JAMES STANLEY, MD, PA

(469) 341-5676/(469) 341-5677 fax

Date: _____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City, State, Zip: _____

Sex: _____ Male _____ Female Marital Status: M S D W

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Emergency Contact (name/relationship/phone number): _____

_____

Primary Care Physician (name/phone number): _____

_____

Referring Physician (name/phone number): _____

_____

Insurance Information: If you are covered under the policy of a spouse, partner, parent or legal guardian, please tell us about them:

Name of Insured: _____ Patient Relationship: _____

Date of Birth: _____ Social Security Number: _____

Primary Insurance: Name: _____
Policy Number: _____
Group Number: _____

Secondary Insurance: Name: _____
Policy Number: _____
Group Number: _____

Pharmacy Name/Phone Number: _____

Have you purchased insurance from the health marketplace and receive tax/subsidy for your health insurance? If yes, you MUST provide documentation of active coverage on a month-to-month basis.

Patient Name:_____ Date of Birth: _____

Consent to Treat

I authorize James H. Stanley, M.D., P.A. to provide me with reasonable and proper medical care according to today's standards. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments.

_____ _____

Patient/Responsible Party Signature Date

DISCLOSURE:

Patient contact Information: _____

Home Phone:_____Work Phone:_____Mobile Phone: _____

Emergency Contact Name(s): _____

Relationship:_____Phone: _____

Do you give consent for James H. Stanley, M.D., P.A. staff to leave a message with pertinent medical information at the provided phone numbers?
YES / NO
Do you give consent for James H. Stanley, M.D., P.A. staff and/or your physician to discuss your medical condition with this person(s) if needed?
YES / NO

Printed Name: _____

Signature:_____Date: _____

COBRA PATIENTS:

Cobra patients must provide documentation of active coverage on a month-to-month basis provided by employer.
I_____am currently on a Cobra plan through my employer and am aware that I am responsible for verification of coverage. In the event that I am unable to provide the necessary documentation and my coverage is not valid, I understand that I am personally responsible for all charges incurred at the time services are rendered.

Signature:_____Date: _____

Patient Name:_____ Date of Birth: _____

Authorization for Release and Disclosure of Protected Health Information

In accordance with state law and regulatory agency requirements, the health record is the property of James H. Stanley, M.D., P.A. I hereby authorize the Medical Records Custodian to release information from the medical record of:

Patient Name:_____DOB:_____SSN: _____
Address:_____City/State/Zip: _____
Telephone:_____Alternate Contact Number: _____

Information May Be Released to: Facility or Physician:
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

Please release the following information:
____Problem List____X-ray Reports____Mental Health____Outside Reports
____Progress Notes____X-ray Films____Drug/Alcohol____Immunizations
____History & Physical Exam____EKG Reports____Lab Reports____HIV/AIDS Test
____Medications____Other Reports (Specify) _____

This information is necessary for the following purpose:
____Continued Patient Care____Personal Use____Attorney/Legal____Insurance
____Other (Specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol/drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to receive treatment. I understand that with certain exceptions, I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Health Information Management Manager at (469) 554-0213.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

Patient Name:_____ Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I,_____, understand that as part of my health care, James H. Stanley, M.D., P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for healthcare operations James H. Stanley, M.D., P.A. of such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as part of James H. Stanley, M.D., P.A.'s treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of how James H. Stanley, M.D., P.A. may use and disclose my protected my protected healthcare information. I further understand that James H. Stanley, M.D., P.A. reserves the right to change its *Notice of Privacy Practices*. Should James H. Stanley, M.D., P.A. change its *Notice of Privacy Practices*, an amended copy will be posted in a prominent location in the practice site, or upon my request, an amended copy will be sent to the address I have provided.

I agree that James H. Stanley, M.D., P.A. may do the following unless I specifically give direction prohibiting such activity:

- Send visit reminders and test results to the address I have provided.
- Send routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

FOR OFFICE USE ONLY

[ ] Receipt received by_____on_____.
[ ] Patient refused to sign receipt._____(Signature of Practice Rep.)

Patient Name:_____ Date of Birth: _____

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **James H. Stanley, M.D., P.A.** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. In the event that I receive the insurance payment, I realize that I will be billed personally until the balance is paid.

Authorization to Release Information

I hereby authorize **James H. Stanley, M.D., P.A.** to: (1) release any information necessary to insurance carriers 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 for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **James H. Stanley, M.D., P.A.** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

Patient Name:_____ Date of Birth: _____

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our billing staff or Business Office Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. We have made prior arrangements with many insurers and health plans (HMO & PPO) to accept assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.

1. Private Pay patients are required to pay in full at the time of check-in.
2. Unless other arrangements have been made in advance by you or your health insurance carrier, full payment for office services are due at the time of service. For your convenience we accept VISA, and MasterCard. Please be advised that there is a $35 service charge on all returned checks.
3. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor—in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
4. If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
5. All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. Fees for fracture care are often billed as "global" and include fracture care and office visits for a specified time period. X-rays, supplies, cast application fees, etc. is charged separately. Fracture care codes are listed under the insurance code section for surgery even though no "surgery" may have been performed.
7. We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
8. For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. In the event it should become necessary to place for collection an unpaid balance due for services rendered to James H. Stanley, M.D., P.A., I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fee and any other costs the court determines proper.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time-to-time.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

Patient Name: _____ Date of Birth: _____

Age	Gender	Height	Weight

CHIEF COMPLAINT (Circle all that apply)

Date of Onset _____

Neck Pain	Arm Pain	Arm Numbness	Arm Weakness
Back Pain	Leg Pain	Leg Numbness	Leg Weakness

How did the pain or symptom start? (Please circle all that apply)

Suddenly	Twisting	Car Accident
Gradually	Lifting	Work Injury
Fall	Pulling	Sports Injury
Bending	Pushing	No apparent cause

What makes your pain or symptoms *worse*? (Please circle all that apply)

Sitting	Sneezing	Coughing
Standing	Bending forward	While exercising
Walking	Bending Backward	After exercising

Other : _____

What makes your pain or symptoms *better*? (Please circle all that apply)

Sitting	Exercise	Pain medication
Standing	Muscle relaxant	Nothing
Lying down	Anti-inflammatories	

Other : _____

What % of your pain is in your back and what % of pain is in your leg totaling 100%? (example: 25% back pain + 75% leg pain= 100%)	% Back Pain		% Leg Pain
		+	=100 %

What % of your pain is in your neck and what % of pain is in your arm totaling 100%?	% Neck Pain		% Arm Pain
		+	=100 %

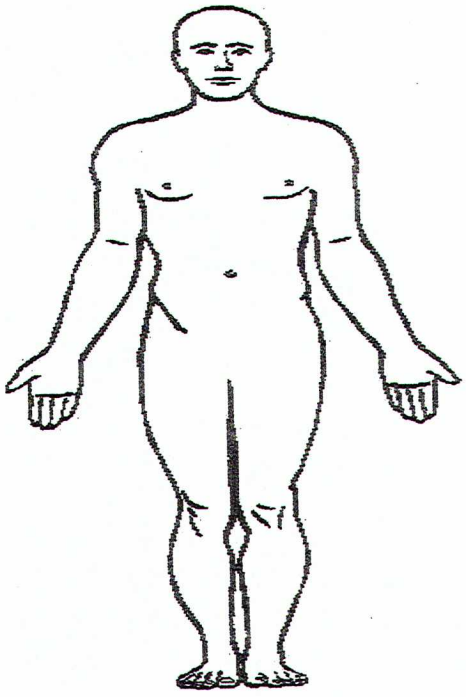
(example: 25% back pain + 75% leg pain= 100%)

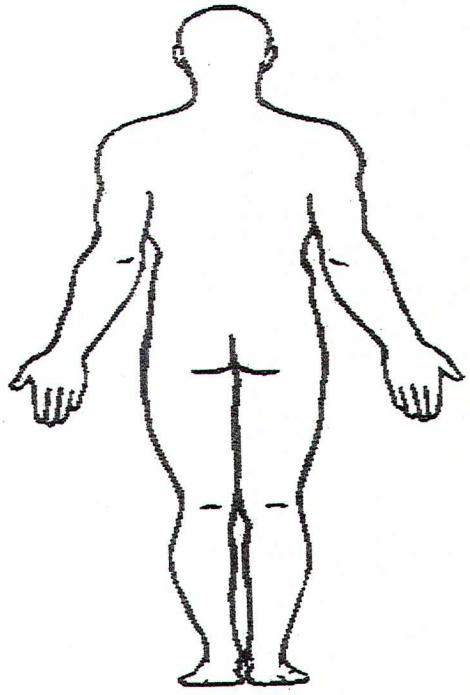
Patient Name:_____ Date of Birth: _____

Have you had recent loss of bowel or bladder control? (Incontinence) Yes No

On average, what would you rate your pain on a scale of 1-10?	0 1 2 3 4 5 6 7 8 9 10 No Pain Moderate Severe

Mark the diagram below to indicate the areas you are experiencing pain, numbness or other sensations using the symbols in the key.





Stabbing Pain //// Burning Pain VVVV Aching Pain OOOO

Pins and Needles Numbness XXXX

TREATMENT HISTORY

Please indicate the types of treatments you have undergone for your current problem, and if it made your symptoms better, worse or neither.

Type of treatment	Yes	No	If yes:	Better	Worse	No Change
Anti-inflammatory (Aleve, Ibuprofen, etc.)			Medication:			
Prescription Pain medication			Medication:			
Injections (ESI, trigger point or other)			Type: Date of last:			
Physical Therapy			How Long:			
Pain Management			Name of Doctor:			
Chiropractor			Name of Doctor:			
Acupuncture			Name of practitioner:			
Other:						

Patient Name:_____ Date of Birth: _____

Review of Systems

General		Endocrine		Neurological		MEN Only	
Fever		High Blood Sugar		Weakness		Enlarged Prostrate	
Dizziness		Low Blood Sugar		Poor Balance		Erectile Dysfunction	
Fatigue		Under Active Thyroid		Tremors			
Insomnia		Over Active Thyroid		Seizures			
Nightsweats				Headaches		**Psychiatric**	
Weight Changes		**Eyes, Ears, Nose & Throat**		Stroke		Depression	
		Poor Vision		Migraines		Anxiety	
Gastrointestinal		Blurry Vision				Mood Swings	
Nausea/Vomiting		Hearing Loss		**Musculoskeletal**		Hallucinations	
Heatburn		Ringing in Ears		Joint Pains		Sleep Disturbances	
Ulcers		Sinus Congestion		Aching Muscles			
Excessive Thirst		Sore Throat		Stiffness			
Diarrhea		Voice Changes		Osteoarthritis			
Constipation		Difficulty Swallowing		Rheumatoid Arthritis			
Poor Appetite				Osteoporosis			
		Cardiovascular		Gout			
Genitourinary		Chest Pain					
Frequent Urination		Shortness of Breath		**WOMEN Only**			
Painful Urination		Palpitations		Hot Flashes			
Blood in Urine		High Blood Pressure		Severe Menstrual Pain			
Urgent Urination		Ankle Swelling		Breast Lumps			
Weak Stream		Heart Arrhythmias		Irregular Periods			
Kidney Stones		Previous Blood Clots					
		Excessive Bleeding					

Patient Name:_____ Date of Birth: _____

Family History Please indicate any medical issues that your family may have been diagnosed with.
Mother
Father
Sibling
Grandmother
Grandfather
Children

Social History	
Occupation:	Do you smoke or use tobacco products?
Marital Status :	Do you drink Alcohol?
Number of children :	Do you use any illegal drugs?

ALLERGIES

Use the chart below to list all medication you are allergic to, including nonprescription drugs.

Medication	Reaction (rash, itching, breathing problems, etc.)

Medical History

Please list any medical issues you may have or had. (Diabetes, hypertension, asthmia, etc.)

Surgical History

Please list any surgeries you may have had.

Surgery - Year	Physician

Patient Name:_____ Date of Birth: _____

MEDICATION LIST

Use the chart below to list all of your current medications,
including vitamins, supplements and over the counter medications.

MEDICATION	PRESCRIBED BY	REASON FOR TAKING	DOSE	FREQUENCY

Date Initially Completed: _____