PATIENT INFORMATION

Last name _____ First name _____ MI ____

Address _____

City _____ State _____ Zip _____ Gender M / F

Home (____) _____-_____ Cell (____) _____-_____ Work (____) _____-_____

Date of Birth ___/___/_____ SSN _____ E-mail _____

Ethnicity/ Race _____ Preferred Language _____

Emergency Contact

Last name _____ First name _____

Relationship _____ Contact Number (_____) _____-_____

Employer

Name _____

Address _____

City _____ State _____ Zip _____

Problem

Body Region _____ Right Left Bilateral (circle one) Date of Injury___/___/_____

Referring Physician_____ Primary Care Physician_____

Work Related Injury Y / N If Yes, What is your claim number? _____

Is your claim currently open? Y / N Claim Manager's Name _____

Motor Vehicle Accident? Y / N If Yes, What is your claim number? _____

Primary Insurance

Insurance _____ Group # _____ ID # _____

Policy Holder Name _____ Relationship _____ Date of Birth ___/___/_____

Secondary Insurance

Insurance _____ Group # _____ ID # _____

Policy Holder Name _____ Relationship _____ Date of Birth ___/___/_____

How Did You Hear About Us

Health Care Provider Friend/ Relative Internet Search Phone Book Other_____(circle one)

Consent for Treatment, Assignment of Benefits & Release of Information: I hereby authorize you to evaluate & treat me (or my dependent) & I assign directly to Patrick Shih, M.D., P.A. all medical insurance benefits, if any, for services rendered.
I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Patient or Guardian Signature _____ Date ___/___/_____

Financial Policy

Our Billing Department is available to discuss any questions you may have regarding your Insurance or account at 832-529-7289 or 210-485-1842 during the hours of 9:00 AM to 5:00 PM Monday through Friday.

The following is our Financial Policy. Please review carefully, then sign and date at the bottom of the form.

- All co-pays are due at the time of service.
- We accept cash or check.
- Payment in full may be required at the time of service depending upon services rendered.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct and current information. Your contract dictates the services that are covered and the amount of payment for those services. You are ultimately responsible for payment of services provided.

Secondary Insurance: As a courtesy, we will bill your secondary insurance, but we require all the plan details at the time of service. Once the primary insurance pays, we allow 45 days for the secondary insurance to process their portion. At the end of 45 days, the balance becomes the patient's responsibility.

Worker's Compensation Claims / Self-Insured Claims: We request your private insurance information at the time of service. In the event State L&I or the third party administrator does not accept your claim, we will bill your private insurance. *You are ultimately responsible for payment of services rendered, if your claim is not accepted.*

Doctor Referrals: You are responsible for obtaining the appropriate referral from your physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral in the office at the time of your appointment.

Payment Issues: If financial problems arise, please contact our Billing Department as soon as possible. If an account becomes past due, necessary action will be taken, up to and including turning the account over to our attorney or collections service. The undersigned understands that he/she, or his/her agent, is responsible for charges incurred.

Uninsured Patients: A $150 deposit ($252 for spine surgeons) is required at time of check-in for our patients without insurance.

No Shows: Patients who no show their appointment(s) are at the risk of being discharged from the practice.

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that the benefits quoted to me are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have carefully read the Financial Policy. I understand and agree to the terms therein.

Patient or Responsible Party Signature _____ Date ___/___/_____

Print Name _____

Acknowledgement of Receipt: Notice of Privacy Rights

I acknowledge receipt of a copy of the Notice of Privacy Practices from Patrick Shih, M.D., P.A.

Patient or Responsible Party Signature _____ Date ___/___/_____ _____

Print Name _____

Voice Message Consent

I hereby give permission for Patrick Shih, M.D., P.A. to leave a detailed message on my voicemail / answering machine.

Patient or Responsible Party Signature _____	Date ___/___/_____

OR ☐ I would NOT like any detailed messages left on my voicemail/ answering machine

Release of Information

In addition to those described in the Privacy Policy, I give my permission for Patrick Shih, M.D., P.A. to discuss my healthcare and billing information with the following people:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient or Responsible Party Signature _____	Date ___/___/_____

OR ☐ I do NOT want my private health information disclosed to any individual asking about me, regardless of whether or not they may be a family member or friend

Parental Consent to Treat Minors

In the event that you are unable to accompany your child to their appointment, we are required to obtain parental consent prior to treating a child. This is to certify that the person(s) listed below has my permission to authorize necessary medical care for my child. This authorization will be in effect until revoked in writing by me. I accept financial responsibility for necessary treatment and services.

Name _____ Relationship _____

Name _____ Relationship _____

OR ☐ I do NOT authorize anyone other than myself to authorize treatment of the above named minor.

Parent or Guardian Signature _____	Date ___/___/_____
Printed Name _____	Relationship _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, hereby assign and convey directly to Dr. Patrick Shih, M.D., P.A, 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 the above-named health care provider, 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 the above-named health care provider 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 the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider 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 an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, 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 (above-named provider) 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. The above-named provider 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 (health care 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..

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date

Dr. Patrick Shih, M.D.

Staff Only:
BP _____
Pulse _____

PATIENT INFORMATION SHEET

Height: _____ Weight: _____	☐ Right Handed Left Handed

Briefly describe your current symptoms: _____

When did your symptoms begin? _____

Any injury or trauma related to the onset of your symptoms? _____

Please rate your pain on a scale of 1 to 10, with 1 being no pain and 10 being the most severe pain imaginable:

		1	2	3	4	5	6	7	8	9	10	
Today:	least	O	O	O	O	O	O	O	O	O	O	worst
least (yet):		O	O	O	O	O	O	O	O	O	O	
Worst (yet):		O	O	O	O	O	O	O	O	O	O	

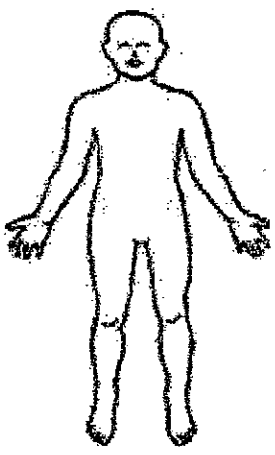
How would you describe your pain? (Please circle all that apply)

Sharp **Burning** **Dull** **Aching** **Cramping** **Stabbing** **Electric Shock**

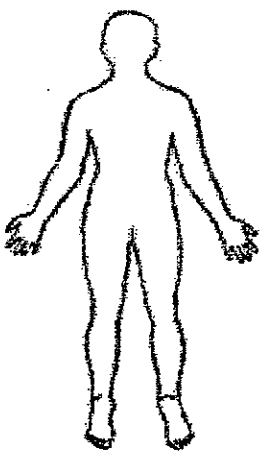
Do you have Numbness? Y **N** Tingling? Y **N** Weakness? Y **N**

Use the letter symbols listed below and mark them where you are experiencing your sensations:

Ache: **AAAA** Numbness: **NNNN** Burning: **BBBB** Stabbing: **SSSS** Tingling: **TTTT**



FRONT



BACK

Dr. Patrick Shih, M.D.

PATIENT INFORMATION SHEET (continued)

What makes your symptoms better? _____

What makes them worse? (Please select all that apply)

O Bending forward O Bending backward O Twisting O Coughing/Sneezing

O Standing from seated position O Walking O Climbing stairs

Have you had spine surgery before? Y / N

If yes, please describe: _____ _____

What Non-surgical treatments have you tried in the past? (Please select all that apply)

☐ Physical Therapy ☐ Traction ☐ Epidural Steroid Injections ☐ Nerve Block

☐ Trigger Point Injections ☐ Acupuncture ☐ Yoga/Pilates

☐ Aquatic (Water) Therapy ☐ Tens Unit ☐ Massage & Ultrasound

☐ Physiatrist Physician ☐ Pain Management Physician ☐ Chiropractor

Have you ever had a bone mineral density scan (DEXA scan)? Y / N

Past Medical History: (Please check any current or past problems)

D Depression
O Lung Disease
O Ulcers
O Hepatitis
O Liver Abnormality
O Asthma
O Arthritis
O Blood clot or Deep Venous Thrombosis (DVT)

D Thyroid Disorder
O Anemia
O Bleeding Disorder
D Cancer
O Sleep Apnea
O Kidney/Bladder problems
O Blood Abnormality

o Heart Disease/Attack
o High Blood Pressure
o HIV or exposure
o Diabetes year onset
o Stroke
o Seizures
o Pacemaker
o Glaucoma
o Psoriasis
o Other

Dr. Patrick Shih, M.D.

PATIENT INFORMATION SHEET (continued)

Surgery History

Surgery name	Date	Location

Have you had surgical complications? Y / N

If yes, please describe: _____

Current Medications: Please include all prescription, over the counter, herbal supplements and vitamins you are taking

Name of Medication	Reason	Dose	Frequency

Are you taking blood thinners? Y / N

If yes, please circle which one(s): Coumadin Aspirin Plavix NSAIDs (Ibuprofen, Motrin, Aleve, Naprosyn, etc.)

Drug Allergies: Please include reaction to medications

Medication you are allergic to	Reaction

Are you allergic to any of the following?

- o Latex
- o Tape/Adhesive
- o Iodine
- o Soap
- o X ray contrast
- o Shellfish

Dr. Patrick Shih, M.D.

PATIENT INFORMATION SHEET (continued)

Family History: Please indicate medical conditions (Cancer, Diabetes, Heart Disease, other conditions)

Relationship (Mother, Father, Siblings, Children)	Medical Condition	Age (at death is deceased)

Social History:

Are you currently: (Please select your status)

O Married O Single O Separated O Divorced O Widowed O Domestic Partner

Are you currently employed? Y / N

If yes, occupation: _____ If no, when was the last time you were employed? _____

Do you use tobacco? Y / N

If yes, do you:

Smoke Cigarettes?	Years of Use?	How many per day?
Smoke Cigar or Pipe?	Years of Use?	How many per day?
Chew Tobacco?	Years of Use?	How much per day?

Are you a former tobacco user? Y / N

If yes, when did you quit? _____

Have you ever used recreational/ non-medical drugs? Y / N

If yes, type: _____

Do you drink alcohol? Y / N

If yes, how many drinks a week (on average)? _____

Review of Systems:

Please mark if you are experiencing or currently have any of the following:

Psychiatric

O Depression
O Bipolar Disorder
O Mood Swings
O Personality Changes

Ophthalmologic

O Glasses
O Blurry Vision
O Double Vision
O Loss of Vision
O Dry Eyes
O Other

ENT

O Difficulty Hearing
O Ringing in Ears
O Sinus Disease
O Snoring

Pulmonary

O Shortness of Breath
O Asthma/Wheezing
O Cough
O Bloody Cough/Sputum

Infectious Disease

O Fever
O Chills
O Sweats
O Recent
O Infections

Hepatitis

O Hematologic
O Anemia
O Low Platelets
O Bleeding Disorder

Dr. Patrick Shih, M.D.

PATIENT INFORMATION SHEET (continued)

Review of Systems (continued): Please mark if you are experiencing or currently have any of the following:

Gastrointestinal

- O Abdominal Pain
- O Nausea
- O Vomiting
- O Constipation
- O Diarrhea
- O Heartburn
- O Stomach Ulcer
- O Bloody Stool
- O Black Tarry Stool
- O Bowel Incontinence

Musculoskeletal

- O Painful Joints
- O Swollen Joints
- O Neck Pain
- O Back Pain
- O Generalized Weakness
- O Gout
- O Osteoporosis
- O Osteopenia

Endocrine

- O High Thyroid
- O Low Thyroid
- O Sexual Dysfunction
- O Menstrual Difficulty
- O Diabetes
- O Weight Loss

Genitourinary

- O Bladder Incontinence
- O Bloody Urine
- O Foul Smelling Urine
- O Kidney Stones
- O Erectile Dysfunction

Cardiovascular

- O Chest Pain
- O Irregular Heart Beat
- O Circulation Problems in your Arms or Legs
- O High Blood Pressure
- O Other

Dermatologic

- O Skin Rashes
- O Skin Cancer

Neurologic

- O Impaired Thinking
- O Memory Loss
- O Difficulty with Taste/Smell
- O Difficulty Walking
- O Falling Down
- O Tremors/Shaking
- O Spasticity
- O Poor Coordination
- O Seizure
- O Numbness/Tingling
- O Speech Difficulty
- O Blackouts/Fainting
- O Meningitis
- O Encephalitis
- O Swallowing Difficulty
- O Decreased Attention

I attest all information I have provided is true and correct to the best of my knowledge.

Patient or Responsible Party Signature _____ Date ___/___/_____

Physician Signature _____