\_\_\_\_
- Diverticulosis, diverticulitis
- Cirrhosis of liver
- Gallstones
- Pancreatitis
- Stomach ulcers
- Esophageal reflux/GERD

**GENITOURINARY**

- STD
- Endometriosis
- Prostate disease
- Kidney stones

**MUSCULOSKELETAL**

- Arthritis
- Type \_\_\_\_\_
- rheumatoid
- osteoarthritis
- other
- Fibromyalgia
- Chronic back pain
- Chronic neck pain
- Osteoporosis

**NEUROPSYCHIATRIC**

- Stroke
- Multiple sclerosis
- Headaches
- Type \_\_\_\_\_
- Migraine
- Tension
- Other
- Peripheral nerve disease
- Depression
- Anxiety
- Bipolar disease
- ADD/ADHD
- Down's Syndrome
- Learning disability
- Mental retardation
- Other \_\_\_\_\_

**MEDICATION ALLERGIES**

- Penicillin
- Cephalosporin
- Sulfa drugs
- Codeine/Hydrocodone
- IV Contrast
- Aspirin/ibuprofen
- Local anesthetic
- Other \_\_\_\_\_

**ENVIRONMENTAL ALLERGIES**

- Pollen
- Ragweed
- Mold
- Dust
- Animal dander
- Insect bites/stings
- Type \_\_\_\_\_
- Latex
- Other \_\_\_\_\_

**FOOD ALLERGIES**

- Peanut
- Shellfish
- Eggs
- Wheat
- Milk
- Strawberries
- Soy
- Other \_\_\_\_\_

**SURGERIES---WHAT YEAR?**

- None
- Appendectomy
- Back
- Bladder
- Breast
- Carotid artery
- Carpal tunnel
- Colonoscopy
- Coronary/heart bypass
- Ear
- Gallbladder
- Hysterectomy
- Joint
- Which \_\_\_\_\_
- Ovary
- Prostate
- Sinus
- Stomach
- Testicle
- Tubal ligation
- Trauma related
- Vasectomy
- Other \_\_\_\_\_

**FAMILY HISTORY**

- Heart disease Who \_\_\_\_\_
- Diabetes Who \_\_\_\_\_
- High blood pressure Who \_\_\_\_\_
- Stroke Who \_\_\_\_\_
- Cancer Who \_\_\_\_\_
- Type \_\_\_\_\_
- Who \_\_\_\_\_
- Type \_\_\_\_\_



# KENNETH E. BAIRD, M.D., P.A.

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## CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

*The consent you are about to read was written by the Texas Medical Association and require that all physicians have patient consent for general treatment. \*\**

"I, knowing that I am suffering from a condition requiring, diagnostic evaluation, medical or surgical treatment, or other form of necessary treatment, do hereby voluntarily consent to such procedures and care during my episode of care or other services under the general and specific instructions of the Physician(s) of Kenneth E. Baird, M.D., P.A., or their designee(s) as is necessary in their judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examinations by Kenneth E. Baird, M.D., P.A. I further understand that all options will be discussed prior to the administration of such examinations and / or treatment."  
----Texas Medical Association----

I hereby consent to the use and disclosure of my protected health information necessary for my medical care to other providers assisting or consulting in my medical care and to any parties necessary to process medical claims and participation in workers compensation programs or applications for financial benefits or to conduct the health care operations of Kenneth E. Baird, M.D., P.A. by Kenneth E. Baird, M.D., P.A. I understand that diagnosis or treatment of me by a physician or designee of this practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Kenneth E. Baird, M.D., P.A. is not required to agree to the restrictions that I may request. However, if Kenneth E. Baird, M.D., P.A. agrees to a restriction that I request, the restriction is binding on Kenneth E. Baird, M.D., P.A. and its physician(s) and staff. I have the right to revoke this consent, in writing, at any time, except to the extent that Kenneth E. Baird, M.D., P.A. has taken action in reliance on this consent.

My Protected Health Information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review "Kenneth E. Baird, M.D., P.A. Care Notice of Privacy Practices" prior to signing this document. The Kenneth E. Baird, M.D., P.A. Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Kenneth E. Baird, M.D., P.A. This Notice of Privacy Practices also describes my rights and the Kenneth E. Baird, M.D., P.A. duties with respect to my protected health information.

Kenneth E. Baird, M.D., P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

**TREATMENT OF MINORS** (persons 17 years of age and under): Pursuant to Texas law, Consent for Treatment of Minors must be completed.

**Assignment of Benefits:** I understand that all fees incurred in the course of my treatment by Kenneth E. Baird, M.D., P.A. and/or their authorized agent(s) are my responsibility. I hereby authorize the insurance companies to make payment directly to the above said party for those fees I have not previously paid. Additionally, I agree that all charges not paid by my insurance company (ies) are ultimately my responsibility.

Furthermore, I have read, understand, and agree to the statements that appear herein.

PRINTED NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

KENNETH E. BAIRD, M.D., P.A.

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**NOTICE OF PRIVACY PRACTICES:  
Acknowledgement of Receipt**

By signing this form, you acknowledge you have read the *Notice of Privacy Practices of Kenneth E. Baird, M.D., P.A.*, located in our waiting area. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information and your rights related to the Use and Disclosure of your protected health information. We encourage you to read it in full. Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by requesting a copy from our office:

Kenneth E. Baird, M.D., P.A., 3012 E. Hebron Parkway, Suite 110, Carrollton, Texas, 75010.  
972-820-6900 (phone) 972-820-7300 (fax). **If you would like a copy of the *Notice of Privacy Practices* that you have just read, please advise our office staff.**

If you have any questions about our *Notice of Privacy Practices*, please contact the *Privacy Officer* at the phone number listed above.

I acknowledge I have had the opportunity to read the *Notice of Privacy Practices of Kenneth E. Baird, M.D., P.A.*

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Office Staff)

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\*\*\*\*For office staff only\*\*\*\*

**INABILITY TO OBTAIN ACKNOWLEDGEMENT**

*To be completed only if no signature is obtained.* If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

- Notice of Privacy Practices Given - Patient Declined to Sign
- Notice of Privacy Practices Given - Patient unable to sign:
  - Unconscious
  - Communication / Language Barrier
  - Other reason patient / legal representative unable to sign: \_\_\_\_\_

Name of Privacy Officer: \_\_\_\_\_

Signature of Privacy Officer: \_\_\_\_\_ Date: \_\_\_\_\_

**KENNETH E. BAIRD, M.D., P.A.**

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**APPOINTMENT CANCELLATION AND/OR NO SHOW POLICY**  
**and PATIENT'S WHO ARE RUNNING LATE FOR THEIR APPOINTMENT**

We are always happy to be able to work with you and your health care needs and reserve a time in your providers schedule just for you. However, in consideration of others we do request at least 24 hours notice prior to cancellation of an appointments. We do understand that there are circumstances that may prevent you from keeping your appointment, however in providing us with as much notice as possible; we may be able to contact another patient who needed an appointment on the day yours was scheduled. Morning and afternoon appointments fill quickly, and cancelling with less than 24 hours notice does not allow us enough time to schedule another patient in need of treatment, therefore a cancellation or no show fee of \$25 may apply if our office is not notified that you will be unable to make your appointment.

Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment. Patients, who are more than 15 minutes late for their appointment, may need to be re-scheduled to another day and time, in consideration of other patients and their scheduled appointment times.

We greatly appreciate your understanding of and cooperation with our office policies, and assisting us with accommodating our patients scheduling needs.

Please sign below that you have read, and acknowledge the above information provided to you. If you would like a copy of any of your paperwork, please ask one of our team to make copies for you.

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**PAYMENT POLICY**

Our office is a fee for service office and we thus expect payment of patient's responsibility to their costs of services provided, to be paid at time of service. This includes any co-pays, deductibles and co-insurance as well as any outstanding balances.

YOUR INSURANCE COVERAGE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. PAYMENT OF YOUR ACCOUNT IS YOUR RESPONSIBILITY. Accounts 60 days past due will be billed to you. At the time we receive your explanation of benefits from your insurance company, if there is a portion of the claim determined as your responsibility, you will be sent a statement for payment within 30days.

Payment is due at the time services are rendered. Patients are expected to pay their portion of the office visit bill at this time.

In office Procedures: Most Non-HMO coverage consists of a deductible and/or percentage, which is the responsibility of the patient. This will be calculated on the expected costs of procedure (according to our contracted allowable) and must be prepaid. Any overpayment will be refunded after your insurance company has paid its portion. Any underpayment will be billed to you.

If you have any questions regarding our payment policy, please ask to speak to either one of our insurance specialists or our practice manager. They will be happy to explain the reasons behind these policies. These policies have been established to protect the rights of all patients.

**PATIENTS MAY PAY USING CASH, CHECK, OR CREDIT CARD.**

Thank you for your understanding of, and cooperation with the financial policies of this practice.

I, \_\_\_\_\_ have read and understand the above payment policy:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PRESCRIPTION POLICY**  
**KENNETH E. BAIRD, M.D., P.A.**

Dr. Kenneth Baird does prescribe medications for pain (**not chronic pain**), insomnia, muscle spasms, ADD, ADHD, etc. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harm to patients and others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulate the use of these medications. Kenneth E. Baird, M.D., P.A. follows these laws.

Our policy:

1. Written prescriptions will not be replaced if lost, stolen, or misplaced.
2. Prescriptions are to be taken as directed. In other words, do not change the frequency or dose unless otherwise directed by Dr. Kenneth Baird. If a change is recommended by this office, it will be noted in your chart.
3. Certain controlled substances such as Oxycodone, Dilaudid, Percocet, Adderall, Ritalin, etc. are written for a 30 day supply for local pharmacy use and 90 day supply for mail order pharmacy use. It is necessary to make follow up appointments every 3 months in order to receive a refill. By law, controlled substance medications cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every 3 months. As a result, if you were not seen in the clinic or the hospital in the 3 months prior to a prescription refill request, the medication will not be refilled without an office visit.
  - a. Sleep aids such as Ambien, Lunesta, Sonata, Restoril, etc.
  - b. Opiates such as Lortab, Vicodin, Hydrocodone, Darvocet, etc.
  - c. Muscle relaxers such as Soma, Robaxin, Flexeril, etc.
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office to make an appointment.
6. Refill requests **WILL NOT** be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough pills.
7. Before your visit to Kenneth E. Baird, M.D., P.A., please check your supply of medication. If you need a refill, please ask.
8. Refill requests for medications not prescribed by Dr. Kenneth Baird will not be authorized.
9. When controlled medications are being prescribed to you by Kenneth E. Baird, M.D., P.A., you may not have the same condition being treated by someone else or the same or similar medication being prescribed by someone else.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescriptions refilled. If I do not comply with the above policies, I understand that Kenneth E. Baird, M.D., P.A. has the right to not refill my medications and the right to terminate their physician-patient relationship with me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**KENNETH E. BAIRD, M.D., P.A.**  
**LEGAL IRREVOCABLE ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

In considering the amount of expenses to be incurred, I have insurance and/or employee health care benefits coverage with (insurance co. information) \_\_\_\_\_, and hereby irrevocably assign and convey directly to Kenneth E. Baird, M.D., P.A. (hereafter "provider") all right, title and interest in all medical benefits payable and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider /practice. Said irrevocable assignment and transfer shall be for the purpose of granting the provider and practice an independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the provider and practice to pursue any such right to recovery. I hereby authorize all responsible parties to pay directly to the provider and practice all benefits and amount due for services rendered by the physician.

I understand that if the provider and practice is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the provider and practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider and practice for all charges in excess of the benefits paid. All payments will be made to provider and practice at: Dr. Kenneth Baird, 3012 E. Hebron Pkwy, Suite 110, Carrollton, Texas, 75010.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and practice any and all summary plan documents, insurance policy and/or settlement information upon written request from such provider and practice in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or the right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and practice and to the extent permissible under law to claim such benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider and practice in any attempts by such provider and practice to pursue such claim, chosen action or right against any insurers and/or employee health care plan, including, if necessary, bring suit with such provider and practice against any insurers and/or employee health care plan in my name but at such provider and practice's expense.

This lifetime assignment of benefits will remain in effect until revokes by me in writing. A photocopy of this assignment of benefits is to be considered as valid as the original.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the physician.

\_\_\_\_\_  
**Signature of Insured / Payment Responsible Party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient (or Guardian)**

\_\_\_\_\_  
**Date**

KENNETH E. BAIRD, M.D., P.A.