PASC Institute New Patient Info Form

The Dallas PRP and Stem Cell Institute

Date

MM / DD / YYYY

Patient Name *

First Last

Date Of Birth *

MM / DD / YYYY

Patient Age

Gender *

- (•) Male
- ( ) Female

Patient Social Security Number

Please Select Your Referral Source

- (•) Current or Former Patient
- ( ) Insurance Company Website
- ( ) Internet Search
- ( ) Northpark Movies
- ( ) Doctor
- ( ) Physical Therapist
- ( ) Coach
- ( ) Trainer
- ( ) Other

Referral Source Name
(doctor, therapist, coach, trainer, patient)

none

Patient Home Address

Street Address

Address Line 2

City State / Province / Region

Postal / Zip Code

United States

Country

Patient Cell Phone

– –

####

Patient Home Phone Number

– –

####

Patient Work Phone Number

– –

####

Patient Email (for office correspondence/reminders)

Name of Patient School (High School or College)

N/A

Name of Patient Employer

N/A

Parental Information For Patients Under 18

Please skip this section if the patient is not a minor

Mother's Name

First Last

Mother's Birthday

/ /

MM DD YYYY

Mother's Social Security Number

Father's Name

First Last

Father's Birthday

MM / DD / YYYY

Father's Social Security Number

Person Responsible For Payment

Same As Patient
(Skip section if answer is yes, otherwise please fill out section)

- [ ] Yes

Responsible Party Name

First Last

Relationship To Patient

Responsible Party Date Of Birth

MM / DD / YYYY

Responsible Party Social Security Number

Responsible Party Home Address

Street Address

Address Line 2

City State / Province / Region

Postal / Zip Code Country

United States

Responsible Party Email

Responsible Party Home Phone Number

– –

####

Responsible Party Work Phone Number

– –

####

Responsible Party Cell Phone Number

– –

####

Insurance Company Information

If you have more than one insurance carrier please fill out the information for primary, secondary, and tertiary insurance companies where indicated.

Please Check Box If This Visit Should Be Filed Under A Current Or Pending Workers' Comp Claim

- [ ] Yes

Is the Insured the Same As The Patient? (If No, Please Enter Insured's Name and Info)

- [ ] Yes
- [ ] No

Insured's Name

First Last

Insured's Phone Number

– –

####

Insured's Date Of Birth

/ /

MM DD YYYY

Insured's Social Security Number

Primary Insurance Company Name

Primary Insurance Company Telephone Number

– –

####

Primary Insurance Patient ID Number

Primary Insurance Patient Group Number

Effective Date of Primary Insurance

MM / DD / YYYY

Secondary Insurance Company Name

Secondary Insurance Company Telephone Number

– ### –

Secondary Insurance Patient ID Number

Secondary Insurance Patient Group Number

Effective Date of Secondary Insurance

MM / DD / YYYY

Tertiary Insurance Company Name

Tertiary Insurance Company Telephone Number

– ### –

Tertiary Insurance Patient ID Number

Tertiary Insurance Patient Group Number

Effective Date of Tertiary Insurance

MM DD YYYY

Workers' Compensation Claim Information

Please Skip If Not Applicable

Employer Name

Workers' Comp. Insurance Carrier

Workers' Comp. Claim Number

Date Of Work Injury

/ /

MM DD YYYY

Treating Doctor/Chiropracter

Workers' Comp. Claim Adjustor

First Last

Adjustor Phone Number

– –

####

Personal Physician/Internist

Please fill out if applicable.

Personal Physician Name

First Last

Personal Physician Address

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

United States

Country

Emergency Contact Information

Emergency Contact Name

First Last

Emergency Contact Phone Number

– –

####

Emergency Contact Email

Emergency Contact Address

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

United States

Country

Authorization To Treat

I, the undersigned, hereby give my permission to receive evaluation and/or consultation and/or treatment or any other professional services rendered by The Dallas PRP and Stem Cell Institute Physicians, their employees, and agents.

Insurance Certification and Verification

I, the undersigned, hereby confirm that my health insurance coverage is current within 30 days and that I am not more than 30 days past due on my insurance premium payments. I understand that if my insurance coverage cannot be verified by the insurance carrier, I may be required to pay for medical services at the time rendered and request reimbursement from my insurance carrier directly.

Signature

(please enter your name below to authorize treatment) *

PASC Institute Patient Medical History

The Dallas PRP and Stem Cell Institute

Date

/ /

MM DD YYYY

Patient Name

First Last

Patient Age

Patient Date Of Birth

/ /

MM DD YYYY

Email (for office reminders/correspondence)

Date Of Injury or Onset of Problem

/ /

MM DD YYYY

Briefly Describe Your Injury Or Problem

Have You Had Surgery For This Condition? *

- [ ] Yes
- [ ] No

If Yes, Please Enter Surgery Date and Surgeon

N/A

Did The Injury Result From An Automobile Accident? *

- [ ] Yes
- [ ] No

Were you Injured At A School Activity? *

- [ ] Yes
- [ ] No

If Yes, Please Enter Sport Below

N/A

If Yes, Please Enter School Name Below

N/A

If Yes, Please Enter Trainer's Name Below

N/A

If Yes, Please Enter Coaches' Name Below

N/A

Were you Injured On The Job? *

- [ ] Yes
- [ ] No

Are There Any Lawsuits Regarding Your Injury? *

- [ ] Yes
- [ ] No

Lawsuits (Please describe if pending or completed)

None

Check all symptoms you are currently experiencing

- [ ] Allergy
- [ ] Cardiovascular
- [ ] Chest Pain
- [ ] Connective Tissue Disease
- [ ] Diabetes Mellitus
- [ ] Eating Disorder
- [ ] Ear / Nose / Throat
- [ ] Eye
- [ ] Fever
- [ ] Gastrointestinal
- [ ] Genitourinary
- [ ] Hemtalogical
- [ ] Lymphatic
- [ ] Musculoskeletal Pain
- [ ] Neurological
- [ ] Psychiatric
- [ ] Respiratory
- [ ] Skin
- [ ] Weight Gain
- [ ] Weight Loss

Check all that apply to you

- [ ] Asthma / Lung Problems
- [ ] Cancer
- [ ] Cardiac Disease
- [ ] Diabetes
- [ ] History of Back Pain
- [ ] Hypertension
- [ ] Psychiatric Disorders
- [ ] Seizure Disorder
- [ ] Stroke

Please list any additional medical or health problems

None

Please list any surgeries

None

Please list any medication allergies that you have :

None

Please list any medications you are currently taking (and dosage if known) :

None

If you are a woman, are you currently pregnant, or is there a possibility that you are pregnant?

- [ ] Yes
- [x] No

How Much Do You Smoke?

- (•) None
- ( ) Less Than 5 Cigarettes A Day
- ( ) 5-10 Cigarettes A Day
- ( ) 10-20 Cigarettes A Day
- ( ) More Than 1 Pack A Day

Are you currently using marijuana, cocaine, methamphetamine, ecstasy, narcotics, or any other recreational drugs?

- ( ) Yes
- (•) No

Are you currently taking any blood thinning medications? *

- ( ) Yes
- (•) No

Are you currently using aspirin or other NSAID drugs? *

- ( ) Yes
- (•) No

Are you currently using steroids or other performance enhancing drugs?

- ( ) Yes
- (•) No

Do you feel you are at risk for falls or falling injuries?

- ( ) Yes
- (•) No

Please describe your alcohol consumption :

- ( ) Daily
- ( ) Weekly
- ( ) Monthly
- ( ) Occasionally
- ( ) Rarely
- (•) Never

Authorization To Release Medical Records/Assignment To Physicians

I hereby authorize any surgeon in the Sports Medicine Clinic Of North Texas to furnish information to insurance carriers concerning my illness or treatments. I hereby assign to the physicians all payments for medical services rendered to myself or

my dependents. I understand that I am responsible for any amounts not covered by my insurance company. A copy of this authorization shall be as valid as the original. Typing my name in the space below its equivalent to signing this form.

Insured's Signature

PASC Institute Protected Health Information Form

The Dallas PRP and Stem Cell Institute.

In the course of your medical care, we may release relevant medical information to your other physicians or health care providers, or as directed by court order.
You have the right to request restrictions on how your medical information is used or disclosed.
You may make changes to how your medical information is disclosed at any time by sending your new request in writing to our office or filling out the form again.
Please fill out this form to indicate any additional people with whom we may share your medical information.
If we do not have specific approval, we will only release your medical information to you and your other healthcare providers.

Date *

MM / DD / YYYY

Patient Name *

Title First Last Suffix

Patient Date Of Birth *

MM / DD / YYYY

Patient Email

Patient Phone Number

– ### –

Please check how we may release your Protected Health Information to you (check all that apply) *

- (•) Direct contact only (phone or in person)
- ( ) Email
- ( ) Mailed to Home Address
- ( ) Home phone voicemail
- ( ) Office phone voicemail
- ( ) Fax
- ( ) Other

Are there any additonal people that you wish to approve receiving your Protected Health Information? *

- [ ] Yes
- [ ]

No

Additional Authorized Persons With Contact Info

Please check how we may release your Protected Health Information to your Additional Authorized Person(s) (check all that apply)

- Direct contact only (phone or in person)
- Email
- Mailed to home address
- Home phone voicemail
- Office phone voicemail
- Fax
- Other

Signature (please type your name) *

PASC Institute Consent/Privacy Notice/Disclosures

This form is required by the PASC Institute and the government. Please read thru it and enter your name to give your approval. Thank You.

Date

/ /

MM DD YYYY

Patient Name

First Last

Email (for office correspondence/reminders)

Patient Consent/ Patient Privacy Notice

I understand that as part of the provision of healthcare services, The Dallas PRP and Stem Cell Institute creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides more complete descriptions of uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing or typing my name on this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3.I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must: agree to any restrictions by signing or typing my name on this form that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions by signing or typing my name on this form on the use and disclosure of my Protected Health Information which have been previously agreed upon.
4. I give consent to be contacted by mobile phone or email to verify my account information, payment information, or account balance.

By signing or typing my name in the space below, I am confirming that I have read and understood this document.

PASC Institute Disclosures

The physicians associated with the Dallas PRP and Stem Cell Institute (PASC Institute) are required by Texas law (SB 872, 2005) to disclose any ownership or financial interest in any health care facilities where our patients may receive care. We respect the rights of our patients to choose not only their surgeon but also where they wish to have any medical services provided for them. Some of the surgeons in our practice have ownership in Pine Creek Medical Center which is a private, state of the art physician owned and operated full service hospital founded in 2003. The hospital is owned by over 50 health care providers interested in bettering the health of the community thru a more efficient and personalized delivery of health care. The hospital is fully accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO) and by the Centers for Medicare and Medicaid Services (CMS).

The Surgeons at the PASC Institute also have in office MRI facilities to further allow us to obtain MRI tests efficiently for our patients.

The Surgeons at the PASC Institute also own in office digital imaging including radiography, sonography, and fluoroscopy.

We have taken these measures to ensure the quality of the medical care that we provide our patients.

We encourage our patients to discuss any concerns they have with us at the time of their office visit.

For further information on Pine Creek Medical Center please visit their website at:
www.pinecreekmedicalcenter.com

Patient's Signature
(Type In Box)

Responsible Guardian Signature For Minors
(Type in Box)

Last 4 Digits Of Signers' Social Security #