

# Pro-Care Medical Center

## Patient Registration Form

(Please Print)

Patient Information						
Patient's Last Name	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Legal name, if different than above:	Former/Maiden name:	Social Security no.:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Home phone no.:	Cell phone no.:	Okay to email, leave voice messages, or text you regarding appointments, test results, referrals, or for any other reason?    YES    NO				
E-Mail Address:						
Street address:			City:	State:	ZIP Code:	
Occupation (if student please specify):			Employer:		Employer/Work phone no.:	
Were you referred by a physician?    NO    YES by Dr. _____						

Insurance Information				
Is patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No    Primary Insurance Company: _____				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:
Patient relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				

### Authorization to Release Medical Information / Emergency Contact

Do you want Pro-Care Medical Center, and all employees thereof, to be able to discuss financial matters or medical care with any family members or other emergency contacts? This permission will be valid indefinitely and must be revoked in writing. If so, please specify who and which information below.

You may discuss my financial matters or medical care with the following:

INFORMATION OK TO DISCUSS	Name	Relationship	Phone Number	Also Emergency Contact?
____ FINANCIAL ____ MEDICAL CARE				YES    NO
____ FINANCIAL ____ MEDICAL CARE				YES    NO

Any other emergency contacts? (Name and Phone Number): \_\_\_\_\_

# Pro-Care Medical Center

## Consent for Treatment, Notice of Privacy Practices Policy, and Financial Policy

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Pro-Care Medical Center unless revoked by me orally or in writing. I understand that the practice uses audio recording of patient encounters and unrecorded live video feeds of rehabilitation treatment from time-to-time solely for educational and training purposes within the practice and I consent to audio recording and unrecorded live video of my patient encounters for this purpose.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Pro-Care Medical Center's infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Pro-Care Medical Center if any of these situations occur during your treatment period.

### Consent To Treatment Of A Minor Child (*Under the age of 18*)

I authorize this office to administer services as deemed necessary to my minor child, \_\_\_\_\_ . My relation to the minor child is \_\_\_\_\_ .

A **Notice of Privacy Practices (NPP)** is available to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, has access to a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

As a part of our professional relationship, it is important that you have an understanding of our financial policy.

- It is your responsibility to provide us with your most current insurance and billing information.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim - regardless of our estimation.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (512) 371-7478 or (210) 881-0630.
- Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$35.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

**We may charge you a fee if you fail to attend, cancel, or reschedule your appointment with less than one full business day's notice. Cancellation fees are \$40 for MD/DO/FNP appointments, \$20 for DC/Ideal Protein appointments, and \$200 for any specialist/procedures.**

My signature below indicates that I have read and fully understand the Consent for Treatment, Privacy Practices Policy, and Financial Policy.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Representative Relationship

\_\_\_\_\_  
Date

# Pro-Care Medical Center

## Assignment of Benefits and Authorization for Direct Payment

### Assignment of Benefits, Assignment of Rights to Pursue ERISA and other Legal and Administrative Claims associated with my Health Insurance and/or Health Benefit Plan (Including Breach of Fiduciary Duty), Designation of Authorized Representative and Authorization for Direct Payment

I hereby assign and convey directly to Pro-Care Medical Center (also doing business as Injury Medical Group and Injury Diagnostic Services), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Pro-Care Medical Center (hereinafter refers to Pro-Care Medical Center, Injury Medical Group and Injury Diagnostic Services), regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Pro-Care Medical Center to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and /or attorney to release to Pro-Care Medical Center any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Pro-Care Medical Center or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose in action arising under any group health plan, employee benefits, plan, health insurance or tort feisor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Pro-Care Medical Center (including any right to pursue those legal or administrative claims or chose in action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Pro-Care Medical Center all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by Pro-Care Medical Center, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Pro-Care Medical Center) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Pro-Care Medical Center as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator, or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment of valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

**PERSONAL INJURY PATIENTS:** I hereby direct any and all party's insurance companies to make direct payment to Pro-Care Medical Center for all services, items and/or supplies furnished to me or my family members for and in relation to my care at Pro-Care Medical Center. I am choosing to forgo the use of my own health insurance, if any health insurance is available, in order to preserve my healthcare benefits. I am requesting that all of my medical bills are billed solely to the responsible 3rd party insurer, UIM and/or PIP. My health insurance may only be billed at the sole discretion of Pro-Care Medical Center.

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Patient's Printed Name

Date of Birth

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Patient/Legal Representative Signature

Representative Relationship

Date

# Pro-Care Medical Center

Please tell us the **REASON FOR TODAY'S VISIT** or any special concerns you would like to discuss with your doctor today:

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Please list your **CURRENT MEDICATIONS**:

Name of Medication	Dosage (ie, milligrams)	How Taken (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (ie, rash, nausea)

Please provide your **IMMUNIZATION HISTORY**:

	Yes	No	Date		Yes	No	Date
Tetanus-Diphtheria Booster				Hepatitis A Vaccine			
Influenza Vaccine (Flu Shot)				Hepatitis B Vaccine			
Pneumococcal Vaccine				Human Papilloma Virus (HPV)			
Tuberculosis (TB) Skin Test				Varicella Vaccine			

Please provide your **PAST MEDICAL HISTORY** (check all that apply):

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Gallbladder Disease     | <input type="checkbox"/> MI (Heart Attack)       |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cancer, type_____   | <input type="checkbox"/> GERD (Reflux)           | <input type="checkbox"/> Osteoarthritis          |
| <input type="checkbox"/> Angina (Chest Pain)     | <input type="checkbox"/> CVA (Stroke)        | <input type="checkbox"/> Hepatitis C             | <input type="checkbox"/> Osteoporosis            |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> COPD (Emphysema)    | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Peptic Ulcer Disease    |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> CAD (Heart Disease) | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Renal Disease (Kidneys) |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Crohn's Disease     | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Seizure Disorder        |
| <input type="checkbox"/> Atrial Fibrillation     | <input type="checkbox"/> Depression          | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> BPH (Enlarged Prostate) | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Migraine Headaches      | <input type="checkbox"/> Other: _____            |

Please tell us about any **SURGERIES** you have had, you may indicate the **date/year if known**:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Angioplasty                   | <input type="checkbox"/> Cholecotomy (Colon Removal) | <input type="checkbox"/> Pacemaker             | <b>Gender Specific Female:</b>               |
| <input type="checkbox"/> Angioplasty with Stent        | <input type="checkbox"/> Colostomy                   | <input type="checkbox"/> Small Bowel Resection | <input type="checkbox"/> Tubal Ligation      |
| <input type="checkbox"/> Appendix                      | <input type="checkbox"/> Gastric Bypass              | <input type="checkbox"/> Thyroidectomy         | <input type="checkbox"/> Breast Biopsy       |
| <input type="checkbox"/> Arthroscopy Knee              | <input type="checkbox"/> Hernia Repair               | <input type="checkbox"/> Tonsillectomy         | <input type="checkbox"/> Cesarean Section    |
| <input type="checkbox"/> Back Surgery                  | <input type="checkbox"/> Hip Replacement             | <b>Gender Specific Male:</b>                   | <input type="checkbox"/> D & C               |
| <input type="checkbox"/> CABG (Open Heart Surgery)     | <input type="checkbox"/> Knee Replacement            | <input type="checkbox"/> Prostatectomy         | <input type="checkbox"/> Hysterectomy        |
| <input type="checkbox"/> Carpal Tunnel Release         | <input type="checkbox"/> LASIK                       | <input type="checkbox"/> TURP                  | <input type="checkbox"/> Mastectomy          |
| <input type="checkbox"/> Cataract                      | <input type="checkbox"/> Liver Biopsy                | <input type="checkbox"/> Vasectomy             | <input type="checkbox"/> Breast Reduction    |
| <input type="checkbox"/> Cholecystectomy (Gallbladder) | <input type="checkbox"/> ORIF (Repair Broken Bone)   |  | <input type="checkbox"/> Breast Augmentation |

## Pro-Care Medical Center

Please list any **ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY:**

Please provide your **FAMILY HISTORY:**

	M O T H E R	F A T H E R	S I S T E R	B R O T H E R	O T H E R		M O T H E R	F A T H E R	S I S T E R	B R O T H E R	O T H E R
ADD/ADHD						Heart Disease					
Alcoholism						Premature Heart Disease (Male <55yr, Female <65yr)					
Allergies						High Cholesterol					
Alzheimer's Disease						High Blood Pressure					
Asthma						Irritable Bowel Disease					
Blood Clots						Learning Disability					
Blood Disease						Mental Illness					
Cancer, Type _____						Migraines					
Stroke						Obesity					
Depression						Osteoarthritis					
Developmental Delay						Osteoporosis					
Diabetes						Renal Disease					
Eczema						Seizures					
Hearing Deficiency						Other:					

Please provide your <b>SOCIAL HISTORY:</b>	<b>FOR FEMALES ONLY:</b>
Do you smoke? Yes No Former Type of Tobacco: _____ Packs/Day: _____ Years Smoked: _____ Year Quit: _____ Have you ever tried to quit? Yes No  Do you drink alcohol? Yes No Former Type of Alcohol: _____ Frequency: _____ Amount: _____ When was your last drink: _____	Age at First Period: _____ Date of Last Menstrual Period: _____ Date of Last Mammogram: _____ Date of Last Pap Smear: _____ Any history of abnormal pap smears? Yes No If yes, when? _____ Are periods regular? Yes No Do you have pain with periods? Yes No Is flow: Normal Heavy Light Spotting  # of Pregnancies: _____ # of Children: _____ # of Miscarriages: _____ # of Abortions: _____

## Pain History

1. What is your **main complaint**? \_\_\_\_\_
2. On the scale below, please circle the severity of your **main complaint** (at its worst)

None	Slight	Mild	Moderate	Severe					
1	2	3	4	5	6	7	8	9	10

3. On the scale below please circle how often you experience your **main complaint**:  

Infrequent	Occasional	Intermittent	Frequent	Constant
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4. How long have you been experiencing your main complaint? \_\_\_\_\_

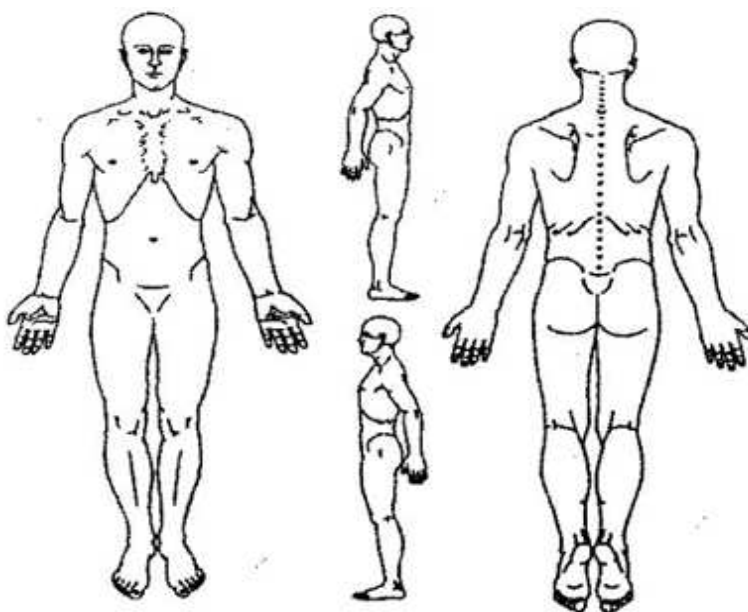
Please circle if you are you currently experiencing:

- Neck Pain • Neck Stiffness • Headaches • Shoulder Pain • Radiating Arm Pain • Arm/Hand Tingling & Numbness •  
 Low Back Pain • Radiating Pain into Buttocks Radiating Pain Down One Leg • Radiating Pain Down both Legs •  
 Muscle Weakness Pain While Sneezing or Coughing • Bowel or Bladder Problems

5. On the diagram below, please show where you are experiencing all of your present complaints using the following letters:

A: Ache B: Burning Pain C: Cramping D: Dull Pain R: Throbbing Pain N: Numbness T: Tingling

Don't forget to mark your areas of complaint on the diagram!



Do you have **pain** and/or **difficulty** performing any of the following activities?

Personal Care	_____
Lifting	_____
Reading	_____
Concentrating	_____
Working	_____
Driving	_____
Sleeping	_____
Recreation	_____
Walking	_____
Sitting	_____
Standing	_____
Social Life	_____
Job Performance	_____
Relationships	_____
Exercise	_____

6. When do you notice your **main complaint** most?  AM  PM      How long does it last? \_\_\_\_\_ Mins \_\_\_\_\_ Hrs
7. What makes you feel better? \_\_\_\_\_
8. What makes you feel worse? \_\_\_\_\_
9. Have you ever had this problem in the past?  Yes  No
10. Have you lost time from work because your **main complaint**?  Yes  No      Dates? \_\_\_\_\_ to \_\_\_\_\_
11. Since the onset of your problem, has the intensity..  Gotten Worse  Gotten Better  Stayed the Same
12. Have you been diagnosed with any herniated disc?  Yes  No  Not Sure      If yes, what disc levels?  
 \_\_\_\_\_
13. Have you had any spinal surgeries?  Yes  No      If yes, specify what type: \_\_\_\_\_

# Accident Injury Report

Name \_\_\_\_\_ Date \_\_\_\_\_

Date and Time of Accident \_\_\_\_\_ Location of Accident \_\_\_\_\_

Damage to Your Vehicle/Property (\$) \_\_\_\_\_ Type of Vehicle/Property \_\_\_\_\_

Was there a police report filed? YES NO Was a citation issued? YES NO

If yes, to whom? \_\_\_\_\_

Description of Accident \_\_\_\_\_

Did you receive medical care immediately after the accident? YES NO

Did you go to the ER? YES NO If yes, when? \_\_\_\_\_

Did you receive any diagnostic imaging (x-rays, CTs, MRI, Ultrasound, etc)? YES NO

If yes, what tests did you receive? \_\_\_\_\_

Have you seen another doctor since the accident? YES NO Doctor's Name \_\_\_\_\_

## Auto Accidents Only

Your location in vehicle: \_\_\_\_\_ driver \_\_\_\_\_ front seat passenger \_\_\_\_\_ back seat passenger

Were you wearing a seatbelt? YES NO Shoulder harness? YES NO

Location of impact: \_\_\_\_ front center \_\_\_\_ right front \_\_\_\_ left front \_\_\_\_ from behind \_\_\_\_ right rear \_\_\_\_ left rear \_\_\_\_ side

## Your Insurance Information

Do you have PIP (personal injury protection) on your vehicle insurance policy? YES (fill out below) NO

Insurance co. \_\_\_\_\_ Policy # \_\_\_\_\_

Phone # \_\_\_\_\_ Claim # \_\_\_\_\_

Adjustor's Name \_\_\_\_\_

## Responsible Party's Insurance Information

Are you filing under the responsible party's insurance? YES (fill out below) NO

Insurance co. \_\_\_\_\_ Policy # \_\_\_\_\_

Phone # \_\_\_\_\_ Claim # \_\_\_\_\_

Adjustor's Name \_\_\_\_\_