

NEW PATIENT PACKET

STRICT POLICY:

THE FOLLOWING DOCUMENTS MUST BE
COMPLETED & RETURNED
TO OUR OFFICE NO LATER THAN
"7 DAYS BEFORE YOUR APPOINTMENT"

IF YOU FAIL TO RETURN THIS PACKET ON TIME,
YOUR APPOINTMENT WILL BE **CANCELLED**.

Please Note:

The information you provide on the following pages is entered into our computer, in preparation for your consultation. If you fail to return this packet to our office, we will contact you to cancel the appointment. Once we receive your completed packet, we will then be able to reschedule your consultation.

PATIENT REGISTRATION

PATIENT INFORMATION

Last: _____ First: _____ DOB: _____ Sex: Male Female

SSN: _____ Home #: _____ Work#: _____ Cell#: _____

Patient Address City / State / ZIP Code

Patient's Occupation Employer's Name

Family Doctor Phone No. Referring Doctor Phone No.

PRIMARY INSURANCE INFORMATION

Self Insured

Primary Card Holder's Name Relation to patient DOB SSN

Name of Insurance Co. ID Number Type of Insurance Plan: Medicare Tricare / Triwest
 PPO POS HMO EPO Lien Other

SECONDARY INSURANCE INFORMATION

Self Insured

Primary Card Holder's Name Relation to patient DOB SSN

Name of Insurance Co. ID Number Type of Insurance Plan: Medicare Tricare / Triwest
 PPO POS HMO EPO Lien Other

EMERGENCY CONTACT

Name of spouse, local friend, or relative Work # Cell # Relationship to patient

WORK COMP INFORMATION (IF APPLICABLE)

Work Comp Carrier Claim Number Injury Date Accepted Body Parts

Work Comp Address Phone Fax

Name of Adjuster or Nurse Case Manager Primary WC Doctor Phone Fax

ATTORNEY INFORMATION

Name of Attorney Address Phone # Fax #

I hereby authorize Hendrickson & Hunt Pain Management Physicians and Watland Billing Consultants to furnish information to insurance carriers concerning my treatments. I hereby assign to Hendrickson & Hunt Pain Management Physicians and Watland Billing Consultants all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Patient's Signature

Date

NAME _____ DOB: _____ AGE: _____ TODAY'S DATE: _____

NEW PATIENT HISTORY AND PHYSICAL QUESTIONNAIRE

- This information will be used in the physician's final report.
- Write an answer for **each** question.
- If a question does not apply to you, please write "DOES NOT APPLY"
- If any portions of this survey are blank or incomplete, we may have to reschedule your appointment until we obtain your **complete** history.

1. Why were you referred to H&H Pain Management? _____

2. Where is the majority of your pain located (low back, neck, etc.)? _____

3. When did you first start to experience your pain symptoms? _____

4. Please give a **complete description** of the initial incident, injury, or condition that caused your pain?
(Be sure to include **ALL** details pertaining to the cause of your pain. We need a **COMPLETE** description.)

5. Please check up to "3" boxes, which best describe your pain: Shooting Sharp
 Stabbing Throbbing Burning Dull Aching Pricking Squeezing Tingling Cramping

6. Does your pain radiate to other parts of your body (down your leg, into your right arm)? No Yes
If Yes, please explain: _____

7. Circle the number/s below that best describes the level of your pain **RIGHT NOW**:
(No pain)- 0 1 2 3 4 5 6 7 8 9 10 - (Worst Pain Imaginable)

8. What helps to relieve your pain (heat, rest, medicine, etc)? _____

9. What activities increase your pain, and how long are you able to do them before your pain increases?

ACTIVITY

LENGTH OF TIME BEFORE PAIN INCREASES

| <u>ACTIVITY</u> | <u>LENGTH OF TIME BEFORE PAIN INCREASES</u> |
|-----------------|---|
| | |
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| | |
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10. Do you feel your pain interferes with your ability to perform daily activities? Yes No

11. List all doctors you have seen for this injury/incident/ or condition. Include how long you treated with that doctor, and what type of treatment you received while treating with that doctor:

| <u>Doctor's First Name</u> | <u>Doctor's Last Name</u> | <u>Month/Year Seen</u> | <u>Treatment Received</u> |
|----------------------------|---------------------------|------------------------|---------------------------|
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12. Please list any physical therapy that you have had or are currently receiving.

| <u>Facility/Therapist</u> | <u>Month/Year Seen</u> | <u>Treatment Received</u> |
|---------------------------|------------------------|---------------------------|
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13. Please list "ALL" medications you are taking "RIGHT NOW":

| <u>Medication Name</u> | <u>Strength</u> | <u>Daily Dosage</u> |
|------------------------|-----------------|---------------------|
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14. Please list any medications that you are allergic to, or caused adverse reactions (rash, nausea, etc.):

| <u>Medication Name</u> | <u>ADVERSE REACTION</u> |
|------------------------|-------------------------|
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20. Are you currently experiencing any of the following symptoms? Check all boxes that apply.

- | | | | | |
|--|---|---|---------------------------------------|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Severe weight loss | <input type="checkbox"/> Rashes | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tightness in the chest | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> None of these |

21. Have you ever been treated by a psychiatrist or psychologist? Yes No

If Yes, Name of MD: _____

Treatment Diagnosis: _____

22. Which of the following drugs or substances, if any, have you used in the PAST? Check all boxes that apply, and write "O" for *occasionally*, "F" for *frequently*, or "C" for *continuously*.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Alcohol _____ | <input type="checkbox"/> Barbiturates _____ | <input type="checkbox"/> Heroin _____ | <input type="checkbox"/> Cocaine _____ |
| <input type="checkbox"/> Marijuana _____ | <input type="checkbox"/> Amphetamines _____ | <input type="checkbox"/> None of these _____ | <input type="checkbox"/> Other: _____ |

23. Which of the following drugs or substances, if any, have you PRESENTLY using? Check all boxes that apply, and write "O" for *occasionally*, "F" for *frequently*, or "C" for *continuously*.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Alcohol _____ | <input type="checkbox"/> Barbiturates _____ | <input type="checkbox"/> Heroin _____ | <input type="checkbox"/> Cocaine _____ |
| <input type="checkbox"/> Marijuana _____ | <input type="checkbox"/> Amphetamines _____ | <input type="checkbox"/> None of these _____ | <input type="checkbox"/> Other: _____ |

24. Do you presently smoke cigarettes or use tobacco products? Yes No

If Yes: Smoke Cigarettes or Chew Tobacco _____ each day, for the past _____ years.

25. If you currently do not use tobacco products, have you ever used them in the PAST? Yes No

If Yes: Smoked Cigarettes or Chewed Tobacco _____ every day, for _____ years.

How long ago did you stop using tobacco products? _____

26. What is your current work status?

- Full-time Part-time Not working Student Retired

27. Are you currently receiving any type of disability benefits? Yes No

If Yes, from: Work Comp State of CA Disability Social Security Other:

Type of disability: Partial Disability. I am working _____ hours per week

Temporary Total Disability as of _____

Total Disability

Currently in Rehabilitation Training

Other: _____

Physician's Name: Doctor's First Name: _____ Doctor's Last Name: _____

Effective Date: What date did your doctor place you on disability? _____

Please make sure you have answered all "27" questions

2575 E. Bidwell Street, Suite 230, Folsom, CA 95630
Phone: (916) 984-3899 Fax: (916) 984-6522

NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USE AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand, and controls how your health information is used. "HIPPA" provides penalties for covered entities that issue personal health information.

As require by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical exam.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill to your insurance company for payment of your visits.
- **Healthcare operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing any references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Any other uses and/or disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction we must abide by it, unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us, by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

PLEASE READ AND SIGN ALL OF THE FOLLOWING PAGES



HENDRICKSON AND HUNT
Pain Management Physicians

Jay A. Hendrickson, M.D.
Brian Kelly Hunt, M.D.

2575 E. Bidwell Street, Suite 230, Folsom, CA 95630
Phone: (916) 984-3899 Fax: (916) 984-6522

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and/or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

| | | |
|---------------------------|----------------------------|-------------|
| PRINT PATIENT NAME | PATIENT'S SIGNATURE | DATE |
|---------------------------|----------------------------|-------------|

If signed by someone other then the patient, please complete this section.

| | | |
|--------------------------------|------------------|-------------|
| RELATIONSHIP TO PATIENT | SIGNATURE | DATE |
|--------------------------------|------------------|-------------|

| | | |
|--|--------------------------|------------------|
| OFFICE USE ONLY | | |
| I attempted to obtain the patient's signature for this <i>Notice of Privacy Practice Acknowledgement</i> , but was unable to due to: | | |
| Date: | Name of Employee: | Initials: |
| | | |

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INSURANCE COVERAGE ADVANCED NOTICE
PATIENT RESPONSIBILITY IN EVENT OF INSURANCE DENIAL

In the event that your insurance denies services as not being “reasonable and necessary”, or your policy is terminated or cancelled in the course of treatment, **you as the patient are responsible, and will be liable for charges in full.**

Some health insurance plans will only pay for services that they determine to be “reasonable and medically necessary”. This document is to serve notice that in the event of some cases, prior authorization for services/procedures is not provided by insurance. In these cases, payment is based solely on “reasonable and medically necessary” when billing is received. If an insurance carrier determines that a particular service, although it would otherwise be covered, is **not** “reasonable and necessary”, the insurance plan may deny payment for that service.

PAYMENT AT TIME OF SERVICE

Unpaid balances and/or Co-payments are due at the time of service. This is expressed in the information provided to you by your insurance carrier. Please be prepared to pay at the time of service so that this policy need not change. For your convenience, we accept Cash, Visa, and Master Card payments. *Please note, personal checks are not accepted.*

POLICYHOLDER/PATIENT AGREEMENT

I have read and understand the above statements. I agree to be personally and fully responsible for payment of service(s) that are denied based on medical necessity, or is not paid due to termination or cancellation of my policy.

PATIENT/POLICY HOLDER SIGNATURE

DATE

STAFF/WITNESS SIGNATURE

DATE



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OFFICE CANCELLATION POLICY

There will be a \$25.00 charge for failed appointments and/or late-notice cancellations.

This charge will be billed directly to you, and is not the responsibility of your insurance carrier.

We all agree that time is our most valuable asset, and we understand that time is a factor for everyone. We recognize that a special time just for you is sometimes hard to find in your busy schedule, and we thank you for spending your precious time with us.

- If you are unable to keep your scheduled appointment, we require no less than a **24-hours** notice.
- If you cancel your appointment and fail to give a 24-hour notice, a **“late-notice cancellation”** will be recorded in your chart.
- If you fail to present at the time of your visit, a **“no-show”** will be recorded in your chart.
- If you are 15 minutes late, or more, your appointment will have to be rescheduled for a later date. This too will be recorded as a **“no-show”**.
- If **three** such events occur in your chart, you may be asked to find a new provider, as this is unfair to our other patients in need of the appointment times you failed to keep.

SURGICAL CANCELLATION POLICY

There will be a \$75.00 charge for failed appointments and/or late-notice cancellations.

This charge will be billed directly to you, and is not the responsibility of your insurance carrier.

Surgery appointments must be coordinated with our office, the surgical facility, and authorized with your insurance company. Your surgical date and time have been set-aside especially for you, and you must check-in with that facility **one hour** prior to your scheduled appointment time. Surgical cancellations should be limited to emergencies only.

- If you are unable to keep your scheduled surgical appointment, we require no less than a **48-hours** notice. This is due to the amount of time required to coordinate surgical appointments.

We thank you for your cooperation and understanding, and look forward to providing you with excellent medical care.

PATIENT SIGNATURE

DATE