Patient Registration Form

Galveston Physical Medicine

2724 61st #5

Galveston, Texas 77551

Office: 409-744-9355 • Fax: 409-744-9356

Patient Name: ____
Last First Middle

Address: ____
Street City State Zip Code

Home: ( ) ____________ Work: ( ) ____________ Cell: ( ) ____________

S.S.N.: ____________________ Date of Birth: ______________ Age: ______________

Gender: Male ☐ Female ☐ Email Address: ______________________________

Marital Status: Married ☐ Divorced ☐ Single ☐ Widowed ☐

Referring Physician: _________________________ Reason for your visit? _______________

Phone: ( ) ____________________________________

Address: ____
Street City State Zip Code

Employer or School: _________________________ Address: _____________________________

Emergency Contact: _______________________ Relation: ___________ Phone: ( )_______

Spouse's Name: ____ S.S.N.: _________________

Spouse's Date of Birth: _______________________ Employer: ___________________________

Spouse's Phone: ( ) ____________________ Are you insured under their policy? Yes ☐ No ☐

Responsible Party Name and Address (Under 18):

Relation to Patient: ____

Date of Birth: ____________ Employer: ___________________________ Phone: ( ) ________

Health/Medical Insurance ☐ Yes ☐ No ☐ Self-Pay

PATIENT INSURANCE INFORMATION TO BE COMPLETED ON PATIENT INSURANCE FORM ATTACHED

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

Signature: ____ Date: _______________

Patient Name: ____DOB: _________________

Primary **Insurance Information:**

Insurance Name: _________________________________ Effective Date: _______________

Subscriber/ID#: _________________________________ Group # _____________________

Claims Address: ____

Phone Number: __________________________________ Copay: ______________________

Primary Insured: (circle one) Self Spouse

Employer: ____

Date of Birth: __________________________ Social Security Number: _________________

Secondary **Insurance Information:**

Insurance Name: _________________________________ Effective Date: _______________

Subscriber/ID#: _________________________________ Group # _____________________

Claims Address: ____

Phone Number: __________________________________ Copay: ______________________

Primary Insured: (circle one) Self Spouse

Employer: ____

Date of Birth: __________________________ Social Security Number: _________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request the payment of the authorized Medicare/other Insurance Company benefits be made to me or on my behalf to Galveston Physical Medicine for any services furnished to me by that party who accepts assignments/medical professional. Regulations pertaining to Medicare assignment benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act & 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature: ____ Date: _________________

Galveston Physical Medicine

Insurance & Financial Policy

Welcome to our practice. We are committed to providing you with the best possible care by offering you treatment options that may or may not be covered by your insurance. We are open to discussing these options with you at any time.

Currently we are participating with many major insurance companies. Insurance is a contract between you and your insurance company. <u>It is your responsibility to be aware of your benefits.</u> If you are unsure of your insurance benefits, you will need to contact your insurance carrier for clarification of your benefits. Certain services may or may not be covered by Medicare or Medicaid and it is the patient's responsibility to inquire as to the eligibility of a treatment for Medicare or Medicaid coverage.

This office bills your insurance for services performed by our providers. The laboratory will bill you or your insurance company of all labs performed. If you have question regarding your lab bill, please contact the laboratory directly or your insurance carrier.

Please bring your insurance card to each appointment. <u>If you change insurance companies or benefits, you must call our office with the new information at least 48 hours prior to your appointment.</u> If you do not, you will be responsible for the bill.

All insurance information, including referrals, and claim forms when necessary must be provided at the time of services. Please be sure to check that referral from your primary care physician has been received two (2) days prior to your appointment. We cannot see you without a valid referral if a referral is required by your insurance company. It is your responsibility to ensure that a referral has been created through your Primary Care Physician's office when required by your insurance. Balances for any reason, co-pay, deductible, coinsurance and denials for any reason are the responsibility of the patient or guarantor.

All co-pays, deductibles, and payments are due at the time of service, with co-pays being collected prior to you seeing the doctor. When receiving a statement after your visit, payment is due immediately upon receipt. To better accommodate your needs, we accept cash, personal checks, debit cards, Visa and Mastercard as forms of payment. Any personal checks returned to us from you bank will be subject to a fee of $40.00.

We will assign all accounts thirty (30) days or more past due to an outside collection agency for assistance. This may be an automatic assignment unless prior arrangements have been approved by management. Should this step be necessary, we may add a $45.00 service charge to your balance. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go to our collection agency, any arrangements/payments will need to be made directly to the collection agency. In addition, once an account has been turned over to the collection agency, the patient will receive a letter of discharge from our practice.

We understand that <u>situations may arise that require you to cancel your appointment; however we do request a 24 business hour notice of such cancellation. We may charge a $50.00 fee for any appointments that have not been cancelled within this timeframe.</u>

An administrative fee of $75.00 per form will be charged for any forms (relating to disability, auto injury, life insurance applications, motor vehicle division, employment matter, etc.) that need to be reviewed and/or filled out by our medical professionals. All administrative fees must be prepaid.

Please keep all copies of all patient receipts. Should you need an end of year statement for tax purposes, an administrative fee of $25.00 will apply.

Any patient who commits any of the following offenses, including but not limited to: abusive behavior, non-compliance with treatment, Rx misuse, multiple missed office visits, or failure to pay account shall be grounds for immediate dismissal from the practice.

Thank you for understanding our financial and insurance policies. If you have questions about the above information, please do not hesitate to ask us. We are here to assist you.

I have read the above Insurance & Financial Policy, and understand and agree to these terms.

Printed Patient Name: ____

Patient Signature: ____ Date: ____________________________

Galveston Physical Medicine

Protected Health Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual also has the right to request that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ HOME TELEPHONE (   ) ___________________________________

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ O.K. to fax to: (   ) ___________________________________

☐ WORK TELEPHONE (   ) ___________________________________

- ☐ O.K. to leave message with detailed information   ☐ Use other:
- ☐ Leave message with call-back number only

☐ WRITTEN COMMUNICATION

- ☐ O.K. to mail to my home address on file   ☐ Use other:
- ☐ O.K. to mail to my work address

☐ Email

O.K. to email detailed information to the following email address:

____

___________________________________	___________________________
Patient Signature	Date
___________________________________	___________________________
Print Name	S.S.N.

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum information necessary to accomplish the intended purpose. These provisions do not apply to the uses or disclosures made pursuant to an authorization requested by the individual.

Disclosure of treatment records, payment information, and healthcare operations may be permitted without prior written consent in an emergency.

Galveston Physical Medicine

Authorization for Release of Information

Patient Name: ________________________________ DOB: ___/___/___SSN: ____-____-____

Address: ____

Home Phone: (   ) _________________   Cell Phone: (   ) ________________

I authorize: ____

Physician Name   Facility Name   Facility Phone

____

Facility Address   Facility Fax

To send/release photocopies of medical records concerning the above named person to:

Galveston Physical Medicine
2724 61st #5
Galveston, Texas 77551

For the purpose of treatment for ________________________________. I authorize the release of photocopies of the following medical records and information in their possession including all confidential HIV related information, confidential alcohol or drug abuse related information and confidential mental health diagnosis and treatment information. I agree that these provisions will remain in effect until I provide written revocation to Galveston Physical Medicine.

☐ Medical Records   ☐ Hospital Records   ☐ Procedure Records   ☐ Laboratory Records

_____ Inpatient   _____ Outpatient   ☐ Other

______________________________________   ______________________   ____________

Signature of Patient/Legal Guardian   Relationship to Patient   Date

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AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse and HIV or communicable disease) requested by my health insurance carrier, Medicare or any other third-party payers, and I authorize Galveston Physical Medicine to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Galveston Physical Medicine.

I agree that these provisions will remain in effect until I provide written revocation to Galveston Physical Medicine.

______________________________________   ______________________   ____________

Signature of Patient/Legal Guardian   Relationship to Patient   Date

Galveston Physical Medicine

Patient Consent Form

I, ____, understand that as part of my health care, that Galveston Physical Medicine creates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I acknowledge that I have been provided with a *Notice of Privacy* which provides a more completes description of information uses and disclosures.

I understand that Galveston Physical Medicine is not required to agree to the restrictions requested and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Federal and State Regulations.

I further understand that Galveston Physical Medicine reserves the right to change their notice and practices and prior to implementation, in accordance with Federal and State Regulations.

Galveston Physical Medicine has my consent to give out my private health information, including my identity, diagnoses and treatments, whether in writing or verbally, to the following persons or entities (e.g. spouse, child or other representative):

____
Name Relationship to Patient

____
Name Relationship to Patient

____
Name Relationship to Patient

I understand that as require for Galveston Physical Medicine's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

____ _________________________________
Patient or Guardian Witness

____ _________________________________
Date Date

Neuropathy Symptom Questionnaire

Areas affected: (circle one): Feet Hands Legs

Please answer **Yes** or **No** to each question by marking a **Circle**

Pain	Yes	No
Numbness	Yes	No
Tingling	Yes	No
Burning	Yes	No
Coldness	Yes	No
Pins & Needles	Yes	No
Crawling sensations	Yes	No
Walking on rocks	Yes	No
Cannot stand sheets	Yes	No
Have to wear socks	Yes	No
Balance problems	Yes	No
Discoloration of your legs	Yes	No
Have you had any amputations	Yes	No
Has your physician diagnosed "Neuropathy"	Yes	No
Have you ever had an EMG or Nerve Conduction Test	Yes	No
Do you have Diabetes	Yes	No
Have you had back surgery	Yes	No
Have you ever had an MRI of your back	Yes	No

Comments: (For Doctor's Use Only)

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Patient's Name: ______________________________ Date: ______________

Age: ________________ Sex: ________________

Neuropathy Medical History

1. Do you have any allergies____________________________________ Yes No
2. Are you on Anticoagulant Therapy____________________________ Yes No
3. Do you suffer from palpitations________________________________ Yes No
4. Do you suffer from arrhythmias of your heart beat_______________ Yes No
5. Do you use a pacemaker______________________________________ Yes No
6. Do you use a defibrillator______________________________________ Yes No
7. Do you have a mechanical heart valve__________________________ Yes No
8. Are you on dialysis____ Yes No
9. Do you suffer from epilepsy or convulsions______________________ Yes No
10. Is there any metal in your body_________________________________ Yes No
11. Have you had knee replacement surgery________________________ Yes No
12. Have you had hip replacement surgery__________________________ Yes No
13. Have you had any transplants__________________________________ Yes No
14. Have you had cancer____ Yes No
15. Have you had chemotherapy___________________________________ Yes No
16. Have you had radiation treatments______________________________ Yes No
17. Do you have arthritis____ Yes No
18. Do you have gout____ Yes No
19. Have you had back problems___________________________________ Yes No
20. Have you had problems with your feet__________________________ Yes No
    (Fractures-deformities-ingrown toe nails-fungus
    Infection-bunions-hammer toes-amputation of foot/toes)
21. Do you have chronic swelling of your legs_______________________ Yes No
22. Have you experienced leg ulcers? Foot__________________________ Yes No

Patient's Name: ____ Date: ___________

Neuropathy Medication Questionnaire

Please answer Yes or No to each question by marking a circle

Any allergies to medication____Yes No

Any allergies (poison ivy, bee stings, etc.)____________________________Yes No

Are you taking:

- Gabapentin (Neurontin)____Yes No
- Cymbalta____Yes No
- Lyrica____Yes No
- Hydrocodone____Yes No
- Percocet____Yes No

List other medications you are taking:

_____________________ _____________________ _____________________

_____________________ _____________________ _____________________

_____________________ _____________________ _____________________

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_____________________ _____________________ _____________________

Comments: (For Doctor's Use Only)

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Patient's Name: ____ Date: _______________

Please **<u>circle</u>** **<u>Yes</u>** or **<u>No</u>** appropriately if you have or have not had any of the following:

Allergies	Yes	No
Overweight	Yes	No
Hypertension	Yes	No
Cholesterol Problems	Yes	No
Diabetes	Yes	No
Mental Illness	Yes	No
Drug Addiction	Yes	No
Alcoholism	Yes	No
Respiratory Problems	Yes	No
Heart Problems	Yes	No
Liver Problems	Yes	No
Stomach Problems	Yes	No
Reflux (Gerd)	Yes	No
Liver Problems	Yes	No
Pancreas Problems	Yes	No
Kidney Problems	Yes	No
Urinary Problems	Yes	No
Stroke Problems	Yes	No
Rectal Problems	Yes	No
Vascular Problems	Yes	No

Males		
Sexually transmittable disease	Yes	No
Penile Problems	Yes	No
Testicular Problems	Yes	No
Prostate Problems	Yes	No
Herpes	Yes	No

Comments: (For Doctor's Use Only)

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Patient's Name: ____________________________________ Date: ___________

Hospitalization, Accidents, Surgeries

Hospitalizations: (Do not include surgeries)

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Date of Accidents:

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Date of Surgeries or Procedures:

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Comments: (For Doctor's Use Only)

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Patient's Name: ____ Date: ____________