Pro-Care Medical Center

Patient Registration Form

(Please Print)

Patient Information						
Patient's Last Name	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ 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: ❑ M ❑ 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? ❑ Yes ❑ No	Primary Insurance Company:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:
Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ 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 feasor 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.

Patient's Printed Name Date of Birth

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:

_____

_____

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):

____ Allergies
____ Anemia
____Angina (Chest Pain)
____ Anxiety
____ Arthritis
____ Asthma
____ Atrial Fibrillation
____ BPH (Enlarged Prostate)
____ Blood Clots
____ Cancer, type_____
____ CVA (Stroke)
____ COPD (Emphysema)
____ CAD (Heart Disease)
____ Crohn's Disease
____ Depression
____ Diabetes
____Gallbladder Disease
____ GERD (Reflux)
____ Hepatitis C
____ High Cholesterol
____ High Blood Pressure
____ Irritable Bowel Disease
____ Liver Disease
____ Migraine Headaches
____MI (Heart Attack)
____ Osteoarthritis
____ Osteoporosis
____ Peptic Ulcer Disease
____ Renal Disease (Kidneys)
____Seizure Disorder
____ Thyroid Disease
____ **Other:** _____

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

____ Angioplasty
____ Angioplasty with Stent
____ Appendix
____ Arthroscopy Knee
____ Back Surgery
____ CABG (Open Heart Surgery)
____Carpal Tunnel Release
____Cataract
____ Cholecystectomy (Gallbladder)
____ Cholectomy (Colon Removal)
____ Colostomy
____ Gastric Bypass
____ Hernia Repair
____ Hip Replacement
____ Knee Replacement
____ LASIK
____ Liver Biopsy
____ ORIF (Repair Broken Bone)
____ Pacemaker
____ Small Bowel Resection
____ Thyroidectomy
____ Tonsillectomy

Gender Specific Male:
____Prostatecomy
____ TURP
____ Vasectomy

Gender Specific Female:
____ Tubal Ligation
____ Breast Biopsy
____ Cesarean Section
____ D & C
____ Hysterectomy
____ Mastectomy
____ Breast Reduction
____ Breast Augmentation

Pro-Care Medical Center

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

_____

_____

Please provide your **FAMILY HISTORY:**

	MOTHER	FATHER	SISTER	BROTHER	OTHER		MOTHER	FATHER	SISTER	BROTHER	OTHER
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 **SOCIAL HISTORY:**

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: _____

FOR FEMALES ONLY:

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

4. How long have you been experiencing your main complaint? _____

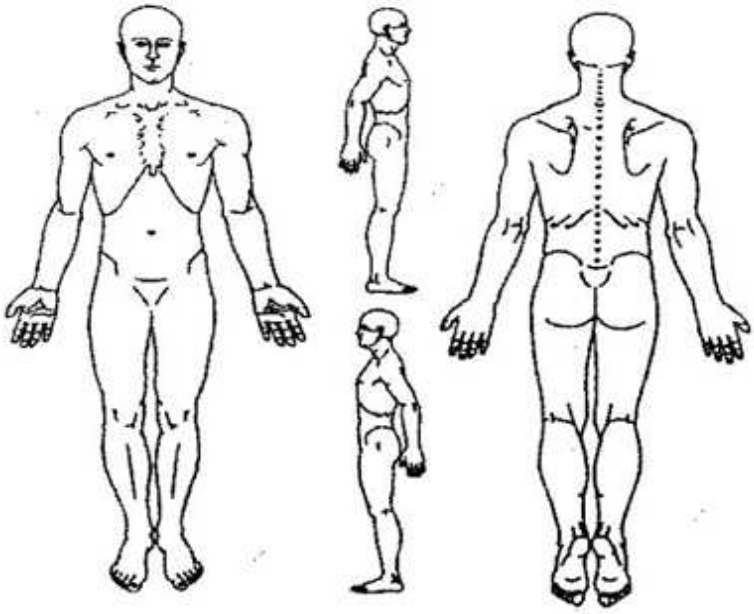
Please circle if you are you currently experiencing:

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: _____

Workers' Compensation Injury Information

Patient Name: _____DOB: _____

Date of Injury: _____ **Claim #**: _____ **(cannot proceed w/out claim #)**

Have you been seen by any other doctors for this work related injury? YES NO

If yes, please list: _____

_____

Treating Doctor: _____
(If we are the first doctor you are seeing, we will be considered your treating doctor.)

Employer Information

Employer Name: _____ Occupation: _____

Are you currently employed by this employer? YES NO

Supervisor Name: _____

Phone: _____Fax: _____

Insurance Information

Insurance Carrier:_____ Adjuster Name: _____

Adjuster Phone: _____ Fax: _____

In your own words, please describe the accident:_____

_____

_____

_____

_____

Please Note: If you do not know your claim number, date of injury, or insurance carrier, you are responsible for getting this to our office *within 3 business days* of being seen. If you do not know this information, please ask your employer. We will not be able to treat you or proceed with pre-authorization without this information. Thank you.