Pro-Care Medical Center - Patient Registration Form

Patient Information			
Patient's **Legal** Last Name, First:			Today's Date:
Name Patient Goes By (if different):	DOB:	SSN (Required):	Sex: ☐ Male ☐ Female ☐Other
Cell Phone:	Other Phone:	Okay to email, leave voice messages, or text regarding appointments, test results, referrals, or for any other reason? ☐ Yes ☐ No	
Email:			
Address (Street, City, State, Zip):			

Is the patient covered by insurance? ☐ Yes ☐ No	**Is the patient covered by another insurance? ☐ Yes ☐ No**
Primary Insurance Information	**Secondary / Supplement Insurance Information**
Primary Insurance Company:	Secondary Insurance Company:
Policy No:	Policy No:
Group No:	Group No:
Patient's relationship to policyholder: ☐ Self (skip section below) ☐ Spouse ☐ Child ☐ Other	Patient's relationship to policyholder: ☐ Self (skip section below) ☐ Spouse ☐ Child ☐ Other
Policy Holder Name:	Policy Holder Name:
Policy Holder SSN:	Policy Holder SSN:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder's Address: ☐ Same as listed above ☐ This Address:	Policy Holder's Address: ☐ Same as listed above ☐ This Address:

Authorization to Release Medical Information / Emergency Contact

Do you want Pro-Care Medical Center, and all employees thereof, to be able to discuss financial matters or medical care with any family members or other emergency contacts? This permission will be valid indefinitely and must be revoked in writing. Pro-Care Medical Center may discuss my financial matters or medical care with the following:

Information OK to Discuss	Name	Relationship	Phone Number	Also Emergency Contact?
☐ Financial ☐ Medical Care				Yes No
☐ Financial ☐ Medical Care				Yes No
☐ Financial ☐ Medical Care				Yes No

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Consent for Treatment, Notice of Privacy Practices Policy, and Financial Policy

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Pro-Care Medical Center unless revoked by me orally or in writing. I understand that the practice uses audio recording of patient encounters and unrecorded live video feeds of rehabilitation treatment from time-to-time solely for educational and training purposes within the practice and I consent to audio recording and unrecorded live video of my patient encounters for this purpose.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Pro-Care Medical Center's infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Pro-Care Medical Center if any of these situations occur during your treatment period.

A Notice of Privacy Practices (NPP) is available to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, has access to a copy of the Notice of Privacy Practices, and is the patient, or the patient's personal representative.

As a part of our professional relationship, it is important that you have an understanding of our financial policy.

- It is your responsibility to provide us with your most current insurance and billing information. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance, and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company; however, you are responsible for paying the full amount determined by your insurance company once they have paid your claim regardless of our estimation.
- We will send a statement (to the address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (512) 371-7478 or (210) 881-0630. Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $35.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

We may charge you a fee if you fail to attend, cancel, or reschedule your appointment with less than one full business day's notice. Cancellation fees are $40 for medical and Ideal Protein, $20 for chiropractic, and $200 for any procedures.

Consent To Treatment Of A Minor Child *(Under the age of 18)*

I authorize this office to administer services as deemed necessary to my minor child, _____. My relation to the minor child is _____ and my name is _____.

My signature below indicates that I have read and fully understand the Consent for Treatment, Privacy Practices Policy, and Financial Policy.

_____

Patient/Guardian Signature | Today's Date

_____

Signer's Printed Name | Signer's Date of Birth

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Assignment of Benefits and Authorization for Direct Payment

I hereby assign and convey directly to Pro-Care Medical Center, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Pro-Care Medical Center, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Pro-Care Medical Center to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Pro-Care Medical Center any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Pro-Care Medical Center or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose in action arising under any group health plan, employee benefits, plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Pro-Care Medical Center (including any right to pursue those legal or administrative claims or chose in action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Pro-Care Medical Center all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by Pro-Care Medical Center, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Pro-Care Medical Center) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Pro-Care Medical Center as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator, or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

PERSONAL INJURY PATIENTS: I hereby direct any and all parties' insurance companies to make direct payment to Pro-Care Medical Center for all services, items and/or supplies furnished to me or my family members for and in relation to my care at Pro-Care Medical Center. I am choosing to forgo the use of my own health insurance, if any health insurance is available, in order to preserve my healthcare benefits. I am requesting that all of my medical bills are billed solely to the responsible 3rd party insurer, UIM and/or PIP. My health insurance may only be billed at the sole discretion of Pro-Care Medical Center.

Patient/Guardian Signature | Today's Date

Signer's Printed Name | Signer's Date of Birth

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Please tell us your **PHARMACY NAME** and its **CROSS STREETS**.

Please tell us the **REASON FOR TODAY'S VISIT** or any special concerns you would like to discuss with your doctor today.

Please list your **CURRENT MEDICATIONS** with dosage and directions:

☐ None

Please list any **ALLERGIES** and **TYPE OF REACTION** to medications/foods:

☐ None

Please provide your **PAST MEDICAL HISTORY** (ex. stroke, migraines, high/low BP, cancer, seizures, blood clots, etc…):

☐ None

Please tell us about any **SURGERIES** you have and indicate the month/year if known:

☐ None

Please tell us about any notable **FAMILY HISTORY** (ex. stroke, cancer, heart disease, etc…):

☐ None

Please provide your **SOCIAL HISTORY**:

Do you smoke or vape? ☐ Yes ☐ No ☐ Former
Type of Tobacco: _____
Amount/Day: _____
Years Smoked: _____
Year Quit: _____
Have you ever tried to quit? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No ☐ Former
Type of Alcohol: _____
Frequency: _____
Amount: _____
When was your last drink: _____

For **FEMALES** only:

Age at First Period: _____
Date of Last Menstrual Period: _____
Date of Last Mammogram: _____
Date of Last Pap Smear: _____
Any history of abnormal pap smears? ☐ Yes ☐ No
If yes, when? _____
Are periods regular? ☐ Yes ☐ No
Do you have pain with periods? ☐ Yes ☐ No
Is flow: Normal Heavy Light Spotting

# of Pregnancies: _____ # of Children: _____
# of Miscarriages: _____ # of Abortions: _____

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REVIEW OF SYSTEMS: Please check all that apply.

Constitutional
- ☐ Fever / Chills
- ☐ Weight Loss / Gain
- ☐ Sleep Problems
- ☐ Fatigue / Malaise

Musculoskeletal
- ☐ Joint Pain
- ☐ Join Stiffness
- ☐ Muscle Weakness
- ☐ Muscle Pain
- ☐ Limitation of Movement
- ☐ Edema
- ☐ Deformity

Neurologic
- ☐ Dizziness
- ☐ Seizures / Involuntary Movement
- ☐ Numbness / Tingling
- ☐ Headaches
- ☐ Tremors
- ☐ Unclear Speech
- ☐ Fainting / Blackouts
- ☐ Disorientation
- ☐ Paralysis
- ☐ Vertigo
- ☐ Memory Loss
- ☐ Dementia

Psychiatric
- ☐ Depressed Mood or Crying
- ☐ Anxiety / Worry
- ☐ Thoughts of Suicide
- ☐ Thoughts of Homicide
- ☐ Cognitive Impairment
- ☐ Mood Swings
- ☐ Outburst
- ☐ Change in Behavior
- ☐ Hallucinations

ENT/Mouth
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Hearing Problems
- ☐ Tinnitus
- ☐ Ear Pain
- ☐ Hay Fever
- ☐ Frequent Colds
- ☐ Nasal Congestion / Runny Nose
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Dental Pain
- ☐ Hoarseness
- ☐ Sneezing
- ☐ Ear Drainage

Eyes
- ☐ Wears Glasses or Contacts
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Vision Loss / Blindness
- ☐ Eye Pain
- ☐ Redness
- ☐ Itchy Eyes
- ☐ Light Sensitivity
- ☐ Discharge

Skin / Hair / Nails
- ☐ Rash
- ☐ Mole Changes
- ☐ Pigmentation Change
- ☐ Lesions / Sores
- ☐ Hair Loss
- ☐ Change in Hair Texture
- ☐ Insect Bites
- ☐ Injury to Nails
- ☐ Change in Nails
- ☐ Burn
- ☐ Acne
- ☐ Hives

Cardiovascular
- ☐ Chest Pain
- ☐ Swelling
- ☐ Palpitations
- ☐ Murmur
- ☐ High BP

Respiratory
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Coughing
- ☐ Respiratory Pain with Activity
- ☐ Blood in Mucus
- ☐ Snoring
- ☐ Pain or Difficulty with Breathing

Gastrointestinal
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Dark or Blood in Feces
- ☐ Vomiting Blood
- ☐ Heartburn / Indigestion
- ☐ Loss of Appetite
- ☐ Bloating / Fullness

Lymphatic
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Nose Bleeds
- ☐ Anemia
- ☐ Blood Transfusion

Endocrine
- ☐ High Blood Glucose
- ☐ Hot / Cold Intolerance
- ☐ Change to Urine Volume
- ☐ Excessive Thirst
- ☐ Excessive Sweating
- ☐ Growth Issues
- ☐ Steroid Use
- ☐ Excessive Hunger
- ☐ Hot Flashes

Genitourinary
- ☐ Incontinence
- ☐ Altered Color / Odor of Urine
- ☐ Weak Stream / Dribbling
- ☐ STD Exposure
- ☐ Hernia
- ☐ Vaginal Discharge / Itching
- ☐ Painful / Irregular Periods
- ☐ Painful Intercourse
- ☐ Fibroids
- ☐ Menopausal Symptoms

Please tell us about your **PAIN HISTORY**:

☐ I am not experiencing pain (skip section).

1) What is your main complaint? _____

2) Please rate the pain of your main complaint:

Mild Moderate Severe Very Severe Worst Pain Possible

3) How often do you experience the pain of your main complaint:

Infrequent Occasional Intermittent Frequent Constant

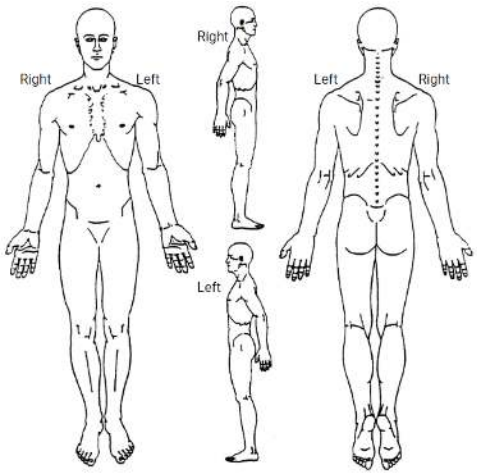
4) How long have you been experiencing your main complaint?

#_____ days / weeks / months / years

5) Have you lost time at work?

☐ No ☐ Yes #_____ days / weeks / months / years

Please mark where you have pain.



Do you have pain with any of these tasks?
- ☐ Personal Care
- ☐ Lifting
- ☐ Reading
- ☐ Concentrating
- ☐ Working
- ☐ Driving
- ☐ Sleeping
- ☐ Recreation
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Social Life
- ☐ Job Performance
- ☐ Relationships
- ☐ Exercise

6) Are you currently experiencing any of these?

- ☐ Muscles Weakness
- ☐ Pain w/ Sneezing
- ☐ Pain w/ Coughing
- ☐ Bowel or Bladder Problems
- ☐ Shoulder Pain
- ☐ Radiating Arm Pain
- ☐ Arm/Hand Tingling or Numbness
- ☐ Low Back Pain
- ☐ Radiating Pain into Buttocks
- ☐ Radiating Pain Down One Leg
- ☐ Radiating Pain Down Both Legs
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Headaches