Patient Registration Form

Legal Name: ___________________________________ _______________________ _________________ __________________________
Last First Middle Preferred

DOB: _________________________________ Age ___________ E-mail ____

Phone(s) Home: __________________________________ Cell: ____________________________ Work: __________________________

Home Address: ____
Street City/ST/Zip

Gender: ___M ___F Marital Status: ___Single / ___Married / ___Divorced / ___Widowed / **SS#** ________________________________

Primary Care Doctor: ____ Doctor Phone#: ______________________________

PRIMARY INSURANCE INFORMATION:

Name of **Primary Policy Holder**: ____ Relationship to Patient: ________________________

DOB: _________________ Insurance Company: ________________________________ Insurance Phone#: __________________________

Policy ID#: ___________________________________ Group#: ____

SECONDARY INSURANCE INFORMATION:

Name of Secondary Policy Holder: ____ Relationship to Patient: ______________________

DOB: _________________ Insurance Company: ________________________________ Insurance Phone#: __________________________

Policy ID#: ___________________________________ Group#: ____

RESPONSIBLE PARTY INFORMATION: (*Mark "X" IF SAME AS ABOVE* ___________)

Name: ____ Address:____

DOB: _______________Relationship to Patient: _______________________________ Phone#:___________________________

EMERGENCY CONTACT/LEGAL GUARDIAN:

Name: ______________________________________ Phone#: ______________________Relationship to Patient: ______________________

ASSIGNMENTS OF BENEFITS: I hereby authorize the above-named agency to release my treatment information requested by attorneys, physicians, insurance companies, employers, healthcare providers or any other entity which may be concerned with the payment of charges incurred for the treatment of services of Texas Spine & Rehabilitation, P.A., and hereby authorize payment directly to Texas Spine & Rehabilitation, P.A. for services rendered. I accept responsibility for payment of any charges not paid for or accepted by my insurance. This authorization remains valid and effective from the date of signing until revoked in writing.

(Optional)

We are always interested to learn how our patients found us. Do you mind if we ask?

Former patient: ______ Physician Referral: ______ Friend/Family Referral: _____ Other: _____________________________

____ _________________________________

Signature of Patient or Legal Guardian **Date**

Financial Agreement, HIPAA & Privacy Policies, Consent to Treat, Financial Interest Disclosure

PLEASE INITIAL ALL SECTIONS, SIGN, & DATE FORM

________**FINANCIAL RESPONSIBILITY AGREEMENT:**
Initials

I agree to assign insurance benefits to Texas Spine & Rehabilitation, P.A. who bills all insurance companies that it are contracted with as "network" providers as a courtesy to our patients. I understand that if my contractual agreement with my insurance provider requires me to pay a copayment, deductible, and/or coinsurance, I must do so at the time of service to receive treatment.

I acknowledge full financial responsibility for services rendered by Texas Spine & Rehabilitation, P.A. and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, co-pays, deductibles, co-Insurance, pre-existing clause conditions/services, excluded conditions, denied claims, and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to Texas Spine & Rehabilitation, P.A.

________**PATIENT PRIVACY PRACTICES:**
Initials

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent OR to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our "Notice of Privacy Practices" policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records, except as authorized in this document.

________**HIPAA & RELEASE OF INFORMATON:**
Initials

I hereby authorize Texas Spine & Rehabilitation, P.A. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and other health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Texas Spine & Rehabilitation, P.A. can refuse to see me. I have been provided with access to either review and/or receive a copy of "Notice of Privacy Practices" for Texas Spine & Rehabilitation, P.A. which more fully describes the uses and disclosures, and I understand that I have the right to review such "notice" prior to signing this consent. I understand I can revoke this consent at any time by notifying Texas Spine & Rehabilitation, P.A. in writing. I understand Texas Spine & Rehabilitation, P.A. has the right to change its privacy policies and that I can receive such changed notices upon request. I understand that I have the right to request that Texas Spine & Rehabilitation, P.A. restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or other healthcare operations. I understand that Texas Spine & Rehabilitation, P.A. does not have to agree to such restrictions, but that once such restrictions are mutually agreed to, Texas Spine & Rehabilitation, P.A. must adhere to such restrictions.

________**CONSENT OF TREATMENT:**
Initials

I authorize Texas Spine & Rehabilitation, P.A. Physicians, Physician Assistants, Nurse Practitioners, Physical Therapists, and other health care professionals to evaluate and/or treat me or my family member for illness or injury for which I seek medical care. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies.

________**RELEASE OF MEDICAL INFORMATION AUTHORIZATION:**
Initials

I give Texas Spine & Rehabilitation, P.A., authorization for the release of any/all "Medical Records/Privacy Information" to my **referring physician, primary care physician**, **or entities to which I am referred for medical care**, which includes my PHI, any medical conditions and treatments, and/or billing and financial information, as well as to the following persons/entities:

Name: ____ Relationship to Patient: ____

Name: ____ Relationship to Patient: ____

________ **24-HOUR CANCELLATION & "NO-SHOW" FEE POLICY:**
Initials

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Texas Spine & Rehabilitation reserves the right to charge a fee of up to $50.00 for missed office appointments and $100.00 for missed in-office EMG appointments or out of office procedures. This will apply to both "no shows" and appointments which, absent a compelling reason, are not cancelled with 24-Hour advance notice. I understand these will be owed by me and must be paid prior to my next appointment.

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_______**CONSENT REGARDING TELEMEDICINE:**
Initials
Telemedicine services involve the use of secure interactive videoconferencing or audioconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. It may be used in cases of infectious illness, inclement weather days, patient immobility or transportation issues, or other reasons when approved by my providers. I understand that there are potential risks to using technology, including service interruptions, interception, cyber-crime, and technical difficulties.

I understand that the same standard of care applies to telemedicine as in-person care. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room. Further, if it is determined that the videoconferencing/audio equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.

I understand that my health care information may be shared with other individuals for scheduling and billing purposes and that my insurance carrier will have access to my medical records for quality review/audit. I understand that I will be responsible for any out-of-pocket costs such as copayments, deductibles, excluded coverage, and coinsurances etc. that apply to my telemedicine visit **AND** that when telemedicine is not covered by my insurance company, I will pay at a private pay rate of $100 per visit. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

________ **FMLA/SHORT-TERM DISABILITY PAPERWORK POLICY:**
Initials
The fee for **EACH** FMLA/Short-Term Disability Paperwork/Provider Letter is $25.00. This fee must be collected PRIOR to the forms being released or submitted to your employer or designated representative.
Please note that we have 10 business days to complete your paperwork. Per our office policy, we will begin working on your FMLA/Short-Term Disability Paperwork once payment has been collected. Payment of the processing fee does not influence our determination of your work status nor our clinical findings.
As per our office policy, we will NOT provide comment for or against regarding Social Security Disability. However, you may request your records be submitted at any time.

________ **DISCLOSURE OF FINANCIAL INTEREST:**
Initials
Texas Spine & Rehabilitation, P.A. physicians may have a financial interest in the facilities listed below. The facilities and our physicians are committed to providing clinical excellence in a safe and attractive environment for you and your family members. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality of care for you. Should you have any concerns regarding this notice, please ask your physician or a member of the staff. My initials above verify that I have read and understand the above statement and information.

Methodist McKinney Hospital 8000 West Eldorado Parkway, McKinney, TX 75070
Methodist Craig Ranch Surgery Center 6045 Alma Rd., Suite 100, McKinney, TX 75070

_______**CONFIDENTIAL COMMUNICATION AUTHORIZATION:**
I have been presented with a copy of the notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal law, outlining my rights regarding my health information. I agree to text messages for appointment reminders, and I request that communications to me by Texas Spine and Rehabilitation and staff other than by mail, person to person phone calls, or in person are handled as follows:

Preferred phone number____________________ May we leave a **detailed** voicemail? Yes ____ or No ____

________**CONFIDENTIAL TEXT AND EMAIL AUTHORIZATION**:
Initials
EMAIL: ____: I give permission to receive emails about appointments, bills, or, when applicable, other information I may request.

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PLEASE INITIAL ALL SECTIONS, SIGN, & DATE FORM

ACKNOWLEDGEMENT:

I acknowledge that I received access to the “Notice of Privacy Practices” information for Texas Spine & Rehabilitation, P.A. I have read and understand the "Patient Financial Responsibility", "Patient Privacy Practices", "HIPAA and Release of Information", "Consent of Treatment”, and “Disclosure of Financial Interest”. I understand and accept the terms outlined in each of these policies.

X

____ ______________________________

Patient or Guardian Signature Date

Medication Policy

Policy for Any Medications From our Office:

Please contact your pharmacy to initiate your request for medication refill. Medication refills will be monitored during the following hours: Monday-Thursday 830AM-430PM and Friday 830AM-1200PM. No refills will be approved after working hours or on weekends.

Please call several days before your supply of medication is depleted. This allows adequate time for your physician to review your medical record to determine if a refill is medically appropriate. Failure to initiate your request in a timely manner does not translate to an urgent matter for our office/staff.

Policy for Controlled Medications From our Office:

Due to the nature of controlled substances and our concern for the safety of our patients, our office will strictly abide by the requirements set forth by the Drug Enforcement Administration. **We ask that you use one pharmacy if pain medications are prescribed and obtain pain medications from only one provider.**

I agree to use ________________________________ pharmacy, located at ________________________________, for filling prescriptions for all my pain medicine.

We reserve the right to access the Texas Prescription Monitoring Program (PMP) database to determine if a refill for a controlled substance is medically warranted.

We have the right to require urine drug screens when clinically warranted and may utilize them when prescribing opioids to ensure compliance with medication policy.

By signing this agreement, you agree not to share, sell, or trade your medications with anyone.

You agree not to use any illegal substances including cocaine, marijuana, etc.

You agree not to obtain any controlled substances, including opioid pain medications, from any other doctors.

You will safeguard your medications from loss or theft. Lost or stolen medications will not be replaced. No refills will be sent outside the DFW area or out of state.

You agree that you will use the medication at a rate no greater than the prescribed rate and that use of the medication at a greater rate will result in you being without the medication for a period of time.

I, the patient, understand the above and that if I break this agreement, my doctor may stop prescribing these controlled substances. In this case, the doctor may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

______________________________ ______________________

Patient or Guardian Signature Date

Medical History

Patient Name: ______________________________________**DOB:** _______________

Referring Physician: ___________________________ **New Patient**____ **or Prior Patient** _____

Height: ______ **Weight:** _________ **Age:** ______**Occupation:** ____________________________

Do you smoke? Yes ____ **No** ____ **How many packs a day?** ________

Do you consume alcohol? Yes ____ **No** ____ **How often?** ______________________________

My Pharmacy (Name/Location): ____ **Phone:**___________________

List All Allergies/Drug Allergies:____
____

List All Current Medications/Dose/Frequency: ____
____
____
____
____

Family History: ____

List Current Fitness Activities:____

Medical History: ____
____
____
____
____

Past Surgeries/Hospitalizations **(INCLUDE ALL COSMETIC/IMPLANTS)**:_______________________________
____
____

Reason for your visit today:: ____
____
____
____

List any prior testing/evaluation/treatments you have tried for this problem:: ______________________________
____
____
____
____

Patient/Guardian Signature: ____________________________________***Date:*** _________________