ConquestMD®
Spine Care and Sports Medicine, PLLC
6850 TPC Drive, Suite 110, McKinney, TX 75070 phone: (214) 544-9887 Fax: (214) 544-9888 www.conquestmd.com

Patient Demographics

Patient Information: (please print)

Patient's legal name: ______________________________ Date of Birth: ______________ Gender: M / F

Address: ______________________________ City: ______________ State: _______ Zip Code: ____________

Home #: ____________________ Work #: ____________________ Cell #: ____________________

Driver's License #: ____________________ Social Security #: ____________________ E-mail: ____________________

Ethnicity: ____________________ Preferred Language: ____________________ Marital status: Single / Married / Divorced

Primary Care Physician: ______________________________ PCP Phone #: ____________________
(First and Last Name, MD or DO)
PCP Fax #: ____________________

Pharmacy Address: ______________________________ Pharmacy Phone #: ____________________

Pharmacy Fax #: ____________________

Patient/Parent Employer: ______________________________

Address: ______________________________ City: ______________ State: _______ Zip Code: ____________

Is this a work related injury? Yes / No

If patient is under 18 years of age or residing with parents, please complete this section.

Mother's name: ______________ Date of Birth: __________ Phone #: ____________ SS #: ______________

Father's name: ______________ Date of Birth: __________ Phone #: ____________ SS #: ______________

Insurance Information:

Primary Insurance Company: ____________________ Policyholder's Name: ____________________

Policyholder's Date of Birth: ____________________ Social Security #: ____________________

Relationship to Patient: ____________________ Policyholder's Employer: ____________________

Policy ID#: ____________________ Group #: ____________________

Secondary Insurance Company: ____________________ Policyholder's Name: ____________________

Policyholder's Date of Birth: ____________________ Social Security #: ____________________

Relationship to Patient: ____________________ Policyholder's Employer: ____________________

Policy ID#: ____________________ Group #: ____________________

Person to Notify in Case of Emergency:

Name: ______________________________ Relationship to Patient: ____________________

Address: ______________________________ Home #: ______________ Cell #: ______________

Please give photo ID and insurance card(s) to receptionist for copying.

Authorization: My signature indicates that I have read the above and grant authorization of treatment and am responsible for payment of fees. I also authorize the release of any medical information requested by my insurance carrier and authorize payment of medical benefits to the physician. Photostat of the above is as valid as original.

Patient or Parent/Guardian Signature: ______________________________

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Name: ______________________________

Primary Care Physician: ______________________

Referring Physician: ________________________

Chief compliant: In a few words, please describe the reason for your visit today (examples: neck pain, back pain, hand numbness, headache, etc...).

____

Briefly describe how your pain began.

____
____
____

How long have these symptoms been present?

O 0 - 1 week
O 1 - 2 weeks
O 2 - 4 weeks
O 4 - 6 weeks
O 6 - 8 weeks
O 2 - 3 months
O 3 - 6 months
O 6 - 12 months
O 1 - 2 years
O More than 2 years

What makes your symptoms worse?

O Sitting O Laying down O Standing O Walking

Other: ______________________________

What makes your symptoms better?

O Sitting O Laying down O Standing O Walking

Other: ______________________________

Were these symptoms caused by and injury? O Yes O No

At work? O Yes O No

Motor Vehicle Accident? O Yes O No

Is there a lawsuit involved? O Yes O No

Have you had any physical therapy for this problem? O Yes O No

If yes, when? ______________________

How many times per week? ____________

Age: ______ Weight: ______ Height : ______

O Male O Female

Are you currently performing any exercises on your own at home for this problem? O Yes O No

Do you feel you like the pain prevents you from exercising? O Yes O No

Have you had any type of injections in the past for this problem? O Yes O No

If yes, when? ______________________

What kind? ______________________

<u>Are you on any blood thinner medication</u> to prevent blood clots, heart attack, stroke or for any other reason? O Yes O No

If yes, which one(s)? __________________

Have you been experiencing any fevers or chills? O Yes O No

Have you had any difficulty controlling your bowel or bladder? O Yes O No

Please list all of your medications.

____
____
____

O I am not taking any medication.

Please list all of your allergies.

____
____
____

O I do not have any allergies

Name: ______________________________________

Past Medical History

Have you ever had these symptoms or similar symptoms in the past? O Yes O No

Surgical History

Please list any surgeries you have had and their dates.

____

____

____

O I have had no surgery in the past

Work History

Employer: ______________________________________

Have you taken time off work because of your current symptoms? O Yes O No

How much? ______________________________________

What is your current work status?

- O Unemployed
- O Full duty
- O Light duty

Social History

Are you married? O Yes O No

Do you smoke? O Yes O No

How many packs per day? ______________________

Do you drink alcohol? O Yes O No

How much? ______________________________________

Do you use any recreational drugs? O Yes O No

What type? ______________________________________

Family History

Does anyone in your family have the same or similar problem? O Yes O No

Are there any medical problems that run in your family? O Yes O No

Please describe: ______________________________

____

____

Patient Statement: I fully understand and completed and/or reviewed pages 1 and 2 of this history form.

______________________________ ____________

Patient Signature (or signature of responsible party) Date

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Review of systems

Do you have any of the following symptoms or medical problems?

Symptom	Yes	No
Abnormal Bleeding	O Yes	O No
AIDS/HIV	O Yes	O No
Anxiety	O Yes	O No
Balance Problems	O Yes	O No
Chest Pain	O Yes	O No
Constipation	O Yes	O No
Cough	O Yes	O No
Depression	O Yes	O No
Diabetes	O Yes	O No
Fainting	O Yes	O No
Fever	O Yes	O No
Hepatitis A, B, or C	O Yes	O No
High Blood Pressure	O Yes	O No
Impotence	O Yes	O No
Incontinence of bowel	O Yes	O No
Incontinence of bladder	O Yes	O No
Loss of appetite	O Yes	O No
Mania	O Yes	O No
Muscle Weakness	O Yes	O No
Nausea	O Yes	O No
Numbness of hands	O Yes	O No
Numbness of feet	O Yes	O No
Runny nose	O Yes	O No
Seizure disorder	O Yes	O No
Shortness of breath	O Yes	O No
Skin rash	O Yes	O No
Skin ulcer	O Yes	O No
Sleep disturbance	O Yes	O No
Sore throat	O Yes	O No
Stomach pain	O Yes	O No
Stomach ulcers	O Yes	O No
Suicidal thoughts	O Yes	O No
Swelling in legs	O Yes	O No
Unexplained weight loss	O Yes	O No
Visual disturbance	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No
Wheezing	O Yes	O No

Please list any other medial problems not described above.

____

____

O I have no other medical problems.

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Authorization of Release of Patient Information

Name of Patient: ____ Phone Number: _____________________

Other Names Used: _______________ Date of Birth: ______________Social Security Number: XXX-___-_____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

Patient information is needed for: Continuing medical care

☐ All date(s) of service ☐ Specific date(s) of service: __________________________

Information to be released:

☐ History & Physical
☐ Consultation Report
☐ Radiology Reports
☐ Radiology Images
☐ Emergency Room Record
☐ Operative Reports
☐ Lab/Pathology Reports
☐ Discharge/Death Summary
☐ Face Sheet
☐ Discharge Instructions
☐ Other: ____________________

Format Requested For Information to be Provided:

☐ Paper
☐ Electronic Media (Requires 2 Business days; only applies to data stored electronically)

Method of Delivery:

☐ Patient will pick up
☐ Fax to: **ConquestMD Spine Care and Sports Medicine @ (214) 544-9888**
☐ Mail to address listed below:

____ may release my information to:
(hospital or facility name)

Ainsworth B. Farrell, M.D.
ConquestMD Spine Care and Sports Medicine, PLLC
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I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history , diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records accord Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: ____________________________________

Signature: ____ **Date:**_______________________
Patient or legally authorized representative

____ ____________________
Printed name of patient or legally authorized representative Relationship to patient

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Financial Responsibility Agreement

______ Initial

I understand and agree that I will be financially responsible for any and all charges not paid by my insurance company for my visit(s). This includes any medical visit , service, lab testing, x-ray (s), and any other screening or diagnostic testiing ordered by the physician or the physician's staff.

______ Initial

I understand and agree that it is my responsibility, and not the responsibility of the physician or the physician's staff, to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG or any other screening or diagnostic testing ordered by the physician or the physician's staff.

______ Initial

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual or customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment at the time of service for all office visits, injections, x-rays, lab testing, and any surgical procedures that have been ordered. Additional surgical procedures cannot be anticipated until surgery has been performed, therefore, there may be additional balance due for those unexpected procedures.

______ Initial

I understand and agree that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company and/or plan. If my insurance company or plan does not recognize the physician or provider I am seeing, it may result in claims being denied, higher deductible or out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

______ Initial

If I am a Worker's Compensation patient, I understand that I am to provide all necessary billing information. I am to provide my date of injury, claim number, adjustor name and contact information, employer information and insurance carrier information including phone and fax numbers. I understand that if my Worker's Compensation claim has been denied, I am responsible for payment in full.

Print Name: ______________________________
(patient or responsible party)

Signature: ______________________________ **Date:** ____________
(patient or responsible party)

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HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of your laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or credit card companies that you may use to help pay for services. For example, your health plan may request and receive information on dates of service, services provided, and medical condition being treated.

Health Care Operation. Your health information may be used as necessary to support the day-to-day activities and management of **ConquestMD Spine Care and Sports Medicine, PLLC.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research. Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information the review is not removed from the premises of this practice. Provider may also disclose the medical of decedents for a research project, so long as the information is necessary for the research.

Other Use and Disclosure Requires Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment;
- The right to inspect and copy your protected health information;
- The right to amend or submit corrections to your protected health information;
- The right to receive an accounting of how and to whom your protected health information has been disclosed; and
- The right to receive a printed copy of this notice.

Practice Duties. We are required by law to maintain the privacy of you protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPPA Privacy Officer
ConquestMD Spine Care and Sports Medicine
PO Box 2757
Frisco, TX 75034
214.544.9887

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.

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HIPPA - Consent for Additional uses of Health Information

Patient Name (Print): ____

Additional Uses of Information
Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you **do not** want us to contact you via the phone number you have already provided, and/or leave a voice message on those phone numbers, please choose one or more of the following alternate methods for us to use to contact you:

May we leave messages concerning your appointment with anyone at your workplace?

O Yes O No O N/A

May we leave messages on your voicemail at work?

O Yes O No O N/A

May we leave messages on you voicemail at home?

O Yes O No O N/A

If you are over (or under) the age of 18, may we discuss your appointments and/or treatments with your parents?

O Yes O No O N/A

If you are over the age of 18, may we discuss you appointments and/or treatments with your children?

O Yes O No O N/A

If you answered "no" to any of the above, please inform us of your preferred method of contacting you.

____

____

Please provide us with names of those persons, if any, with whom we may discuss your appointments and/or treatment:

____

____

______________________ ____________ ____________

Signature of Patient (or Person Authorized to Give Informed Consent for the patient) **Date** **Time**

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Acknowledgement of Receipt of HIPPA Notice and Privacy Practices

Our medical practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

____
Name of Patient (Print)

___________________________ __________________
Signature of Patient **Date**

___________________________ __________________
Signature of Patient Representative **Date**
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

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Disclosure

The physician you are seeing may have financial interest in the following facilities:

Eminent Medical Center
1351 W Pres. George Bush Hwy
Richardson, TX 75080
(469) 910-8800

McKinney Surgery Center
4510 Medical Center Drive
Suite 150
McKinney, TX 75069
(972) 547-1580

Dr. Farrell and the ancillary facilities are committed to providing clinical excellence in a safe and attractive environment for you and your family members both in our office and as part of your ancillary health care. His financial interest in these facilities enables him to have a voice in the ancillary facility's administration and their policies. This involvement helps to ensure the highest quality care for you.

If you would like to choose to have your ancillary health care performed at another facility, please inform the physician or his staff during your visit.

If you have any questions or concerns regarding this notice, please ask your physician or a member of his staff.

This verifies that I have read and understood the above statement.

Patient Signature:____ **Date:** __________________

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Notice of Office Policies

Thank you for choosing us for your healthcare needs. We would like to take this time to explain our office policies. Please carefully read and initial the information below.

______ **Initial**

Office Hours: Our office is open Monday to Friday, 8:00AM to 5:00PM. Lunch is between 12:00PM to 1:00PM. If you should have a medical emergency after hours, please contact our office at (214) 544-9887 and the answering service will contact our Physician. **Medication refills are not handled after 4:00pm or on holidays/weekends and are not considered a medical emergency.**

______ **Initial**

Insurance: We will file an insurance claim with your insurance company. However, your deductibles and co-payments/co-insurance payments are expected at the time services are rendered. In order to file your insurance claims appropriately, we ask that you keep our office informed of any insurance or address changes during your course of treatment. If you are insured under an HMO, MC, POS or EPO policy, it is your responsibility to obtain a referral from your primary care physician for your initial visit.

______ **Initial**

Work Related Injuries: It is your responsibility as the employee to provide the Injury Status Report to your employer. Failure to do so may result in claim denial and/or loss of benefits. We will provide information to the Case Manager or Adjuster, including treatment plans and appointment compliance reports.

______ **Initial**

Appointments: There is a **$35.00** missed appointment fee. It is your responsibility as the patient to contact the office **24 hours** before your appointment if you need to cancel or reschedule your appointment.

______ **Initial**

Forms: FMLA, Disability, Etc: Forms will be completed within 5 business days. There is a minimum charge of **$25.00** payable to the office due at the time the forms are dropped off at the office.

______ **Initial**

Prescription Refills: Medication refills are done only during regular office hours. **Refills are not addressed after 4:00pm or on holidays/weekends.** It may take up to 2 business days for your request to be handled.

______ **Initial**

Medical Records: Our office utilizes Health Mark Group for copying medical records. This service may take up to 7 business days to be completed. There is a **minimum charge of $25.00** for this service. Records to other physicians are done free of charge.

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Acknowledgement of Receipt of Office Policies Notice

By signing below, I acknowledge that I have read and fully understand the office policies of the medical practice.

I understand that the medical practice may amend or revise these policies at any time.

I assume full responsibility for any balance owed after my insurance plan has paid including any supplies or services that are not a covered benefit.

____
Name of Patient (Print)

__________________________ __________________
Signature of Patient **Date**

__________________________ __________________
Signature of Patient Representative **Date**
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient