Baha Abu-Esheh, MD PC

1001 12th Ave NW
Ardmore, OK 73401
Phone: 580-223-0447 Fax: 580-223-2989

Patient Registration Form

Name: _____

Address: _____City: _____State: _____ Zip: _____

Phone: _____ Cell Phone: _____ Text available: Y N

E-mail: _____

Sex: o Male o Female Date of Birth: _____ Social Security Number: _____

Marital Status: o Single o Married o Divorced o Widowed o Separated o Decline

Work Status: o Retired o Disabled o Full Time o Part Time o Student o Visually/Hearing Impaired

Race/Ethnicity: o African American/Black o Asian o Caucasian o Native American o Hispanic o Other o Decline

Primary Language: o English o Spanish o Decline o Other _____

Tobacco Use: Smoke cigarettes? o Never o Quit o Yes, how much? _____

Alcohol Use: o Never o Quit o Yes, Average Use: _____ Caffeine Use: o No o Yes Average Use: _____

Who lives with you at home? _____

Emergency Contact: _____

Relationship: _____Phone: _____

Preferred Pharmacy: _____

Address: _____Phone: _____

Unless you object, a copy of the clinic note will be sent to your referring doctor. Please check here o if you do not want that. Please list any other physicians who you wish to receive copies.

_____

Referring Doctor: _____

Are you a past WELDER? Yes O No O Have you had a VASCULAR STENT within the last 8 weeks? Yes O No O

Are you currently on DIALYSIS? Yes O No O Have o TATTOOS or o PIERCINGS? Yes O No O

Are you CLAUSTROPHOBIC? Yes O No O Do you have STIMULATOR/IMPLANTS/HARDWARE? Yes O No O

Are you currently PREGNANT OR NURSING? Yes O No O Do you have a COCHLEAR IMPLANT? Yes O No O

Any recent testing (MRI, CT scan, Labs, etc.) what kind, when, and where?

_____

Do you have a previous neurologist? If yes, please list the name and contact information.

_____

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In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? This refers to your usual life. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation. If none of these apply to you or your situation, please just fill in the number zero in the blank.

0 = You would NEVER doze off **1 = SLIGHT chance of dozing off**
2 =MODERATE chance of dozing off **3 = HIGH chance of dozing off**

Situation	**Chance of Dozing**
Sitting & Reading	_____
Watching TV	_____
Sitting inactive in a public place (I.e. theatre/meeting)	_____
As a passenger in a car for an hour, with no break	_____
Lying down to rest in the afternoon When circumstances permit	_____
Sitting & Talking	_____
Sitting quietly after lunch With no alcohol	_____
In a car while stopped for a few minutes	_____

TOTAL:_____

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General	Skin	HEENT	NECK	Respiratory	Cardiovascular
Appetite Loss	Itching	Headache	Neck Pain	Cough	Chest Pain
Fatigue	Rash	Double Vision	Neck Stiffness	Snoring	Irregular Heart Beats
Fever		Eye Pain	Swollen Glands	Difficulty Breathing	Elevated Blood Pressure
Change in Weight		Visual Disturbances			Swelling of extremities
		Hearing Loss			
		Hoarseness			

Gastrointestinal	Musculoskeletal	Neurological		Psychiatric	Endocrine	Hematology
Abdominal Pain	Back Pain	Decreased Memory	Stroke	Anxiety	Excessive Thirst	Anemia
Difficulty Swallowing	Calf Pain	Difficulty Speaking	In-coordination	Depression	Thyroid Problems	Blood Clots
Heartburn	Joint Pain	Dizziness	Seizures	Insomnia		Easy Bruising
Nausea	Muscle Cramp	Fainting	Tremor			Prolonged Bleeding
Vomiting	Muscle Weakness	Numbness	Visual Changes			
		Tingling	Weakness			

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Personal History

PERSONAL MEDICAL HISTORY: O NONE

Condition		*Condition*	
Cancer		Hand, arm, leg or foot injury	
Diabetes (Type 1 or Type 2)		Head Injury	
Epilepsy		Hepatitis (A, B, C, other)	
Heart Disease		Stroke	
Hypertension		Spinal Injury	
Kidney Stones		Aneurysm Clip/ Metal in Body	
Pacemaker		if yes type: _____	
Thyroid Disease		Other: _____	

SURGICAL HISTORY: O None

Surgical Procedure	*Yes*	*Year*	*Comments*
Abdominal Surgery			
Back Surgery			
Brain Surgery			
C-Section			
Gallbladder Removal			
Heart Surgery			
Hysterectomy			
Lung Surgery			
Neck Surgery			
Sinus/Facial Surgery			
Tubal Ligation			
Vascular Surgery			
Other:			

Family History:

Disease	Mother	Father	Brother	Sister	Other
Alzheimer's					
Cancer					
Cerebral Palsy					
Diabetes					
Epilepsy					
Heart Disease					
High Blood Pressure - Hypertension					
Migraine					
Multiple Sclerosis					
Muscular Dystrophy					
Neurodegenerative Disorder					
Neurofibromatosis					
No significant history known					
Parkinson's Disease					
Peripheral Nerve Disease					
Stroke					
Tremors					
Other (list):					

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Medications: O No Medications

Medication	Dose (e.g. mg/pill)	How many times per day?

Allergies or intolerance to medications (include type of reaction): O NONE _____

O Adhesive Tape O Sulfa drugs O Penicillin O Aspirin O Latex O Iodine

I verify that the information I have provided is accurate.

Parent or Self Signature: _____ Date: ____/____/_____

Consents:

Injection – Informed Consent (If having any injections in the office)

I hereby consent to and authorize the injection of therapeutic medication, such as OCNB, Trigger Point, ect., either intramuscularly (into the muscle) or subcutaneously (under the skin) by Baha Abu-Esheh, MD. I understand that the injection consists of introducing a needle into the muscle or under the skin and insertion of medication for the purpose of treatment for my condition. Preparation for the injection includes cleaning the skin with an antiseptic. This may cause some skin irritation. There exists the possibility of certain complications from this injection. These include pain, nerve damage, bleeding, swelling, allergic reaction to the medication, death or disability. I authorize Baha Abu-Esheh MD to perform any emergency procedures that are in their professional judgement necessary to treat such problems if they occur. I acknowledge that the procedure and its potential risks outlined above have been explained to me.

_____

Patient Signature/Date

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Clinic Rules

- We will be asking for a new copy of every patient's insurance card(s) for the New Year.
- All paperwork fees will be $25. We will not start the paperwork until the payment is received. We have 10 business days to complete all work.
- For all injections that are not covered by insurance, a payment of $30 will be requested before the injection is given.
- All co-pays/*estimated* co-insurances are due at the time of the visit. Note: All co-insurances are estimates of what you will owe from what is paid by your insurance, the price that is quoted to you is not definite as we are not responsible for what your insurance pays.
- All Nursing Home Patients MUST be accompanied by a caregiver/family member capable of giving history or they cannot be seen.
- All Self-Pay Patients are required to pay $175 for the initial consultation and $75 for each additional follow-up appointment, any testing will be additional. Payment is due on the day of the visit before being seen by the doctor.
- All patients are required to bring a detailed (milligrams, dosage, frequency) list of current medications to each appointment.
- We understand your time is important, as is ours, Patients are seen in order of appointment time, not arrival time.
- We have daily booked appointments scheduled out in advance so, if you are 15 or more minutes late to your appointment, it will have to be rescheduled.
- No show policy: a 24-hour notice is required. There will be a $50 charge to you (not your insurance) for the time we were not able to fill.
- Any patient who has been turned to collections will not be able to make an appointment until the balance is resolved.
- If you need a prescription refill, please request it no later than 48 hours prior to running out of your medication.
- Please note all prior authorizations could take up to a minimum of 3 days to be approved by your insurance company.
- The nurse is in clinic with patients all day. Any prescription refills or messages will not be done until clinic is over. (Clinic is usually finished around 4:30pm and clinic is closed for lunch from 12:30-1:30)
- All children are welcome in this clinic; however, if they become disruptive we will ask you to reschedule your appointment for another day.

Thank you.

Signature_____Date:_____

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Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants, and medical assistants; of this medical office to render medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians and physician assistant's choice.
The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____ _____

Signature of Patient or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to Baha Abu-Esheh, MD, PC for services rendered. Authorization is hereby granted to release all information contained in my medical record to my medical insurance company (or it employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Baha Abu-Esheh, MD, PC. I further understand should my account become delinquent; I shall pay any expense incurred by Baha Abu-Esheh, MD, PC in the collection of that account, if any.
The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____

Signature of Patient or Legal Guardian **Date**

Privacy Notice Acknowledgement for the Office of Baha Abu-Esheh, MD

This office takes the confidentiality of your medical information very seriously. We are providing privacy notices which make you aware of what the office can and cannot do with you protected health information (PHI). Please acknowledge receipt of the privacy notice by signing and dating this letter in the space provided below.
If you have any questions regarding this matter, please contact the chief privacy officer:

Contact Privacy Officer: Yousef Abu-Esheh Telephone: 580-223-0447
Address: 1001 12th Ave NW Ardmore, OK 73401

_____ _____

Signature **Date**

Notice for TCPA Prior Express Consent

You agree, in order for us to service your account or to collect any amounts you may owe, we or a collection agency (as necessary) may contact you be telephone at any number associated with your account, including wireless numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

_____ _____

Signature **Date**

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Consent to the Use and Disclosure of Health Information

For Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, at Baha Abu-Esheh, MD's originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed as actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that Baha Abu-Esheh, MD reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Baha Abu-Esheh, MD is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you ... **that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS)**

In addition to the releases outlined above, information may be released to the following ***family/friends/organizations*** for the indicated purpose: (PLEASE LIST ALL PERSONS WE MAY RELEASE YOUR INFORMATION TO OR THAT MAY ACCOMPANY YOU TO AN APPOINTMENT)

_____
_____
_____

I request the following restrictions to the use and/or disclosure of my health information**:**
_____

You ____ may _____ may not leave (appointment reminders) (medical information) on my message service or machine.

_____ _____
Signature of Patient or Legal Representative Date Notice Effective

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Authorization for Release of Medical Records

The undersigned hereby authorizes Dr. Abu-Esheh's office to release and/or obtain copies of certain medical record information as specified below:

Patient Name: _____ Date of Birth: _____

SSN: _____ Phone: _____ Cell: _____

Street: _____ City: _____ State: ____ Zip Code: _____

The information listed below is to be released From (please list all individuals, clinics, and agencies):

_____

_____

To:

Name: _Baha Abu-Esheh, MD PC_ Phone: _580-223-0447_ Fax: _580-223-2989_

Street: __1001 12th Ave NW__ City: ___Ardmore___ State: _OK_ Zip Code: _73401_

Records of the following:

__ Progress Notes _Labs _MRI's (specify which) _____

__Insurance __Full Chart __Other: _____

ONE copy provided FREE. Additional copies are .25 cents per page plus postage & handling if needed.

Purpose or need for disclosure of this information: _____

THIS AUTHORIZATION IS FOR RELEASE OF MEDICAL RECORDS INFORMATION. I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANYTIME PRIOR TO ACTION BEING TAKEN DUE TO THIS AUTHORIZATION FOR RELEASE. I UNDERSTAND THAT THE INFORMATION AUTHORIZED FOR RELEASE MAY INDICATE THE PRESENCE OF COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONNORREHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DIFICIENCY SYNDROME (AIDS). (SEE 63 O.S. 1-502.2)

With this knowledge, I give my authorization to the release of all information in my medical record including any information concerning my identity, and release Baha Abu-Esheh, MD, affiliates, agencies, and employees from liability in connection with the release of the information contained therein.

Patient Signature: _____Date: _____

Parent/Guardian: _____Witness: _____