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PATIENT REGISTRATION SHEET

Please complete the ENTIRE form and sign where indicated. Please provide the receptionist with your insurance card (*if applicable*).

Last Name:_____ First Name:_____ MI:_____

Address:_____City:_____State:_____ Zip Code:_____

Date of Birth:____/____/____ Age:_____ Gender:_____ Social Security:_____-_____-_____

Marital Status:_____ Home Phone:____-____-____ Cell Phone:____-____-____Email Address:_____

Ethnicity (*circle*): Non-Hispanic | Hispanic | Other:_____ Race: _____

Language Spoken: _____

Occupation:_____ Employer Name:_____

Employer Address:_____

Primary Care Physician: _____ Phone:_____-_____-_____

Referring Physician or Chiropractor:_____ Phone:_____-_____-_____

Preferred Pharmacy:_____ Phone:_____-_____-_____

Emergency Contact:_____ Phone:_____-_____-_____

Relationship to patient:_____ Date of Birth:_____/_____/_____

Name of Primary Insurance:_____Phone:_____-_____-_____

Insurance ID Number:_____Group Number:_____

Address:_____City:_____State:_____Zip Code:_____

Name of Policy Holder:_____Date of Birth:_____/_____/_____

Name of Secondary Insurance:_____Phone:_____-_____-_____

Insurance ID Number:_____Group Number:_____

Address:_____City:_____State:_____Zip Code:_____

Name of Policy Holder:_____Date of Birth:_____/_____/_____

Signature of Patient/Guardian Date

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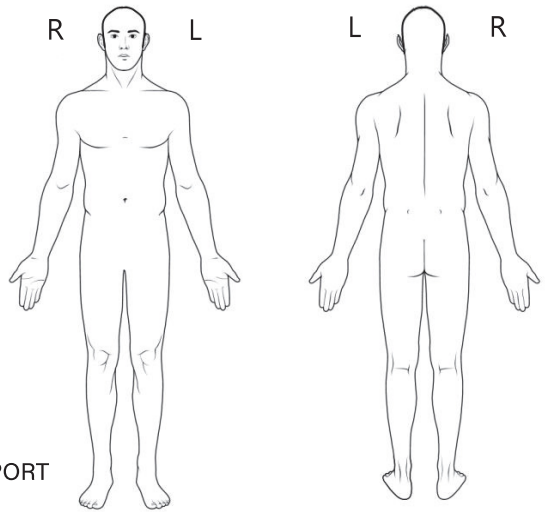
New Patient Form

History of Present Illness



Mark on the diagram above where your pain is located.

Occupation:_____

When did your pain start?_____

Where is your pain? (*circle all that apply*): NECK | BACK | ARM | LEG |
OTHER:_____

Rate your pain (*circle*): SEVERE | MODERATELY SEVERE | MODERATE | MILD

What is the date of injury (*if applicable*): ___/___/____

What caused your pain? (*circle*): MOTOR VEHICLE ACCIDENT | WORK RELATED | SPORT | SLIP OR FALL | OTHER:_____

Describe the inciting event that caused pain (*if applicable)*: DRIVER | PASSENGER | OTHER:_____

Describe your pain (*circle*): SHOOTING | THROBBING | ACHING | BURNING | SHARP | DULL | CRAMPING | OTHER:_____

Is the pain constant? □ Yes | □ No

How does your current condition affect your ability to perform daily activities (such as bathing, dressing, cooking, driving, working, or other routine tasks)?

SEVERE IMPACT | MODERATE IMPACT | MILD IMPACT

What makes your pain worse? (*circle all that apply*): SITTING | STANDING | WALKING | BENDING | COUGH & SNEEZE | LYING DOWN |
OTHER:_____

What makes your pain better? (*circle all that apply*): REST | ICE/HEAT | NOTHING | OTHER:_____

Have you ever received care from a Chiropractor or Physical Therapist? □ Yes | □ No When? _____ With who? _____

Have you been treated by a previous Pain Specialist? □ Yes | □ No When? _____ By who? _____

Current Occupation:_____

MEDICATION

List all the medication you have tried for your pain:		
1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

ALLERGIES

List all known allergies:		
1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

_____ **INITIAL**

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PAST SURGICAL HISTORY

List all known surgeries.	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

PAST MEDICAL HISTORY

Please list all DIAGNOSED conditions:

_____
_____
_____
_____

FAMILY HISTORY Check all appropriate diagnoses as they pertain to your family history.

☐ Please ***check*** if you have no significant family medical history.
☐ Diabetes
☐ Cancer
☐ Hypertension

SOCIAL HISTORY

Are you capable of becoming pregnant? **YES / NO**

If so, are you currently pregnant? **YES / NO**

Circle all that apply below.

ALCOHOL USE
Current Alcoholism
History of Alcoholism
Social Alcohol Use
Never Drinks Alcohol
Daily limited Alcohol Use

TOBACCO USE
Current tobacco user
Former tobacco user
Never used tobacco
Chewing Tobacco
E-Cigarette/Vape

ILLICIT DRUG USE
Denies any illicit drug use
Currently using illicit drugs

HOSPITALIZATION
Please list any recent hospitalizations:

Month/Year Reason Hospital

_____
_____
_____

_____ **INITIAL**

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CONSENT TO TREAT: I consent to the administration of health care by Minivasive Pain & Orthopedics ("MPO"). I understand that I may set conditions or limitations on my treatment and care and that if I wish to provide such conditions, I will be given the opportunity to write those in a separate document. I have been informed and acknowledge that I may withdraw my consent at any time upon written notice to MPO. I am giving my consent to the administration of health care by MPO voluntarily, and that hereby knowingly and voluntarily enter into this Health Care Consent for Treatment. MPO is an interventional pain management clinic only. MPO encourages all patients to obtain a Primary Care Physician.

ASSIGNMENT OF BENEFITS: I hereby irrevocably assign to Minivasive Pain & Orthopedics ("MPO") any and all benefits and interest and rights, including the right to assert a lien or bring a cause of action, under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from any other payer providing benefits on my behalf, for and to the extent of the services and goods provided to me by MPO. Under this assignment, MPO shall have an independent, non-exclusive right to appeal or pursue any denied or delayed claims on behalf of the insured or beneficiary. This assignment is not and shall not be construed as an obligation of MPO to pursue such interest and rights. By signing this form, I, as the patient or patient's legal representative, am directing any applicable health insurer, health benefit plan, indemnity plan, reinsurer, third-party liability insurer or other payer providing benefits on my behalf to pay MPO directly for the services and goods MPO provide to me. I understand that if insurance denies coverage or payment for services provided to me, I am financial responsibility for all charges.

IF MEDICARE or other similar government program should determine that I am not eligible for coverage or that the treatment is not covered, I will be responsible for payment, unless prohibited by law.

IF NO INSURANCE, THIRD-PARTY INSURANCE, or MOTOR VEHICLE ACCIDENTS you will be responsible for all charges associated with your care. We can file insurance claims to third-parties or insurance carriers on your behalf. You will be responsible for all charges as well as billing appropriate carriers as you like.

ACKNOWLEDGEMENT OF PRIVACY POLICIES/ HIPAA: I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time and I have the right to request new copies at any MPO location during regular business hours.
PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST: Texas law requires that your physician disclose to you any financial interest he or she may have in another healthcare entity to which you may be referred, so that you may address any concerns you may have directly with your physician. Your referring physician is a contractor and/or owner of Minivasive Pain & Orthopedics (the "Group"). The physician members of the Group are NOT owners of any of the Ambulatory Surgical Centers, Hospitals, Laboratories, or Imaging facilities to which you have been referred for therapeutic and/or diagnostic services. By signing the below, you acknowledge your receipt of this Physician Disclosure of Financial Interest.

[ ] ACCEPTED [ ] DECLINED _____ **PATIENT'S INITIALS**

By my signature below, I am acknowledging receipt of this document and agree to the terms under all sections of this document. Agreement Consent to Treat, Benefit Assignment and Financial Responsibility, Physician Disclosure of Financial Interest, and receipt of Privacy Policies/ HIPAA.

A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Patient/Guardian Date

Relationship to Patient if signed by someone other than patient

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HIPAA Policy

According to the Texas State Law and per HIPAA policy, our practice is not allowed to release any of your information without your permission. Please list any individuals that you are giving permission to receive or to pick up any prescriptions written by the doctor. Please list any individuals that you are giving permission to receive information in regards to you as a patient at our practice.

Name:_____ Date of Birth:_____/_____/_____

Phone: _____-_____-_____ Email:_____

Relationship:_____

Name:_____ Date of Birth:_____/_____/_____

Phone: _____-_____-_____ Email:_____

Relationship:_____

CHECK ALL THAT APPLY

Phone

- ☐ Okay to leave a message with detailed information
- ☐ Leave message with call back number only

Email

- ☐ Okay to send email with detailed information

I acknowledge that this authorization will remain in effect for up to one (1) year from the date of signature, unless I choose to revoke it earlier by submitting a written request to Minivasive Pain & Orthopedics.

Signature of Patient/Guardian Date

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Deferred Payment Agreement

MEDICAL PROVIDER: *Minivasive Pain & Orthopedics, PLLC*

If you have a pending insurance claim that must be resolved prior to your ability to pay for services rendered by our clinic or facility, we agree to temporarily defer collection actions. In consideration of such deferral, you expressly agree as follows:

You agree to toll and suspend any and all applicable statutes of limitations under Texas law, including but not limited to those under Texas Civil Practice and Remedies Code § 16.004(a)(3) (four-year limitation on debt actions), for the duration of the time your insurance claim remains unresolved, beginning from the date of service. The tolling period shall end thirty (30) days after the resolution of your insurance claim, whether by settlement, judgment, or other final disposition.

You agree to promptly notify your legal counsel, if any, of your outstanding balance with our clinic or facility. You further agree to direct your attorney to hold in constructive trust any proceeds from your insurance claim in an amount sufficient to satisfy your financial obligations to us. You also authorize us to communicate directly with your attorney regarding your account balance. Nothing in this agreement shall waive or prejudice our right to pursue legal remedies in the event of noncompliance.

Signature of Patient/Guardian Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.