NEUROPATHY & PAIN
CENTERS OF TEXAS

Patient Name:______________________________**Date:**____________________

Prefix: **Marital Status:**

□**Mr.** □**Miss.** □**Mrs.** □**Ms.** □**Single** □**Married** □**Separated** □**Divorced** □**Widow**

Primary Care Physician:_______________________ **PCP #:**_________________

Date of Birth:____________ **AGE:**____ **SEX:** □**M** □**F** **SS#:**_____-_____-_____

Email Address:____

Mailing Address:____

City:______________________________**State:**_________**Zip:**_______________

Phone Number: (Home)____________________**(Cell)**______________________

How did you hear about our practice? _____________________________________

Occupation:___________________**Employer:**_____________________________

Work Number:_________________ **Address:**_____________________________

Emergency Contact Name:____

Emergency Contact Number:_____________________ **Relationship:**_________

Is this person able to obtain information regarding your records? _______________

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Personal History (check all that apply to you)

General	Neurological	Psychiatric	Respiratory
☐ Fatigue, Tiredness ☐ Weakness ☐ Chills ☐ Fever ☐ Night Sweat ☐ Appetite Change ☐ Unexplained weight loss/gain ☐ Generalized pain ☐ Unable to tolerate heat ☐ Unable to tolerate cold ☐ Sedentary lifestyle ☐ Active lifestyle ☐ Other_____________ ☐ Headaches	☐ Fainting spells ☐ Seizures ☐ Paralysis ☐ Dizziness ☐ Tremor ☐ Chronic headaches ☐ Poor balance ☐ Fractured back or neck ☐ Peripheral neuropathy ☐ Stroke or Mini-stroke ☐ Numbness of face ☐ Numbness of arms/legs ☐ Tingling of arms/legs ☐ Pain of arms/legs ☐ Other_____________	☐ Depression ☐ Anxiety (abnormal) ☐ Panic Attacks ☐ Alzheimer's ☐ Confusion (abnormal) ☐ Substance abuse ☐ Anorexia ☐ Memory loss ☐ Other_____________	☐ Chronic obstructive disease ☐ Wheezing ☐ Chronic Cough ☐ Coughing up blood ☐ Asthma ☐ Shortness of breath ☐ TB ☐ Lung Cancer ☐ Emphysema ☐ Chronic bronchitis ☐ Pneumonia ☐ Needs to sleep sitting up ☐ Other_____________
Cardiac	**Vascular**	**Gastrointestinal**	**Genitourinary**
☐ Angina (chest pain) ☐ Rapid Heartbeat ☐ Past heart attacks ☐ Heart Murmur ☐ Congestive heart failure ☐ High blood pressure ☐ Aortic Aneurysm ☐ Other Heart problem ☐ **PACEMAKER** ☐ **DEFIBRILLATOR** ☐ Heart disease ☐ Heart surgery ☐ Other_____________	☐ Leg pain walking over 1 block ☐ Leg pain walking less than 1 block ☐ Pain in legs while at rest ☐ Blood clots in legs (Deep **or** Superficial) ☐ Cold feet or hands ☐ Amputation of toes ☐ Amputation of feet or legs ☐ Peripheral vascular disease ☐ Ulcers of lower legs ☐ Varicose veins ☐ Aneurysm of arteries ☐ Other_____________	☐ Diarrhea ☐ Constipation ☐ Stool changes ☐ Bowel habits changes ☐ Hemorrhoids ☐ Indigestion ☐ Ulcers ☐ Irritable bowel ☐ Colon polyps ☐ Cramps/pains ☐ Cancer of the stomach or bowel ☐ Diverticulitis ☐ Gas ☐ Heartburn ☐ Other_____________	☐ Hesitancy / urgency of urine ☐ Need to urinate often at night ☐ Loss of bladder control ☐ Difficult urination ☐ Renal failure ☐ Impotence ☐ Current Dialysis ☐ Renal transplant ☐ Prostate enlargement ☐ Cancer of bladder/ kidneys ☐ Prostate issues ☐ Other_____________

Previous Surgeries:____
____
____

Family History: ____
____
____

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Personal History (Continued)

Blood & Lymph System	Eyes, Ears, Nose and Throat	Musculoskeletal	Skin
☐ Anemia ☐ Blood disease ☐ Transfusions ☐ Leukemia ☐ Bone marrow test ☐ Long term Coumadin use ☐ Blood clotting problems ☐ On blood thinners ☐ On Anticoagulants ☐ Other_____________	☐ Pain ☐ Hearing loss ☐ Polyps ☐ Vertigo ☐ Ringing in ears (tinnitus) ☐ Sinus infections ☐ Deafness ☐ Hearing aides ☐ Other_____________ ☐ Seasonal Allergies ☐ Nose bleeds	☐ Arthritis ☐ Joint swelling ☐ Joint stiffness ☐ Muscle aches ☐ Muscle weakness ☐ Leg cramps ☐ Other_____________ ☐ Knee/ Leg pain	☐ Rashes ☐ Tumors ☐ Sensitivity to sunlight ☐ Malignant melanoma ☐ Squamous cell carcinoma ☐ Basal cell carcinoma ☐ Easy bruising ☐ Fungal infections ☐ Non-healing sores ☐Excessive rough or dry skin ☐ Foot sores ☐ Other_____________
Endocrine	**Abnormal Organs**		
☐ Thyroid problems ☐ DIABETES- TYPE 1 ☐ DIABETES- TYPE 2	☐ Hepatitis A/B/C/D ☐ Cirrhosis (Liver) ☐ Gallbladder disease ☐ HIV	Height:______________ _ Weight:______________	

Allergies:____

Medications list- Please list all medications you are currently taking:

NAME	Dosage	NAME	Dosage
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

If you need additional space, Please use the back of this page.

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Patient Name:__________________________________ **Date:**__________________

What is your major complaint?____

____

____

How long have you had this problem?____

____

Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about? ☐YES ☐ NO If yes, please describe:

____

____

What have you tried for treatment that did not work?

____

____

Have you seen a M.D. , P.T. , or a D.C. **for this problem?**
☐YES ☐ NO

Doctor's Name	Specialty	Year(s) Seen

How does this problem interfere with your daily day life?

____

____

Have you been worried about getting this problem resolved?
☐YES ☐ NO If yes, please describe:

____

____

What is your main concern about your symptoms?

____

____

On a scale of 1 to 10 (10 being the highest), what is your interest in getting help for the problem?

____	1	2	3	4	5	6	7	8	9	10

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NEUROLOGICAL/MRI/VASCULAR PATIENT QUESTIONNAIRE

NAME:____ DATE: _________________

For any YES answer, please explain under comment and notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? No Yes
Comment: ____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? No Yes
Comment: ____

3. Do your hands or arms fall asleep regularly? No Yes
Comment: ____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? No Yes
Comment: ____

5. Do you suffer from a loss of handgrip strength? No Yes
Comment: ____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? No Yes
Comment: ____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? No Yes
Comment: ____

8. Do your legs or feet fall asleep regularly? No Yes
Comment: ____

9. Do you have reduced feeling (sensation) or swelling in your legs or feet? No Yes
Comment: ____

10. Do you suffer from cold hands or feet? No Yes
Comment: ____

11. Have you tried any medications such as anti-inflammatories? No Yes
If yes, what kind of medication? ____

12. Have you tried any Physical Therapy or Chiropractic treatments before? No Yes
If yes, When? For how long? What Kind?: _____________________________________

13. Have you had an MRI? No Yes
If yes, When? Who ordered it? What was it ordered for? ___________________________

14. Have you used any splint or braces or other prescribed treatment by an MD? No Yes
If yes, When? What kind? Who ordered it? _____________________________________

15. If you have tried any treatment or medications, did this make your problem better? No Yes
Comment:____

Note: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may share with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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INSURANCE INFORMATION

Person who carries the insurance?____

Date of Birth:____________________ Home Number:______________________________

Address (if different):____

Is this person a patient here? ☐YES ☐NO

Occupation:_______________________Employer:_________________________________

Employer Address:____

Employer Phone Number:____

Please indicate Primary insurance:____

Subscriber's name:________________________ Subscribers SS no.______-_____-______

Subscribers Date of Birth:_____/_____/_______ Group #:___________________________

Policy #:__________________________________Copay:_____________________________

Patient's relationship to subscriber:

☐SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Name of Secondary insurance (If applicable):_____________________________________

Subscribers Name:__________________________ Group #:___________________________

Policy #:_______________________________

Patients relationship to subscriber:

☐SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

________________________________ ________________________________
PATIENT/GUARDIAN SIGNATURE DATE

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Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

______________________________ ___________________

Patient's Signature Date

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare treatment we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have more detailed account of your policies and procedures concerning the privacy of your Patient Health Information, We encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent
.

1. The patient understands and agrees to allow Neuropathy & Pain Centers Of Texas/ World Medical Group to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Neuropathy & Pain Centers Of Texas/ World Medical Group to submit requested PHI to Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. Patient agrees to e-mailed or mailed postcards, appointment reminders, newsletters, birthday greetings etc.
4. A patient written consent need only be obtained one time for all subsequent care given the patient in this office.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but will apply to any care given after that request has been presented.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patient have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Neuropathy Patient Information

Signature of Patient Print Name Date Signed

________________________ ______________________________ _________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _________________________________ DOB: ____________________

I acknowledge that I have reviewed the Notice of Privacy Practices.

(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

__________ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

__________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Clinic Director about my concerns.

____ _________________________

Signature of Patient/Guardian Date

____ _________________________

Witness (Office Staff) Date

NEUROPATHY & PAIN
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ASSIGNMENT OF BENEFITS- HIPPA-ERISAAUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from World Medical Group, PLLC. (“Provider”) on behalf of myself and/or my dependents, and understand that by making this request, ***I am responsible for all charges incurred during the course of said services.*** I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent’s behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to my dependents or me. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to Provider and myself upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. A copy of our privacy practices is posted and available by request.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

______________________________	________________________
Patient	Date
______________________________	________________________
Policyholder/Insured	Date

CEK 1-2012