

Date: _____

PATIENT INTAKE FORM

<i>Patient Info</i>					
Name		DOB (mm/dd/yyyy)		How did you hear about us?	
Address				City:	Postal Code:
Contact #'s	Home:	Mobile:		Email:	
Occupation		Status	<input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Married <input type="checkbox"/> Separated	<input type="checkbox"/> Common Law <input type="checkbox"/> Widowed
Emergency Contact		Relationship:		Phone:	

<i>Auto Insurance Info</i>	<i>Medical Insurance Info</i>
Name of Insurance Co _____	Name of Insurance Co _____
Policy No _____	Policy No _____
Phone No _____	Phone No _____
Adjuster's Name _____	Policy Holder Name _____
Claim No _____	Date of Birth: ___/___/___ Sex <input type="checkbox"/> M <input type="checkbox"/> F
Precertification Phone No _____	Relationship to Patient:
Address for Claims _____	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse
City: _____ State: _____ Zip Code _____	

<i>Legal Information</i>			
Do you have a lawyer for your accident?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Law Firm:		Telephone:	Fax:

<i>Medical History: Please Complete as thoroughly as possible</i>			
Significant Surgeries	<input type="checkbox"/> None	<input type="checkbox"/> Yes	List:
Fractures / Injuries	<input type="checkbox"/> None	<input type="checkbox"/> Yes	List:
Significant Accidents / Falls	<input type="checkbox"/> None	<input type="checkbox"/> Yes	List:
Medications / Vitamins	<input type="checkbox"/> None	<input type="checkbox"/> Yes	List:

Pain X Ortho Specialists

Patient Consent

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: By signing this form, you are granting consent to the office to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at _____ You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND CONSENT TO RELEASE INFORMATION: I certify that the information given by me in applying for payment under Title XVIII and /or Title of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. **VERIFICATION OF NON-PREGNANCY (Female Patients only):** By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____

PRINT PATIENTS' NAME: _____

PATIENT'S SIGNATURE: _____

OTHER THAN PATIENT, PRINT NAME AND RELATIONSHIP (WITNESS): _____

SIGNATURE ON FILE:

PATIENT NAME: _____

ADDRESS: _____

SSN#: _____

I authorize use of this form on all Medicare/private and secondary insurance submissions.

I authorize releases of any information to Medicare/private and secondary insurance companies to determine the benefits payable for this service.

I understand that I am responsible for my bill if I am not covered by insurance.

I understand that I am responsible for my co-pay and deductible not covered by Medicare/primary and secondary Insurance.

I authorize payment direct to service provider.

I permit a copy of this authorization to be used in place of original.

PATIENT SIGNATURE: _____

PATIENT GAUDRIAN(WITNESS): _____

DATE: _____

By signing below, I acknowledge that I have been provided a copy of Notice of Privacy Practices.

Signature of Patient or Representative: _____

Print name of Patient or Representative: _____

Date: _____

Description of Personal Representative's Authority: _____

Pain X Ortho Specialists

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefit directly to us. This policy reduces your out of pocket expense and allows you to place your family under care.

1. **If You Don't Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Speak to our representatives to set up a payment plan.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule or fees bearing no relationship to the current standard and in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

The undersigned agrees, whether signing as agent or patient, that she/he individually obligates himself/herself to pay for services rendered in accordance with the regular rates and terms of Pain X Ortho Specialists. The practice will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/ patient is responsible for any co-payment, deductible, co-insurance and amounts identified by the insurer as the patient's responsibility. A fee of 33% will be added to the outstanding balance if the outstanding balance will be referred to collection. This information will be used for the purpose of evaluating and administering claims of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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<i>PATIENT HEALTH HISTORY</i>				
Do you have any of the following symptoms?	<input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fainting/ Dizziness <input type="checkbox"/> Numbness/Pain in Arms/Hands <input type="checkbox"/> Numbness/Pain in Legs/Feet <input type="checkbox"/> Fatigue <input type="checkbox"/> Nervousness <input type="checkbox"/> Loss Weight <input type="checkbox"/> Chest Pain <input type="checkbox"/> Coffee _____ cups/day	<input type="checkbox"/> Lower Back Pain <input type="checkbox"/> Pain Between Shoulders <input type="checkbox"/> Painful tailbone <input type="checkbox"/> Foot Troubles <input type="checkbox"/> Weakness <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Neck Pain <input type="checkbox"/> Backache <input type="checkbox"/> Nausea/Fever <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Smoking _____ pks/day	<input type="checkbox"/> Urination Problems <input type="checkbox"/> Digestive Problems <input type="checkbox"/> Bowel Problems <input type="checkbox"/> Anxiety/Panic Attacks <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Acid Reflux/Ulcers <input type="checkbox"/> Blood urine <input type="checkbox"/> Allergies <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Alcohol _____ drks/week	
Do you, or have you ever had?	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Spinal Infection <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease/Pacemaker <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke/TIA/Aneurysm <input type="checkbox"/> Blood Clots <input type="checkbox"/> Abdominal Aortic Aneurysm <input type="checkbox"/> Angina	<input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Asthma/Chronic Bronchitis <input type="checkbox"/> Thyroid disease/problems <input type="checkbox"/> Kidney disease/problems <input type="checkbox"/> Liver disease/problems <input type="checkbox"/> Skin problems <input type="checkbox"/> Psychological disorder <input type="checkbox"/> Fibromyalgia/Chronic Fatigue	
Do you have a family history of any of the following?	<input type="checkbox"/> Cancer <input type="checkbox"/> Obesity <input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Stroke <input type="checkbox"/> Blood disorders	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorders <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Parkinson's <input type="checkbox"/> Huntington's	<input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Digestive disorder <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Mental illness