

WELCOME BACK

PATIENT INFORMATION UPDATE FORM



Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Cell phone _____ Work phone _____

Email address _____

Emergency Contact _____ Phone _____

UPDATED INSURANCE INFORMATION

Insurance provider _____

ID Number _____ Group number _____

PATIENT CONDITION

In order to serve you, please provide information regarding you current health condition.

Have you had any fall, accidents or surgery since your last visit? YES NO

If yes, please explain: _____

What are your symptoms? _____

Have you been treated for a similar problem before? YES NO

If yes, please explain: _____

When did symptoms appear? _____

What have you done at home to treat any pain? _____

Have you seen another doctor since your last visit? YES NO

What medications are you taking?

Muscle relaxant Pain killer Insulin Birth Control Stimulants Anti Depressants

Other: _____

What vitamin supplements are you taking? _____

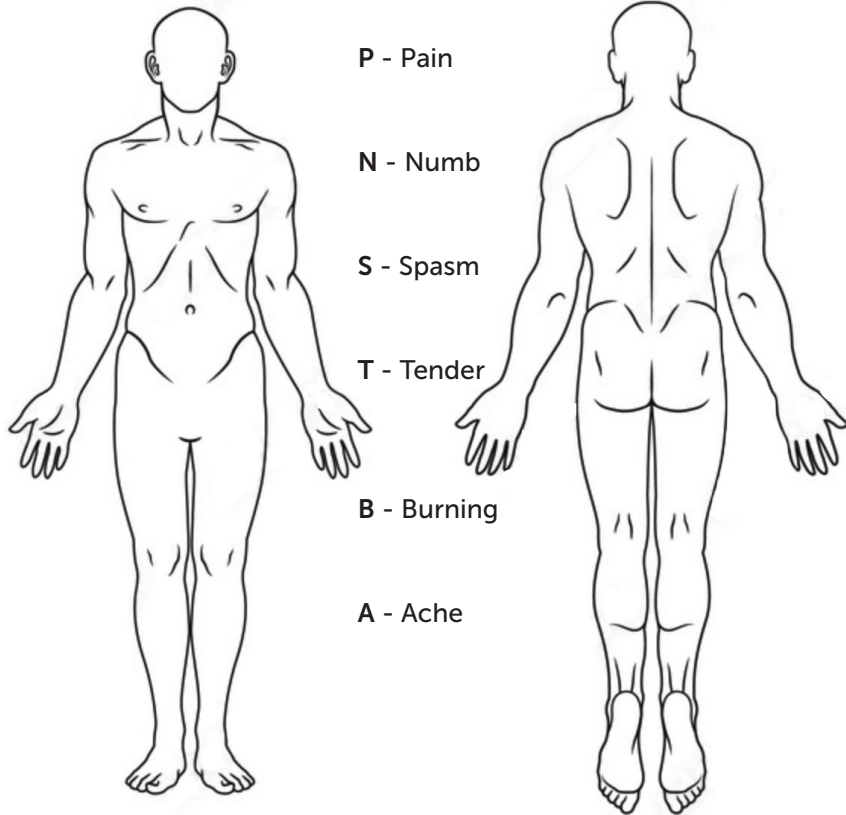
What exercise program are you using? _____

Do you smoke? YES NO Amount per week _____

Do you drink alcoholic beverages? YES NO Amount per week _____

Do you use any back or arch supports, heel lifts, orthotics or any braces of any kind? YES NO

SYMPTOM LOCALIZATION



LEAST 1 2 3 4 5 6 7 8 9 WORST

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder problems

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Depression
- Insomnia

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

CARDIOVASCULAR RESPIRATORY

- Chest pain
- Pain over the heart
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung Problems
- Varicose veins

FEMALES

- Lumps on or in the breast
- Breast pain
- Vaginal pain
- Vaginal bleeding
- Vaginal discharge

ARE YOU PREGNANT Yes No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallowing
- Excessive thirst
- Nausea
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain / discharge
- Hearing loss
- Nose bleeding / discharge
- Difficulty breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus problems
- Allergies
- Jaw pain

HIPAA CONSENT AND FINANCIAL POLICY

HIPAA: The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. By signing below the patient understands:

- Protected health information may be disclosed or used for treatment, payment or health care options.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The practice may condition receipt of treatment upon the execution of this consent.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Patient signature _____ Date _____

RELEASE OF INFORMATION:

Besides myself, I authorize this practice to discuss personal medical information with the following

person(s): _____ and/or _____

INSURANCE AND ASSIGNMENTS OF BENEFITS:

I hereby authorize this practice and its providers to apply for benefits on my behalf for covered services rendered. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration the Health Care Financing Administration). A copy of the authorization may be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

I hereby authorize payment of all medical insurance benefits to be paid directly to this practice and/or its providers for services rendered. I understand and agree that I am financially responsible for charges not paid by insurance company. I understand that in certain instances my insurance may decide that medical services are not medically necessary and that payment may be denied for these services. I agree to be personally and fully responsible for payment or any denied charges. If I have Medicare, I understand that I may be asked to sign an advanced notice/waiver for certain services or procedures.

I hereby certify that the information I have provided is correct. I hereby certify that I have read, understand, and agree with the about HIPAA and Financial Policies. I further agree to pay bank charges for insufficient funds, finance charges and/or collection fees assessed to my account for any overdue balances.

Patient Signature/Responsible party _____ Date _____



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OFFICE POLICIES

CANCELLATIONS/NO-SHOW POLICY

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time.

No show policy: We do require a 24 hour notice of cancellations. If you do not show up to your appointment without notifying us, the first time will be a warning and after that, you will be charged \$75 for the time we were not able to fill when you were a no show.

MEDICAL RECORD POLICY

Each patient has a complete record of all medical care received at our office. Your personal medical record provides a history of treatment and diagnostic information that enables your health care team to make comprehensive medical evaluations. We consider your record to be confidential. Therefore, information will not be released without your written consent, unless required by law. Copies of your medical record will be released to you or transferred to another physician upon written consent. There will be a \$25-50 copying fee for this service. This must be paid prior to records being released.

COMPLETION OF FORMS (Family medical leave and disability forms)

A \$25-50 charge will be assessed for the completion of forms outside of an office visit. The charge varies on the length of the form and the time taken to complete.

REFERRALS

Please be advised that patients are responsible for managing their own referrals and making sure they are covered at time of service. Upon verbal request, our office, as a courtesy, will only be able to provide the referral start and end date to assist in helping determine when referrals will expire. As the patient, this will allow you to request a new referral/ extension in timely manner. Patients are also responsible for communicating with their own PCP and/or insurance companies. We thank you in advance for your understanding and support.