Southern Horizon
PRIMARY CARE

ROUTINE PHYSICAL EXAMS FINANCIAL INFORMATION

Purpose of Exam: Routine physical exams are an important part of your general health care maintenance and are used to assess your overall health. If you have specific concerns or problems, please schedule an office visit to address these issues.

Billing Policies for Routine Physical Exams:

- Your insurance company may or may not cover your physical exam. Please contact your insurance company prior to your scheduled appointment regarding payment for your physical.

- If your insurance company does cover an annual physical exam, please ensure that it has been at least 365 days since your last physical exam.

- Testing which include labwork and EKGs may not be covered by your insurance policy when performed as part of your physical. Provided below is a list of the labwork that your physician may order as part of your physical

    - **COMPLETE METABILIC PANEL (CMP)**- shows the status of your kidneys, liver, electrolytes and acid/base balance in addition to your blood sugar and blood proteins

    - **LIPID PANEL (CHOLESTEROL TEST)**- **Total cholesterol** helps assess risks of heart attack and stroke

    - **COMPLETE BLOOD COUNT (CBC)**- helps detect blood diseases and disorders, such as anemia, infections, clotting problems, blood cancers and immune system disorders

    - **THYROID STIMULATING HORMONE (TSH)**- screens for and helps diagnose thyroid disorders

    - **PROSTATE SPECIFIC ANTIGEN (PSA)**- helps detect prostate cancer in men

    - **URINALYSIS (UA)**- used to diagnose a urinary tract or kidney infection; to screen for progression of some chronic conditions such as diabetes mellitus and high blood pressure (hypertension)

    - **FECAL OCCULT BLOOD TEST (FOBT)**- used as a screening tool for colorectal cancer

    - **URINE HUMAN CHORIONIC GONADOTRIPIN (Urine HCG)**- Pregnancy Test

    - **ELECTROCARDIOGRAM (EKG)**- used as a screening tool to detect any cardiac problems. Helpful to compare previous EKG if you are experiencing chest pain.

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WHEN YOU CONTACT YOUR INSURANCE COMPANY FOR YOUR ROUTINE PHYSICAL BENEFITS, YOU WILL NEED TO PROVIDE THEM WITH THESE TEST CODES. YOUR INSURANCE COMPANY WILL THEN BE ABLE TO TELL YOU IF THESE CODES ARE COVERED UNDER YOUR INSURANCE POLICY.

DIAGNOSIS CODE: Z00.00

ESTABLISHED PATIENT PHYSICAL	CODE
Age 18-39	99395
Age 40-64	99396
Age 65-older	99397

NEW PATIENT PHYSICAL	CODE
Age 18-39	99385
Age 40-64	99386
Age 65-older	99387

LAB TEST	CODE
CBC	85025
LIPID	80061
CMP	80053
TSH	84443
PSA	84153
UA	81002
FOBT	82270
HCG	84703

DIAGNOSTIC TEST	CODE
EKG	93000

- If you request testing for any Sexually Transmitted Diseases (STD), you will need to check your insurance plans benefits for coverage.

DIAGNOSIS CODE: Z20.2

TEST	CODE
HIV	87390
Herpes	86694
Hepatitis	80074
Chlamydia	87491
Gonorrhea	87591
Syphilis	86593

- **For Women Only:** If you have had an annual gynecological exam somewhere else, it may prevent us from being paid by your insurance company for a physical exam.

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ROUTINE PHYSICAL EXAMS FINANCIAL WAIVER

The following labs are recommended by your physician to have drawn during your routine physical exam. Please understand that your insurance policy may not cover these labs as routine care. As the insured it is your responsibility to contact your insurance provider to find out your routine laboratory benefits.

Below is the list of labs that may be ordered by your physician. Please check the box of any tests you **DO NOT** want ordered at this time due to cost.

ROUTINE LABS

- ☐ Complete Metabolic Panel (CMP)
- ☐ Lipid Panel
- ☐ Complete Blood Count (CBC)
- ☐ Thyroid Stimulating Hormone (TSH)
- ☐ Prostate Specific Antigen (PSA)
- ☐ Urinalysis (UA)
- ☐ Fecal Occult Blood Test (FOBT)
- ☐ Urine Human Chorionic Gonadotropin (Urine HCG)
- ☐ Electrocardiogram (EKG)

OPTIONAL STD TESTS

- ☐ HIV Testing
- ☐ Herpes Simplex
- ☐ Hepatitis Panel
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis

I acknowledge that I have read and understand the billing policies for my routine physical exam.

I understand that if my insurance company does not pay for all or part of my physical exam that the balance in full is my responsibility.

Patient Printed Name	Date of Birth	Date
Patient Signature		Southern Horizon Staff Initials
Witness		Date

ph: 469.645.0200/fax: 469.320.9550/w: southernhorizon.org/2014 Justin Road, Suite 104/Highland Village, Texas 75077

Southern Horizon
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RECORDS RELEASE MEDICAL AUTHORIZATION

Patient's Name:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____ DOB:_____ SSN:_____

Which records are needed:_____

Reason for transfer/request:_____

I, the undersigned, do hereby authorize and direct you to

( ) Furnish records **TO** Southern Horizon Healthcare from:
( ) Release records **FROM** Southern Horizon Healthcare to:

******IMPORTANT NOTICE: Per Southern Horizon Healthcare Practice Policy, we only copy, print, mail or fax SHH records. We do not copy, print, mail or fax other Doctor's medical records. Please contact your past Dr. for these records.**

Facility/Dr. Name:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____ Fax:_____

Check how records are to be received: Mail_____ Pick-Up_____ Fax_____

(If **all** records are requested, **Southern Horizon Healthcare will not fax records**)

Southern Horizon Healthcare
2014 Justin Road, Suite 104, Highland Village, Texas 75077
Phone 469-645-0200 Fax 469-320-9550

I understand that my request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I understand that I am responsible for cost for copies.
A copy of this authorization is as valid as an original and will expire 6 months from the date below.

Medical Records Request Fees:

- **Print-** I understand that you may charge me a fee of up to $25 if I request my entire chart for personal use
- **Oversized Document-** I understand that you may charge me a fee of up to $30 if I request my entire chart for personal use and it exceeds 100 pages
- **NO CHARGE-** Any records that are to be released for the purpose of continuation of care to a designated physician or insurance company.

I UNDERSTAND THAT SOUTHERN HORIZON HEALTHCARE DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS OR FACILITIES.

PRINT NAME:_____ DATE:_____

SIGNATURE:_____

WITNESS:_____