Patient Information Form

Last Name: _______________________________________ First Name: __________________________ MI: ______

Address: __________________________________ City: _______________________ State: _______ Zip: _________

Date of birth: ____/____/______ Age: _______ Social Security #: ____-____-______ Marital Status: _________

Home: (____)-____-______ Cell: (____)-____-______ Email Address: ______________________________________

Primary Care Physician: ____ Phone: (____)-____-______

Employer Name: ___________________________________ Employer Address: _______________________________

Employer City: ____________________________ State: ________ Zip: ____________ Phone: (____)-____-______

Referred by: ___________________________________ Reason for Visit: _____________________________________

Other

Is this an on the job injury? Yes ______ No ______ If yes, Date of injury ___/____/______

Is there an attorney involved? Yes _____ No______ Attorney Name and phone: __________________________

Person Responsible for payment: ___________________________________ Relationship to patient:___________

Address: ______________________________ City: _____________________ State: __________ Zip: __________

Insurance

Name of Insurance Company: ____ Phone: (____)-____-______

Address: _________________________________ City: ___________________ State________ Zip: ______________

Name of Policy Holder: ______________________________________ Social Security #: _____-______-_________

Address: _________________________________ City: ___________________ State________ Zip: ______________

Group # (if workers comp, claim # and contact person): ____

Name of Secondary Insurance: ____

Address: _________________________________ City: ___________________ State________ Zip: ______________

Name of Policy Holder: ______________________________________ Social Security #: _____-______-_________

Name of Policy Holder’s Employer: ____________________________ Policy Holder’s Date of Birth:___/___/____

Signature of responsible party: ____ Date: _________________

Patient Name: ____

Date of Birth: ___________________

Meaningful Use Patient Questionnaire

To improve the quality of care that patients receive, Sports & Spine Rehab Systems has implemented an electronic health record and is participating in the Meaningful Use Initiative. The data we are collecting below will help Sports & Spine Rehab Systems efficiently and safely care for you, reduce health disparities and improve care coordination between our office, your primary care physician and local hospitals. Please take a moment to answer the following questions regarding you and your overall healthcare. Thank you for choosing Sports & Spine Rehab Systems.

Please circle your race:

American Indian or Alaska Native **Asian** **Native Hawaiian or Other Pacific Islander**

African American **Caucasian** **Hispanic** **Other Race** **Refuse to Report**

Please circle your ethnic background:

Hispanic or Latino **Not Hispanic or Latino** **Refuse to Report**

What is your preferred language? ____

Patient or Guardian Signature______________________________________ Date: _______________________

Summary of HIPAA Notice of Privacy Practices
Effective March 1, 2014

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

A full version of this Privacy Notice is available to you at the front desk of our locations.
Under the Health Insurance Portability and Accountability Act of 1996(“HIPAA”) we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.
We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new provisions effective for all protected health information that we may maintain. In the vent that we make a material revision to the terms of out notice, a revised notice will be made available to you within 60 days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (817)- 518-1112.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written consent or authorization and you may revoke such authorization in writing at any time.

Treatment: We may use or disclose your health information to provide you with medical treatment or services

Payment: We may use or disclose your health information for services you receive at our office to be paid by your insurance carrier.

Health care Operations: We may use or disclose your health information for health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administration activities

Business Associates: There may be instances where services are provided to our office through contracts with a third party “business associates”. Whenever a business associate involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by federal, local, or state law.

Communication with Family or Friends: Our professionals, using their best judgement, may disclose to a family member, other relative, close friend, or any other person you identify, health information relevant to that person’s involvement in your care or payment related to your care. The office may also disclose your conditions to friends and family members who accompany you to our office.

Coroners, Medical Examiners, and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers’ Compensation: We may disclose health information to the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other programs established by law.

Research: Under certain circumstances, our office may use and disclose medical information about you for medical research purposes.

HIPAA Policy

Sports and Spine Rehab Systems
3120 W. Southlake Blvd Suite #100
Southlake, TX 76092
Ph: 817.431.6628
Fax: 817.796.1833

According to the Texas States Law and per HIPAA policy, our practice is not allowed to release any of your information without your permission. Please list any individuals that you are giving permission to receive or pick up any health information. Please list any individuals that you are giving permission to receive information regarding you as a patient at our practice.

Name: ____ Date of birth: ___/___/______
Address: ____
Phone: __________________________ Relationship: _____________________________

Name: ____ Date of birth: ___/___/______
Address: ____
Phone: __________________________ Relationship: _____________________________

Name: ____ Date of birth: ___/___/______
Address: ____
Phone: __________________________ Relationship: _____________________________

Patient Name: _____________________________ Date of Birth: ___/___/______

Signature: _______________________________ Date: ________________________

Consent to Treat: I consent to the administration of health care by Sports and Spine Rehab Systems. I understand that I may set conditions or limitations on my treatment and care and that if I wish to provide such conditions, I will be given the opportunity to write those on a separate document. I have been informed and acknowledge that I may withdraw my consent at any time upon written notice to Sports and Spine Rehab Systems. I am giving my consent to the administration of health care by Sports and Spine Rehab Systems voluntarily, and that I hereby knowingly and voluntarily enter this Health Care Consent for Treatment. Sports and Spine rehab Systems is a rehabilitation center only and encourages all patients to keep a Primary Care Physician.

Agreement for Benefit Assignment and Financial Responsibility: I agree to pay for all services rendered to me by a Sports and Spine Rehab Systems physician and/or other qualified healthcare provider employed by Sports and Spine Rehab Systems. I agree that I am responsible to provide timely information about my insurance coverage and changes in coverage as they occur. I agree to respond promptly to requests for information from my insurance company as they occur. I assign Sports and Spine Rehab Systems benefits due to me or become due to me as a result of the medical services I receive from a Sports and Spine Rehab Systems physician or other qualified healthcare provider. I further authorize the payments to be paid directly to Sports and Spine Rehab Systems. I also understand that I am responsible to Sports and Spine Rehab Systems for any payments made directly to me for services Sports and Spine Rehab Systems provided to me. If this account is not paid in accordance with Sports and Spine Rehab Systems policies, I agree and guarantee to pay collection costs, including reasonable attorney fees, collection agency fees, and interest from the date of demand.

If Medicare, Medicaid, Workers' Compensation, or other similar government program should determine that I am not eligible for coverage or that the treatment is not covered, I will be responsible for payment, unless prohibited by law.

If no insurance, third-party insurance, or motor vehicle accidents you will be responsible for all charges associated with your care. Any balance on your account is your responsibility to pay in full at the end of the office visit. Likewise, any associated medical procedure will require a prepayment of 50% of the physician's fee and the balance will be billed to the patient. We do not file insurance to third-parties or insurance carriers and do not accept liens. You will be responsible for all charges as well as billing appropriate carriers as you like. For the patients without insurance, we do offer a cash discount to patients who pay in full at time of service. We also can arrange payment plans. There are no discounts for third-party carriers.

Acknowledgement of Privacy Polices/HIPAA: I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time and I have the right to request new copies at any Sports and Spine Rehab Systems location during regular business hours.

☐ Accepted
☐ Declined
_____ Patient's Initials

By my signature below, I am acknowledging receipt of this document and agree to the terms under all five actions of this document. Agreement Consent to Treat, Benefit Assignment and Financial Responsibility and receipt of Privacy Policies/HIPAA.

Name of Patient/Guardian: ____ Date: ____________________

Signature of Patient/Guardian: ____ Date: _____________________

Relationship to Patient if signed by someone other than patient____________________ Date: _____________________

Name: ____ Date of Birth: _______________Todays date: _______________

Brief History of Problem:

____

____

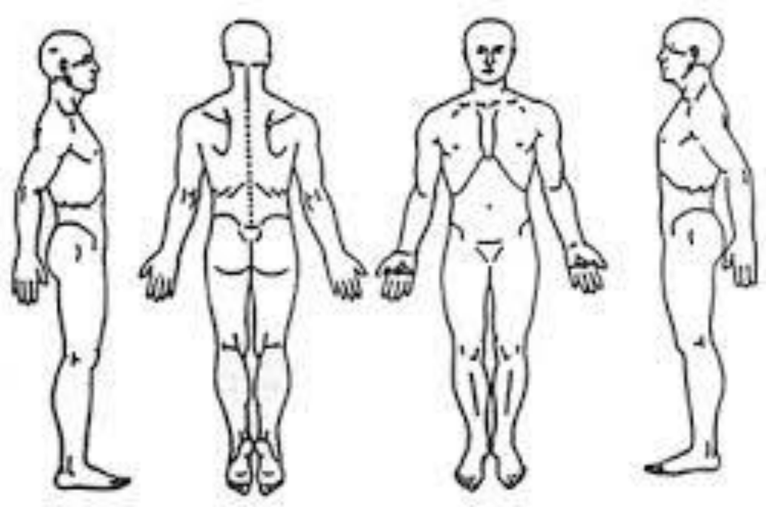
Approximate Onset of Problem: Number of _______Days, _______Weeks, and/or ______Years?

Did you have an injury? ___Yes ___ No If yes, did the injury occur at work? ___ Yes ___ No

Rate severity of Pain from 0-10 (0= None 10= Worst Possible): 0 1 2 3 4 5 6 7 8 9 10

Pain Diagram

Location of pain: Mark or circle the location of the pain you're experiencing



How often does your pain occur: ____ Intermittent ____Continuously ____Acidity Dependent ____ At Rest

Relieves Pain: ___ Rest ___ Activity ____ Other ____

How are you currently treating your pain? ____

Have you had pain management in the past? ___ Yes ____ No

Have you tried any of these in the past for your current condition?

___ Injections What kind? ___________________________________

___ Pain Medications What kind? ___________________________________

___ Physical therapy For how long? _________________________________

Review of Symptoms: [Circle all that apply]

Weakness to: _________________________ Fatigue Headaches Vision Changes Poor Balance

Numbness to: _________________________ Nausea Vomiting Chills/Fever

Tingling to: ___________________________ Depression Dependence Insomnia

Chest Pain Shortness of Breath

Past Medical History: [Circle all that apply]

Diabetes Fibromyalgia Stroke Liver Disease Hypertension COPD Previous Heart Attack Lupus

High Cholesterol Cancer Sleep Apnea Implanted Device: _________________

Heart Disease Mental Illness Renal Disease Other: ___________________________

Please list any medications you currently tale, including anything over the counter:

Medication Name	**Dosage**	**Directions**

Have you had any problems with addiction or dependency? ___ Yes ___ No

Please list any known allergies:

____

Have you had any recent hospitalizations? ___ Yes ___ No

If so, when and what for? ____

Please list ANY past surgical procedures and the date they occurred:

____

____

Have you had recent imaging? ____MRI ____ CT ____ X-ray ____ EMG ____Bone Scan

Family History:

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Substance Abuse	Medication Dependence
Father							
Mother							
Maternal Grandfather							
Maternal Grandmother							
Paternal Grandfather							
Paternal Grandmother							

Social History: ____Single ____Married ____Widowed _____Divorced

Do you smoke: ____ Yes ____ No

Do you drink: ____Yes ____ No

Patient Name:____ **Date of Birth:**__________________

Signature: ____ **Date:** _____________________