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 ☐Widow 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: (☐*CHECK 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. We bill all insurance companies that we 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 Clauses, excluded conditions 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.

_____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 agreed to, Texas Spine & Rehabilitation, P.A. must adhere to such restrictions.

_____RELEASE OF MEDICAL INFORMATION AUTHORIZATION:

Initials

I give Texas Spine & Rehabilitation, P.A. authorization for the release of "Medical Records/Privacy Information", which includes your PHI, any medical conditions and/or billing and financial information to the following:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

_____CONSENT OF TREATMENT:

Initials

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

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

PLEASE INITIAL ALL SECTIONS, SIGN & DATE FORM

_____ 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 Outpatient Surgery Center	1505 Harroun Ave, McKinney, TX 75069

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 Relase 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 Policies

PLEASE REVIEW CAREFULLY and SIGN & DATE FORM

Remembering your medication dosages and strengths can be difficult. In order to meet avoid potential medication errors and meet "Meaningful Use" federal guidelines, we have the capability to electronically communicate with many pharmacy clearinghouses and import a real-time medication list into your medical record with our office. The term for this service is called "Medication Reconcilliation". This process helps both ensure that your medication list is complete/accurate and that any medications dispensed by our physicians are not contraindicated with your current regimen.

This service is free to you, but we do need your permission.

I ☐ do ☐ do not permit Texas Spine and Rehabilitation to perform a "Medication Reconcilliation" on my behalf to help reduce potential medication errors.

Policy for Non-Controlled Medications From Our Office

Please contact your pharmacy to initiate your request for medication refill.

Medication refill requests will be monitored during the following hours: Monday-Thursday, 8:30AM-4:30PM and Friday 8:30AM-11:30AM. No refill requests 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 our physicians to review your medical record to determine if refill is medically appropriate. Failure to initiate your request in a timely manner does not translate to an urgent matter on 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.

As of 10/6/14, all hydrocodone products will be reassigned to a CII controlled substance classification, and like all other CII medications, we are not able to "phone-in" refills on these products. **Patients who currently have CII controlled substances as a component to their treatment plan must keep and attend all scheduled visits. Obtaining a prescription for CII controlled substances will require an appointment from our office.**

We reserve the right to access Texas Department of Public Safety Prescription Access Texas (PAT) database if our providers feel it would aid in determining if a medication refill is appropriate. This database allows practitioners and law enforcement to better track the written prescriptions for controlled substances.

Our office utilizes urine drug screens when clinically warranted, and may utilize when initiating opioid therapy or at random to ensure compliance with medication policy. Our patients have the right to refuse urine drug screens, but in doing so, acknowledge that this will forfeit opioid prescriptions from being a component of their treatment plan. Positive drug screens may be submitted to a laboratory for quantitative anaylsis. This measure is intended to rule out false-positives and to better understand the reasoning for abnormal findings in screening process.

By signing below, I acknowledge that I have provided by preference on permission for Medication Reconcilliation and acknowledge all Medication Policies regarding both Controlled and Non-Controlled Medications.

X _____ _____

Patient or Guardian Signature Date

Referring Physician: _____

Medical History

☐ New Patient ☐ Previous Patient Previous Problem:_____

Patient Name: _____DOB: _____

Height: _____ Weight: _____ Age: _____ Occupation: _____

Smoking Hx? _____ Yes _____ No Pregnant: ☐ Yes ☐ No Ulcers: ☐ Yes ☐ No

Preferred Pharmacy (Name/Location): _____ Pharmacy Phone:_____

List All Allergies/Drug Allergies: _____

List All Current Medications/Dose/Indication: _____

_____

_____

_____

Family History: _____

_____

List Current Fitness Activities: _____

_____

Past Surgeries/Hospitalizations:

_____

_____

_____

_____

Medical Conditions:

_____

_____

_____

_____

Reason for your visit today:

_____

_____

_____

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

_____

_____

Patient Signature: _____ ***Date:*** _____