North Texas Musculoskeletal Medicine

Patient Registration Form

Date: _____

Patient Information:

Last Name: _____ First Name: _____ M.I._____ S.S.#:_____

Address: _____ City: _____ ST: _____ Zip: _____

Date of Birth: ____/_____/_____ Sex: Male□ Female □ Marital Status: S □M □D □W□

Best Phone Number: (____) _____/_____ email address: _____

Employer: _____ Address: _____ City: _____ ST____ Zip_____

Work Status: Full Time □Part Time □Retired □Student □School: _____ FT□ PT□

Guarantor Information (Responsible Party)

Last Name: _____ First Name: _____ M.I._____ S.S.#:_____

Address: _____ City: _____ ST: _____ Zip: _____

Date of Birth: ____/_____/_____ Sex: Male □Female □ Marital Status: S □M □D □W□

Home Phone: (____) _____/_____ Work Phone: (____) _____/_____ Cell Phone: (____) _____/_____

Employer: _____ Address: _____ City: _____ ST____ Zip_____

Work Status: Full Time□Part Time □Retired □Student □School: _____ FT □PT□

Payment & Insurance Information (**We need a Copy of your Insurance card & Driver License**)

Primary Insurance:_____ Address: _____ City:_____ ST: _____ Zip: _____

Phone: ( ) _____/_____ Type: Individual Group Tricare Medicare Aetna BCBS UNH Cigna Other

Group Name: _____ Group/Plan: _____ ID #: _____

Policy Holder:_____ Date of Birth: ____/____/_____ Relationship to Patient: Self Spouse Parent Other

Other Insurance: _____ Address: _____ City: _____ ST: _____ Zip:_____

Phone: ( ) _____/_____ Type: Individual Group Tricare Medicare Aetna BCBS UNH Cigna Other

Group Name: _____ Group/Plan: _____ ID #: _____

Policy Holder:_____ Date of Birth: ____/____/_____ Relationship to Patient: Self Spouse Parent Other

Emergency Information Relative Not Living With You

Last Name: _____ First Name: _____ M.I.:_____

Address: _____ City: _____ ST:_____ Zip:_____

Home Phone: ( ) _____/_____ Cell Phone: ( ) _____/_____ Work phone: ( )_____/_____

Consent to Treatment
The undersigned acknowledges that he/she has requested healthcare services from North Texas Musculoskeletal Medicine, some of which are considered unconventional by the mainstream medical establishment. Although some treatments have been in continuous use for a long period of time, some have been deemed "unproven" or "not medically necessary" by such organizations as the American Medical Association, the Food and Drug Administration, and certain insurance companies. I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment.
I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Disclosure of Information
All information provided to North Texas Musculoskeletal Medicine is strictly confidential except for the following circumstances:
1. Your insurance company requests information about your treatments in order to process a claim or certify care.
2. The patient authorizes the release of information by signing a release form naming the specific person to receive the information.
3. Certain circumstances where we are required by law to release patient information such as, but not limited to, court subpoena, suspected abuse, etc.

Late Arrivals
Arriving late will decrease the amount of time the doctor has to spend with you. If you are running late, please call us at **(817) 416-0970**, and we may be able to reschedule you for later in the day.

Primary Care Physician
Dr. Minotti, Dr. Roop, Dr. Walsh, and Dr. Cox are not serving as your primary care physician. You are advised to seek out a family practitioner or internist to provide these services. Dr. Minotti, Dr. Roop, Dr. Walsh, and Dr. Cox are not responsible for your routine medical screening exams such as mammograms, prostate exams, cholesterol checks etc. If we detect any such problems during our evaluation, you will be informed and referred back to your primary care physician for treatment of these conditions. In order for you to receive the best healthcare possible, we encourage you to tell your primary care physician that you are seeing Dr. Minotti, Dr. Roop, Dr. Walsh, or Dr. Cox and let them know what treatments you are receiving, including, but not limited to, any supplements, herbs or vitamins. If your physician would like to discuss your care with Dr. Minotti, Dr. Roop, Dr. Walsh, or Dr. Cox, please have them contact us.

Emergent/Urgent Medical Needs
Dr. Minotti, Dr. Roop, Dr. Walsh, and Dr. Cox are not available for emergency care. In the event an emergent or urgent medical condition occurs outside of the office, you are advised to call 911, go to the nearest emergency room, or call your primary care physician. If you have questions about the treatment you received please call our office at **(817) 416-0970.** If Dr. Minotti, Dr. Roop, Dr. Walsh, or Dr. Cox is unable to speak to you, please leave a message, and they will return your call as soon as possible. If you have an emergency, please call 911 or go to the nearest emergency room.

Acknowledgement and Agreement
I have read the above information and thoroughly acknowledge and agree to all ofthe above information.

_____ _____ _____
Printed Patient Name Patient Signature Date

Notice of Privacy Practices (HIPAA) is posted on our website. Signature below is acknowledgment that youhave access to this information.

Printed Name_____ Signature_____ Date_____

North Texas Musculoskeletal Medicine
Financial Policy

We strive to give each patient adequate time for the best possible treatment. Because of this practice, last minute cancellations and not showing for appointments create a large gap in our schedule. Please be respectful and assist us in giving you the best care possible.

It is our office policy to inform you of our patient payment procedure. Please review the section below **and initial each item signifying that you have read and understand its content.**

_____ Patient with Insurance: You are responsible for deductibles, co-pays, non-covered services,co-insurance, and items considered "not medically necessary" by your insurance company. These amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

_____ Patient without Insurance (Private Pay): Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to visit to meet with our billing specialist.

_____ Medicare/Tricare: At this time Medicare and Tricare do not recognize Acupuncture, PRP (Platelet Rich Plasma) or Prolotherapy as a medically necessary treatments. Therefore, if these services are rendered, you will be responsible for payment at the time of your visit for these services.

_____ Patient without proof of Insurance: If you do not have evidence of health insurance,payment will be required at the time of visit. If we later receive the appropriate insurance/claim information and obtain payment, your payment will be refunded promptly.

_____ Non-participating provider: If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

GUARANTEE OF PAYMENT

_____ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities. I agree to be held responsible for all attorney fees and court costs in the collection of this account.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.

_____ I have been advised that if my health insurance carrier/HMO/Medicare/Tricareplan requires that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

_____ I understand that if I am participating in an HMO/Tricare plan, my primary care physician (PCP/PCM)must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services, thus I will become responsible for payment of all services.

_____ I authorize payment of benefits from my insurance carriers directly to North Texas Musculoskeletal Medicine. If I choose not to initial this item, the benefit payments will be paid to me, and I will be responsible for paying North Texas Musculoskeletal Medicine.

_____ I understand that there is a $50 reinstatement fee charged if I miss or cancel my appointment with less than 24 hours notice. This fee must be paid prior to scheduling another appointment.

_____ **Minor Patients only:**The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

PAYMENT IS REQUIRED AT TIME OF SERVICE. A $25.00 FEE WILL BE CHARGED FOR RETURNED CHECKS
For your convenience we accept cash, check and VISA, Discover and MasterCard.

I have read and understand my financial responsibilities as outlined in this Financial Policy document.

X_____ _____
Patient's signature Date

_____
Patient's Printed Name

_____ _____
Printed name of person signing on behalf of patient Relationship to patient

NEW PATIENT QUESTIONAIRE

Patient Name:_____ **Date**: _____

Primary Care Physician: _____

Did a Physician refer you? Yes □/No□ If yes: Referring Physician: _____
If referral is other than a physician, please indicate: Friend □/Family □/Internet□/Other_____

What is the reason for your visit today?_____
How long have you had the symptoms? _____ days/weeks/months/years. Are they getting worse? Yes □/ No□

*Where are your symptoms/pain?*_____
_____
What do you think is causing your symptoms/pain? _____
_____
*Do your symptoms/pain radiate? R arm, L arm, R leg, L leg, other:*_____

Did your symptoms begin with an injury? Yes □/No□
If you were injured, did the injury occur: at work□, in a motor vehicle accident□, other circumstances□: Please explain how you were injured:_____
If you were injured, are you currently involved in any lawsuits regarding this injury? Yes □/No□

Pain related questions:

Please rate your pain on a scale from 0 (no pain) to 10 (the most severe pain you can imagine): _____ /10
How severe is your pain at its WORST? _____ /10
How severe is your pain at its BEST? _____ /10
What does your pain feel like? (Circle all that apply) Throbbing, Shooting, Stabbing, Burning, Sharp, Tingling, Numb, Tender, Pressure, Deep, Aching, Cramping, Heaviness, Other:_____

What is the pattern of your symptoms? Continuous (always present), Comes and goes, Gets worse as the day goes on

What makes your symptoms worse? Nothing, Sitting, Bending, Lifting, Twisting, Driving, Coughing, Sneezing, Standing, Walking, Lying down, Other: _____

What makes your symptoms better? Nothing, Rest, Lying down, Bending, Sitting, Medication, Ice or heat,
Other, specify: _____

Do your symptoms interfere with any of the following? (Circle all that apply)
Sleep, Daily activities, Work, Relationships

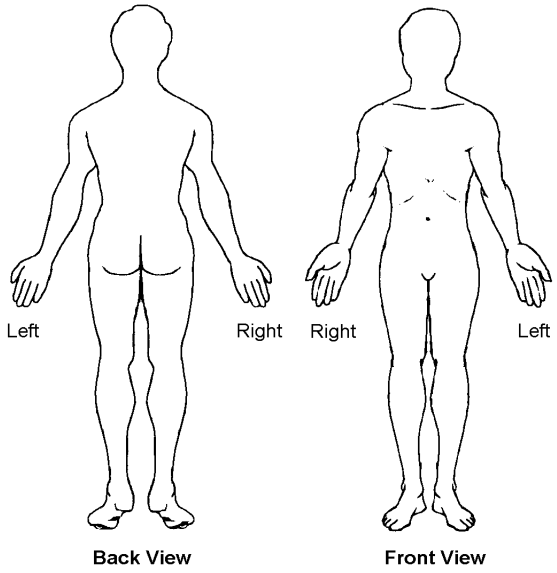
Do your symptoms make you feel: (Circle all that apply)
Depressed, Angry, Frustrated, Helpless/hopeless

Please circle any previous treatments you have had for your current symptoms: None □
Herbal remedies, Physical or occupational therapy, Work hardening, TENS unit, Chiropractor, Injections, Surgery, Counseling, Biofeedback, Acupuncture, Osteopathic Manipulation, Medications
Other: _____

Circle or list any tests you have had related to your current symptoms: None □
X-ray, CT scan, MRI, Myelogram, Bone scan, EMG, Nerve conduction, Blood tests

Using the symbols given below, mark the diagrams in the areas where you feel the described sensations in your body. Include all affected areas.
If more than one area is marked, please rank your preferred order of importance for the physician to address your problems today, using "1" for most important.

Ache	Numbness	Pins / needles	Burning	Stabbing	Other
▲▲▲	====	❍❍❍	xxxx	////	●●●



Please use the space below to describe your condition further if needed:

_____

_____

_____

_____

YOUR MEDICAL HISTORY (circle all that apply)
Allergic Rhinitis, High Blood Pressure, Arrhythmia/Murmur, Heart Attack/Angina, Asthma, COPD(lung disease), Reflux (GERD), Hepatitis, Kidney Disease, Arthritis, Stroke, Migraines, High Cholesterol, Thyroid disease, Diabetes, Skin Cancer, Cancer, HIV/AIDS, Anesthesia Problems, Enlarged Prostate
Other medical problems not listed:_____

SURGICAL HISTORY **DATE**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

FAMILY HISTORY
Please list any known medical problems:
Father: living □/deceased □ _____
Mother: living □/deceased □ _____
Siblings: _____
Children: _____

SOCIAL HISTORY

What was the highest level of education you completed? High school □/ College □/ Graduate school □
What is you marital status? Single □/ Married □/ Separated □/ Divorced □/ Widowed □
How many children do you have? _____
Do you smoke? Yes □/No□ *If yes, how many packs/day* _____ *How many years have been smoking?*_____
Do you drink alcohol? Yes □/No□ *If yes, how much and often do you drink? (e.g. 2 glasses of wine/day)* _____
Do you use recreational drugs? Yes □/No□: *If yes, please describe* _____
*Do you exercise regularly?*Yes □/No□: *If yes, how often?* _____

WORK HISTORY

Are you currently working? Yes □/No□: *If yes, who is your current employer:* _____

What is your occupation? _____

Are you disabled? Yes □/No□: *If yes, how long have you been disabled?* _____

What caused you to become disabled?_____

REVIEW OF SYSTEMS

Please circle any of the following problems that you are now experiencing:

Constitutional*:* weight change, weakness, fatigue, fever

Eyes*:* change in your eyeglass prescription, eye pain, tearing, double vision

Ear, Nose, Throat*:* hearing loss, nasal congestion, ringing in your ears, dizziness, sore throat

Cardiovascular*:* shortness of breath, chest pain, palpitations, ankle swelling

Respiratory*:* cough, sputum, coughing up of blood, difficulty breathing, wheezing

Gastrointestinal*:* heartburn, nausea, vomiting, abdominal pain, constipation, diarrhea, bowel incontinence, bloody stool

Genitourinary*:* pain with urination, bladder incontinence, urgency, blood in urine

Musculoskeletal*:* joint pain, stiffness, neck or backache

Skin*:* rash, lumps, itching, hair changes, nail changes

Neurological*:* headache, weakness, numbness, seizures, blackouts, memory loss, difficulty sleeping

Psychological*:* nervousness, tension, depression, anxiety

Endocrine*:* heat or cold intolerance, sweating, thirst, hunger, change in urination

Hematologic*:* easy bruising, easy bleeding

Is there any chance you could be pregnant? Yes □/No□

MEDICATIONS

Please list all prescription and non-prescription medications, vitamins and supplements you are currently taking (including dosage, frequency and indication):

1._____ 4._____ 7. _____

2._____ 5. _____ 8. _____

3._____ 6._____ 9._____

ALLERGIES

Allergies and intolerances:(including antibiotics, local anesthetics, x-ray contrast dyes, or latex materials, shellfish, aspirin products, foods etc..)

_____

I, the undersigned, have completed these forms to the best of knowledge. The information that I have provided is true and accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

_____ _____

Physician Signature Date