

PATIENT CASE HISTORY

Date: _____



Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____ - _____ - _____ Gender: Male - Female

Status: Single _____ Married _____ Spouse Name: _____

Emergency Contact Name and Number _____

List any **Allergies**:

- Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen
 Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

List any **Surgeries**:

- Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____

List **ALL Past Medical History** conditions:

- Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression
 Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain
 Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure
 Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain
 Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's
 Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain
 Stroke/Heart Attack Other: _____

List Type of **Medications** you are taking:

- Anxiety Muscle Relaxors Pain Killers Insulin Birth control Cardiovascular Allergy Seizure
 Name of daily medications _____

Are you Allergic to any Medications? _____

List your **Family History**:

- Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition
 High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio
 Prostate Problems Stroke/Heart Attack Other: _____

Have you had any auto or other accidents? No Yes

Describe: _____

Date of last physical examination: _____ *Do you smoke? N Y Have you ever smoked? N Y*

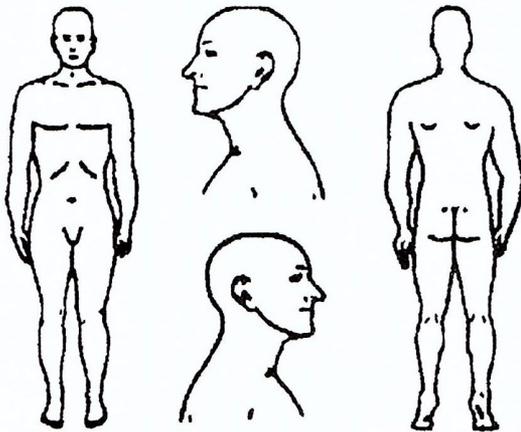
Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often): _____

Average Blood Pressure _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

Current height _____ *weight* _____

What is your major complaint? _____ **Date problem began?** _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Activities of Daily Living Assessment

Any activity which is limited by pain or discomfort.

Self Care and Personal Hygiene

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> bathing/showering | <input type="checkbox"/> brushing teeth | <input type="checkbox"/> putting on shoes | <input type="checkbox"/> eating | <input type="checkbox"/> doing laundry |
| <input type="checkbox"/> grooming hair | <input type="checkbox"/> making the bed | <input type="checkbox"/> putting on pants | <input type="checkbox"/> dishes | <input type="checkbox"/> going to toilet |
| <input type="checkbox"/> washing face | <input type="checkbox"/> putting on shirt | <input type="checkbox"/> cooking | <input type="checkbox"/> taking out trash | |

Physical Activities

- | | | | | |
|------------------------------------|------------------------------------|--|--|---|
| <input type="checkbox"/> standing | <input type="checkbox"/> walking | <input type="checkbox"/> reaching | <input type="checkbox"/> bending right | <input type="checkbox"/> twisting right |
| <input type="checkbox"/> sitting | <input type="checkbox"/> squatting | <input type="checkbox"/> bending forward | <input type="checkbox"/> bending left | <input type="checkbox"/> twisting left |
| <input type="checkbox"/> reclining | <input type="checkbox"/> kneeling | <input type="checkbox"/> bending back | <input type="checkbox"/> looking left | <input type="checkbox"/> looking right |

Functional Activities

- | | | |
|---|---|---|
| <input type="checkbox"/> carrying small objects | <input type="checkbox"/> lifting weights off table | <input type="checkbox"/> pushing/pulling while standing |
| <input type="checkbox"/> carrying large objects | <input type="checkbox"/> climbing stairs/incline | <input type="checkbox"/> exercising upper body |
| <input type="checkbox"/> carrying briefcase/purse | <input type="checkbox"/> pushing/pulling while seated | <input type="checkbox"/> exercising lower body |
| <input type="checkbox"/> lifting object off floor | | |

Social and Recreational Activities

- | | | | |
|----------------------------------|--|---------------------------------|------------------------------------|
| <input type="checkbox"/> jogging | <input type="checkbox"/> swimming | | |
| <input type="checkbox"/> biking | <input type="checkbox"/> hunting/fishing | <input type="checkbox"/> sports | <input type="checkbox"/> gardening |
| <input type="checkbox"/> walking | _____ | | |

Difficulties with Traveling

- | | |
|--|---|
| <input type="checkbox"/> driving in car | <input type="checkbox"/> driving for long periods of time |
| <input type="checkbox"/> riding as passenger | <input type="checkbox"/> riding as passenger for long periods of time |

Other activities

Use this scale for the following activities:

- 1 This activity is slightly affected by my condition
- 2 This activity is moderately affected by my condition
- 3 This activity is severely affected by my condition
- 4 I cannot perform this activity due to my condition

- | | | | | | |
|--|---|----------------------------------|-----------------------------------|----------------------------------|---|
| <input type="checkbox"/> concentrating | <input type="checkbox"/> listening | <input type="checkbox"/> reading | <input type="checkbox"/> studying | <input type="checkbox"/> writing | <input type="checkbox"/> using computer |
| <input type="checkbox"/> sleeping | <input type="checkbox"/> sexual relations | | | | |

Patient Name: _____ Date of Birth: _____ Doctor Signature: _____

NON-COVERED SERVICES STATEMENT

As my patient, I want to provide you with the best care possible. There are services which I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your health benefits contract. You will be expected to pay for those services in full. Let me reassure you that I will order only the tests and treatments which I feel are necessary for your treatment and care.

If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

Patient Signature	Date	Possible Non-Covered Services & Monies Due
		

*** I have read your policy and agree to pay for the services outlined above which are not covered by my contract as indicated by my signature for each date above. ***

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to (*insert name of practice*) to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (*insert phone number*). You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Print Patient's Name

Patient's Signature

Other Than Patient, Print Name & Relationship

Witness



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>		
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)					
CITY			STATE			8. RESERVED FOR NUCC USE						
ZIP CODE		TELEPHONE (Include Area Code) ()			CITY		STATE					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										SIGNED _____		
X SIGNED _____										X DATE _____		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER DATE QUAL. MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
				17b. NPI _____								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.						22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. _____ B. _____ C. _____ D. _____						23. PRIOR AUTHORIZATION NUMBER						
E. _____ F. _____ G. _____ H. _____												
I. _____ J. _____ K. _____ L. _____												
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
1									NPI			
2									NPI			
3									NPI			
4									NPI			
5									NPI			
6									NPI			
25. FEDERAL TAX I.D. NUMBER		SSN EIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()				
SIGNED _____				a. NPI _____				b. _____	a. NPI _____	b. _____		

A. Notifier:

B. PatientName:

C. IdentificationNumber:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: 	J. Date:
--	----------

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.