Prime MD Plus

Divya Javvaji, M.D.

Primary Care & Geriatric Medicine • 452 TX-121, Suite 130, Coppell, TX 75019 • Ph: 972-393-1699 • Fax: 972-393-1702

New Patient Registration

Name: _____

Date of Birth: _____

Social Security #: _____

Full Address: _____

E-Mail: _____

Phone #: _____

Mobile Phone # (for text messages): _____

To receive text (SMS) messages, please complete the Communications & Text Message (SMS) Consent section later in this packet. Text messaging is optional.

Primary Care Provider: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Relationship to Patient: _____

Pharmacy Information

Pharmacy Name: _____

City: _____

Street: _____

Phone: _____

Insurance Information

Primary Insurance

Name of Primary Insurance: _____

Policy Holder Name: _____

Policy Number: _____

Group Number: _____

Relationship to policyholder (select one): ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance (if applicable)

Name of Secondary Insurance: _____

Policy Holder Name: _____

Policy Number: _____

Group Number: _____

Relationship to policyholder (select one): ❑ Self ❑ Spouse ❑ Child ❑ Other

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Chief Complaint: What is the main reason for your visit today?

_____

_____

Medical History (select all that apply)

- ❑ Alcoholism
- ❑ Alzheimer's
- ❑ Amblyopia
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Aneurysm
- ❑ Arrhythmia
- ❑ Arthritis
- ❑ Asthma
- ❑ Biliary Tract Disease
- ❑ Bipolar Disorder
- ❑ Blindness
- ❑ Cancer
- ❑ Cataplexy
- ❑ Cataracts
- ❑ Chronic Pain
- ❑ Cirrhosis
- ❑ Collapsed Lung
- ❑ Color Blindness
- ❑ Congestive Heart Failure
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Crohn's Disease
- ❑ Cryptococcus
- ❑ Cystic Fibrosis
- ❑ Cytomegalovirus
- ❑ Degenerative Arthritis
- ❑ Depression
- ❑ Dermatitis
- ❑ Diabetes
- ❑ Ectopic Pregnancy
- ❑ Endometriosis
- ❑ Epilepsy
- ❑ Erectile Dysfunction
- ❑ Gallstones
- ❑ Glaucoma
- ❑ Glomerulonephritis
- ❑ Gout
- ❑ Headaches
- ❑ Hearing Impairment
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ HIV
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Immune Deficiency
- ❑ Infections (chronic)
- ❑ Infertility
- ❑ Insomnia
- ❑ Ischemic Bowel Disease
- ❑ Kidney Stones
- ❑ Lupus
- ❑ Lyme Disease
- ❑ Macular Degeneration
- ❑ Menopause
- ❑ Multiple Sclerosis
- ❑ Narcolepsy
- ❑ Nephrotic Syndrome
- ❑ Ocular Misalignment
- ❑ Osteoporosis
- ❑ Ovarian Cysts
- ❑ Pancreatitis
- ❑ Parkinson's Disease
- ❑ Peripheral Neuropathy
- ❑ Pleural Effusion
- ❑ Prostate Enlarged
- ❑ Prostatitis (chronic)
- ❑ Psoriasis
- ❑ Pulmonary Embolism
- ❑ Pulmonary Fibrosis
- ❑ Reflux Esophagitis
- ❑ Renal Failure
- ❑ Retinal Detachment
- ❑ Rheumatoid Arthritis
- ❑ Sickle Cell Anemia
- ❑ Sinusitis (chronic)
- ❑ Sleep Apnea
- ❑ Sleepwalking
- ❑ Spina Bifida
- ❑ Stroke
- ❑ Thalassemia
- ❑ Tinnitus
- ❑ Toxoplasmosis
- ❑ Tuberculosis
- ❑ Ulcers

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Previous Hospitalizations / Surgeries / Serious Illness and when?

_____

_____

_____

_____

_____

Are you on medications? ❑ **Yes** ❑ **No** If yes, please list below.

Medication Name	Dose	Frequency	Capsule or Tablet

Are you allergic to any medications? ❑ **Yes** ❑ **No** If yes, which ones?

_____

_____

_____

_____

_____

_____

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Social History

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Yes ❑ No If yes, how much and how often? _____

Smoking: ❑ Yes ❑ No If yes, how much per day? _____

Illicit drug use (past and present): ❑ Yes ❑ No

If yes, what type, how often, and last time of use? _____ Current work status: ❑ Working ❑ Retired ❑ Unemployed ❑ Disabled

Who lives with you at home? _____ Have you had the flu vaccine? If yes, when? _____

Family History

Family History	**YES**	**Family History**	**YES**
Diabetes	_____	Lung Cancer	_____
Heart Disease	_____	Heart Attack	_____
Liver Disease	_____	Colon Cancer	_____
Prostate Cancer	_____	Stroke	_____
Kidney Cancer	_____	High Blood Pressure	_____
Breast Cancer	_____	High Cholesterol	_____

Patient signature: _____ Date: _____

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Financial Policies

- The patient is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing your contracted insurers. However, the patient is required to provide us with the most correct and updated insurance information and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service. For your convenience, we accept Visa, MasterCard, American Express, Discover, and checks at our office.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Prime MD Plus. These charges may include (but are not limited to):
    - the charge for missed appointments without 24-hour advance notice

○ the charge for the copying and distribution of patient medical records ○
the charge for extensive forms completion

○ any costs associated with the collection of patient balances.

- **FMLA / Handicap placard / other paperwork policy**
    - Any FMLA, disability, or other paperwork requiring physician review and completion is subject to a minimum $75 fee per form. Please allow up to 2 weeks for this paperwork to be completed.
- **Canceled Appointments**
    - We require 24-hour notice for the cancellation of all doctor visits. It is the policy of Prime MD Plus to bill a cancellation fee to a patient who does not show or cancel at least 24 hours in advance of a procedure, test, or appointment. This ensures our treatment team is using their time to diagnose and treat patients in need of our services. A patient who arrives 20 minutes past the appointment time will be considered a “no show” for the purposes of this policy. Fees for no-show appointments will be $75.00.

I, _____ (patient’s name), have read, understand, and agree to the above policy of Prime MD Plus. I will be responsible for any non-covered services not covered by my health insurance plan(s).

_____ _____

Patient’s Name (PRINT) Patient Signature & Date

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Communications & Text Message (SMS) Consent

Prime MD Plus may contact you about your care by phone, mail, email, and — with your consent — text (SMS) message. Please review and complete this section. Text messaging is optional and is not required to receive care.

Preferred method of contact (select all that apply): ❑ Phone call ❑ Email ❑ Text (SMS) ❑ Mail

May we leave a detailed voicemail? ❑ Yes May we contact you at work? ❑ Yes ❑ No

❑ No **Text (SMS) messaging consent**

❑ I agree to receive text (SMS) messages from Prime MD Plus, which may be sent using automated technology, at the mobile number I provided, including appointment reminders and confirmations, review requests, and billing and care-related notifications. Message frequency varies. Message and data rates may apply. I can reply STOP to opt out at any time, or HELP for help. I understand consent is not a condition of receiving care, that standard SMS is not encrypted, and that my mobile information and text opt-in/consent data will not be shared with third parties or affiliates for marketing or promotional purposes. I confirm that I am the owner or customary user of this mobile number and agree to notify Prime MD Plus if it changes.

Mobile number for text messages: _____

Patient name (print): _____

Signature: _____ Date: _____

If signing for the patient — Name: _____ Relationship: _____ (e.g., legal guardian or agent under a power of attorney)

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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.

Effective date: July 15, 2026

Our Commitment

Prime MD Plus and Divya Javvaji, M.D. ("we," "us," or "our") are committed to protecting the privacy of your Protected Health Information ("PHI"). We are required by law to maintain the privacy of your PHI, provide you this Notice of our legal duties and privacy practices, notify you following a breach of unsecured PHI, and follow the terms of the Notice currently in effect.

How We May Use and Disclose Your Health Information

We may use and disclose your PHI, without your written authorization, for the following purposes:

- **Treatment:** To provide, coordinate, or manage your health care, including sharing information with other providers involved in your care.
- **Payment:** To bill and obtain payment from you, insurers, or other payers, including verifying coverage and eligibility.
- **Health Care Operations:** For quality assessment, staff review, business management, and other operations of our practice.
- **Appointment Reminders & Communications:** To contact you by phone, mail, email, or text (SMS) with reminders, results notifications, and information about treatment alternatives or health-related services. See the section on text messaging below.
- **As Required by Law:** To comply with federal, state, or local law, and for public health, safety, oversight, judicial, and law-enforcement purposes as permitted by HIPAA.
- **Other Permitted Purposes:** As permitted by HIPAA, we may also use or disclose PHI to family members or friends involved in your care (with your agreement or, when appropriate, in your best interest), to business associates who perform services for us under written agreements, for research under approved protocols, to coroners, medical examiners, and funeral directors, for organ and tissue donation, for workers' compensation, and for certain military, veterans, and national-security purposes.

Text (SMS) Messaging

If you provide your mobile number and opt in, we may send appointment reminders, confirmations, review requests, and other care-related messages by text. Standard SMS is not encrypted, so we limit texts to the minimum necessary information. Message frequency varies and message and data rates may apply. You may reply **STOP** to opt out at any time; opting out will not affect your care. Your mobile opt-in and consent data will not be shared with third parties for marketing purposes.

Uses and Disclosures Requiring Your Written Authorization

Other uses and disclosures — including most uses of psychotherapy notes, uses for marketing, and the sale of PHI — will be made only with your written authorization. You may revoke an authorization in writing at any time, except to the extent we have already acted in reliance on it.

Special Protections for Substance Use Disorder and Other Sensitive Information

Certain information — such as substance use disorder treatment records (42 CFR Part 2), HIV/AIDS information, and mental health information — may receive additional protection under federal and Texas law, and may require your specific consent or authorization before disclosure. Substance use disorder treatment records protected by 42 CFR Part 2 will not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order.

Texas Notice Regarding Electronic Disclosure of Health Information

Texas law requires us to notify you that your PHI may be subject to electronic disclosure. Under the Texas Medical Records Privacy Act, we will not electronically disclose your PHI without your separate authorization, except for disclosures made for treatment, payment, or health care operations, or as otherwise permitted or required by law.

Your Rights Regarding Your Health Information

- Request restrictions on certain uses and disclosures (we will accommodate a request to restrict disclosure to a health plan for services you paid for in full out of pocket);
- Request to receive communications by alternative means or at an alternative location (for example, a specific phone number);
- Inspect and obtain a copy of your PHI, including an electronic copy of electronic records;
- Request an amendment to your PHI;
- Receive an accounting of certain disclosures;
- Receive a paper copy of this Notice, even if you agreed to receive it electronically; and
- Be notified in the event of a breach of your unsecured PHI.

Changes to This Notice

We reserve the right to change this Notice and to make the revised Notice effective for PHI we already have as well as information we receive in the future. The current Notice will be posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

Contact

Nadelya Kinnon, Practice Manager (Privacy Officer), Prime MD Plus — Divya Javvaji, M.D., 452 TX-121, Suite 130, Coppell, TX 75019. Phone: 972-393-1699. Email: staff@primemdplus.com.

Acknowledgment of Receipt

I acknowledge that I have received a copy of the Prime MD Plus Notice of Privacy Practices, which describes how my protected health information may be used and disclosed and how I can access this information.

Patient name (print): _____

Signature: _____ Date: _____

If signing on behalf of the patient — Name: _____ Relationship: _____

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Patient Authorization for Disclosure of Protected Health Information

Patient Name: _____

SSN (last four digits — optional): _____

Date of Birth: _____

Entity Requested to Release Information: Prime MD Plus

Purpose of request — I authorize the entity identified above to disclose or provide protected health information about me to the individual(s) listed below.

Who will be authorized to receive information (family member, friend, or other):

Individual/Entity Name: _____

Relationship: _____

Phone: _____

Individual/Entity Name: _____

Relationship: _____

Phone: _____

Description of information to be disclosed — ❑ Complete Records OR select the following that apply:

❑ History & Physical	❑ Progress Notes	❑ Radiology Reports (U/S, CT, X-ray, MRI)
❑ Care Plan	❑ Lab Reports	❑ Operative Reports
❑ Pathology Reports	❑ Treatment Record	❑ Other (specify) _____
❑ Hospital Records	❑ Medication Record	

Purpose of disclosure: ❑ Patient Request ❑ Other (specify): _____

The released information may contain alcohol or drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.

This authorization will expire on the 365th day after it is signed, unless a different expiration date or event is given here: _____

I understand I may revoke this authorization at any time in writing, but that revocation will not affect actions already taken in reliance on it. If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. I understand treatment and payment are not conditioned on signing this authorization, and I may receive a copy of the signed authorization upon request.

Patient or representative signature: _____ Date: _____

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*** MEDICAL RECORDS REQUEST ***

PLEASE FAX BACK PATIENT RECORDS WITH A COPY OF THIS PAGE AS COVER

FAX TO: 972-393-1702

Records Requested

Patient: _____

DOB: _____

From: _____

Fax: _____

Address: _____

Phone: _____

Date: _____

Time: _____

Description of information being requested — ❑ Complete Records OR select the following that apply:

❑ History & Physical	❑ Progress Notes	❑ Radiology Reports (U/S, CT, X-ray, MRI)
❑ Care Plan	❑ Lab Reports	❑ Operative Reports
❑ Pathology Reports	❑ Treatment Record	❑ Other (specify) _____
❑ Hospital Records	❑ Medication Record	

The released information may contain alcohol or drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. This authorization will expire on the 365th day after it is signed, unless a different expiration date or event is given here: _____

Patient Signature: _____ Date: _____