Dr. Brian Rich, MD 5370 NW Cache Rd, Ste 4 Lawton, OK 73505
1001 W. Eagle Road Decatur, TX 76234
Phone: 580-771-2011/817-442-6300 Fax: 877-292-3457

Patient Information

Name _____ **SSN** _____ **Gender** M F **Race**_____

Address _____ **Home Phone** _____

City _____ **State** _____ **Zip** _____ **Cell Phone** _____

Date of Birth _____ **Marital Status** S M D **E-Mail** _____

Emergency Contact Name/Relationship/Phone Number:

_____

Guarantor Information (If the patient is not the guarantor, please complete this section)

Name _____ **SSN** _____ **Gender** M F

Address _____ **Home Phone** _____

City _____ **State** _____ **Zip** _____ **Cell Phone** _____

Date of Birth _____ **Marital Status** S M D **E-Mail** _____

Guarantor Relationship _____

Primary Insurance

Insurance Company Name _____ **Insurance Co Phone** _____

Policy Holder Name _____ **Date of Birth** _____

ID/Subscriber Number _____ **Group Name/#** _____

Secondary Insurance

Insurance Company Name _____ **Insurance Co Phone** _____

Policy Holder Name _____ **Date of Birth** _____

ID/Subscriber Number _____ **Group Name/#** _____

How did you hear about us? _____

Name of Referring/Primary Care Physician _____

Patient Name _____ **Date**_____

Past Medical History

Do you have any of the following conditions?

Cardiac Arrhythmia Heart Attack Blocked Arteries High Blood Pressure High Cholesterol

Other _____

Pulmonary Asthma Emphysema Bronchitis Sleep Apnea Smoker

Other _____

GI Ulcers reflux Diverticulitis Gall Stones Liver Disease Irritable Bowel

Other _____

GU Kidney Disease Kidney Stones Endometriosis Fibroids Prostate Problems

Other _____

Endocrine Diabetes Thyroid Disease Adrenal Disease

Other _____

Rheumatological Osteoarthritis Ankylosing Spondylitis Rheumatoid Arthritis Polymyalgia Rheumatica Fibromyalgia Systemic Lupus Erthromitosis

Other _____

Hematological Anemia Low Platelets Bleeding Disorder

Other _____

Neurological Seizures Multiple Sclerosis Parkinson's Tremors Stroke Neuropathy

Other _____

Psychological Anxiety Depression Excessive Alcohol Use Substance Abuse

Other _____

Circle any of the medications you are taking:

Aspirin Ticlid Plavix Warafin/Coumadin Aggrenox Herapin Levenox Fragmin

Are you taking any vitamin supplements? Y N **If so, what?** _____

Please list any Medication, Anesthesia, Tape/Soap and/or Latex/Contract Material allergies

_____

_____

_____

Patient Name _____ Date _____

Do you have any of the following? Please circle all that apply on a REGULAR basis.

Loss of bowel Loss of Bladder Leg Weakness Fever/Chills

My pain is increased by only: Circle ONLY the descriptor which usually worsens your pain.

Sitting Relaxing Bending Backwards Bending Forwards Walking up Steps

Walking Down Steps Sneezing Coughing Stress Straining

Sleep on Stomach Weather Changes Sexual Activity Other _____

My pain is improved by: ONLY circle the descriptors which usually relieve your pain.

Sitting Relaxing Leaning Forwards Lying on Back Hot packs Cold Packs

Medication Sleeping Lying on Side Fetal Position Other _____

Have you had any diagnostic studies for your pain: X-Ray, CT/MRI EMG? Where (name of facility)?

_____

_____

Please list all past Surgeries & Dates:

_____

_____

Please note if you have had any of the listed below?

TREATMENT	Did it work?
Physical Therapy	
Ultrasound	
TENS	
Hydro Therapy	
Traction	
Chiropractic	
Acupuncture	

Please note if you have had any of the spinal injections below additional treatments

Injection	Location on the body	Date	Physician	Did it help?
Epidural				
Caudal				
Facet				
Medical Branch Block				
Trigger Point				
Sympathetic Block				

Please list any SPINE surgeries you have had

Spinal Level	**Type: Fusion, Disectomy, Laminectomy, etc,.**	**Date**	**Surgeon**

Patient Name _____ **Date _____**

What medications have you taken for **pain** in the past?	Dosage	How many times a day?	Did it help?	List any side effects

List all current medications	Dosage	How many times a day?	Does it help?	List any side effects

Pharmacy used _____

Social History

Smoking How often per week? _____ How many years? _____

Have you quit? If so, when? _____

Alcohol How often per week? _____ How many years? _____

Have you quit? If so, when? _____

Illegal Substances How often per week? _____ How many years? _____

Have you quit? If so, when? _____

Does your occupation require you to bend in an awkward position? If so, please explain.

_____

Does anyone in your family suffer from chronic pain?

_____

Review of System: Check those that apply on a REGULAR basis.

General: Weight Loss Weight Gain Fever Chills Insomnia

Heent: Eye Problems Ear Problems Nose Problems Throat Problems

Cardiac: Chest Pain Fainting Spells

Pulmonary: Shortness of Breath Cough Bloody Sputum

GI: Blood in Stool Constipation Diarrhea Loss of Bowel

Gu: Difficulty Urinating Loss of Urine Bloody Urine

Musculoskeletal: Joint Pain Muscular Pain Osteoporosis

Neurological: Seizures Tremors Weakness

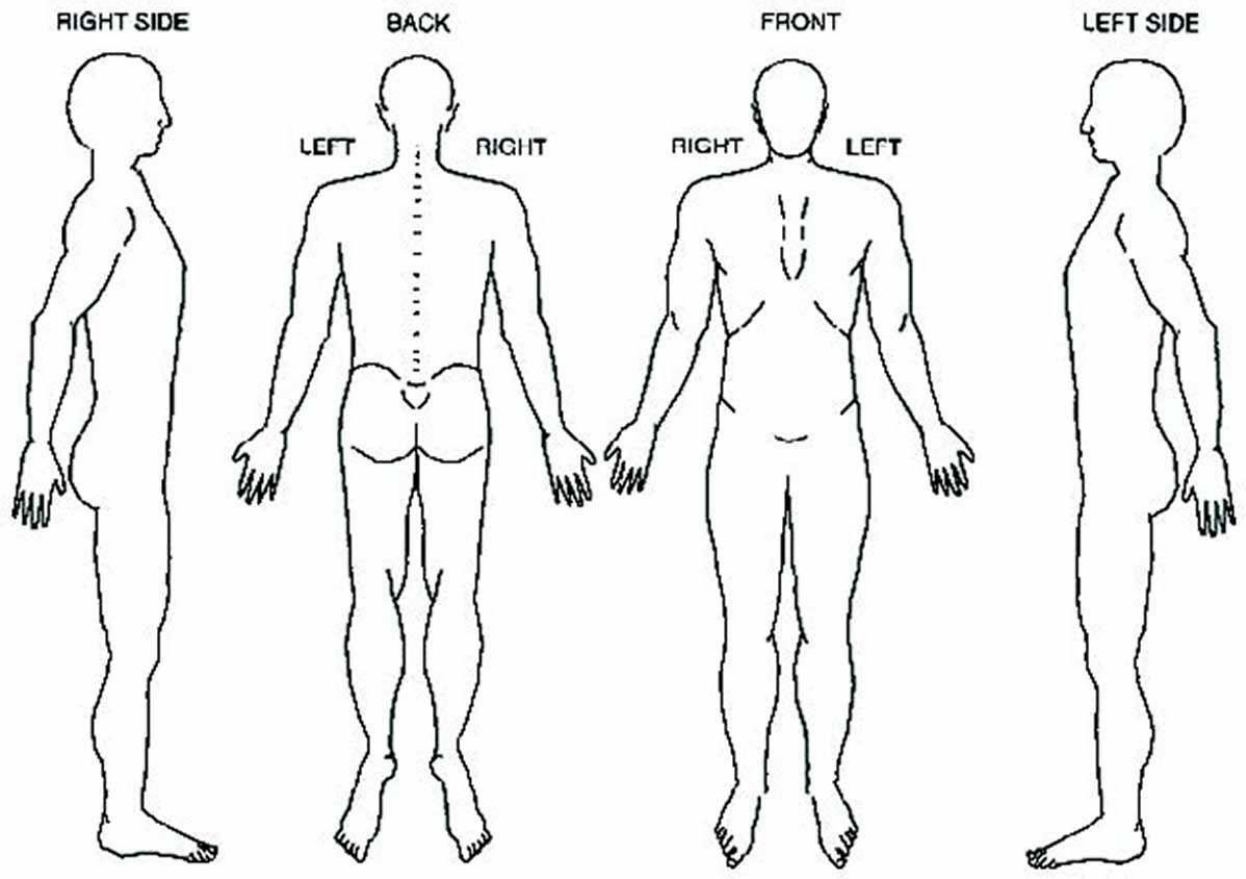
Psychiatric: Depression Anxiety

Patient Name _____ Date _____

Date _____ Name _____ **DOB** _____ **Age** __

Please mark the MAJOR areas of PAIN you are experiencing.

A= ACHE P= PINS & NEEDLES B= BURNING S= STABBING N= NUMBNESS O= OTHER



Thinking back over the last 30 days, rate your pain at its lowest, highest, and most consistent by circling the numbers below.

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Height _____ **Weight** _____ **What is the date your pain began?** _____

How did the pain begin?

_____

_____

Onset of Pain Sudden Gradual

Is the pain constant? Y N **Intermittent?** Y N

Describe the injury. Specify the position of your body at the time of the injury (Twisting, turning, leaning, reaching)

_____

_____

Patient Name _____ **Date** _____

Release of Medical Information

I hereby authorize the provider involved with the above named patents care to release information from the patients medical record to any person, corporation, or agency that is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or part of the provider's charges and/or professional fees or to any entity designated by mefor discharge and planning purposes. _____ (initial)

Assignment of Benefits

I hereby authorize payment directly to Acellerated Interventional Orthopedics, PLLC, all insurance benefit payments due to me as a result of the above-named patient's outpatient treatment or service and pursuant to any insurance contract have which provides for such treatment. I agree to be responsible for any charges incurred that are not paid by insurance or other third-party payers. _____ (initial)

Medicare Consent- if applicable .

I certify that the Information given by me In applying for payment under title WII (Medicare) of the Social Security Act is correct, I authorize the holder of medical or other information about me to release to the Social Security Administration or Intermediaries or carriers any Information needed for this or a related Medicare Claim. request that payment of authorized benefits be made on my behalf, I assign the benefits payable for provider services to the provider or organization furnishing the services or authorize such provider or organization to submit a claim to Medicare on my behalf, if there is an injection procedure that Dr. Rich or staff feels may not be covered by Medicare, I will be asked to sign an Advance Beneficiary Notice or ABN at the time of check-in. _____ (Initial)

Financial Agreement

I understand and agree that co-insurance, co-pays, or deductible amounts are my responsibility, I also acknowledge that the filing of insurance claims is NOT a guarantee of payment and that am financially responsible for payment if such claims are unpaid or non-covered services. **Acellerated Interventional Orthopedics aka Dr. Brian Rich, MD DOES NOT PARTICIPATE WITH BLUE CROSS/BLUE SHIELD OR CIGNA INSURANCE.** _____ (initial)

I understand and agree that there is a $25.00 fee for returned checks. I also agree that any and all collection fees or attorney fees Incurred as a result of delinquent payment will be my responsibility. _____ (initial)

By signing this document, I acknowledge that have read and understand this consent, Further, I hereby consent and authorize Acellerated Interventional Orthopedics to use or disclose my Protected Health Information in conjunction with treatment, payment, or Health Care Operations in accordance with the terms of this consent. _____(Initial)

Please present your insurance card(s) and your photo identification to the receptionist, The receptionist will return them to you once your Information has been entered and the cards have been scanned into our system. **All co-pays and previous balances are due at check-in.**

Signature

_____ Date _____

Patient/Legal Guardian/Power of Attorney

ACELLERATED INTERVENTIONAL ORTHOPEDICS

Dr. Brian Rich, MD 5370 NW Cache Rd, Ste 4 Lawton, OK 73505

Phone: 580-771-2011 Fax: 877-292-3457

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME _____ SOCIAL SECURITY#_____

DATE OF BIRTH _____

I hereby authorize: _____

To release the following information to **Acellerated Interventional Orthopedics**

Information to be shared:

- MRI/CT/X-RAYS
- Other _____
- Entire Medical Record
- Billing information for _____
- Psychotherapy Notes (if checking this box, no other box may be checked)
- Substance Abuse Records
- Mental Health Records
- Medical information compiled between _____ and _____

The information may be disclosed for the following purposes only:

- Continued treatment
- Insurance Legal
- At my or my representative's request

I understand that by voluntarily signing this authorization:

I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.

I have the right to withdraw my permission for the release of my information. If I sign this authorization to use or disclosing the information and will not affect information that has already been used or disclosed.

I have the right to receive a copy of this authorization.

I understand that unless the purpose of this authorization is to determine payment of a claim for benefits signing this authorization will not affect my eligibility for benefits, treatment or payment of claims. My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, HIB or and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.

I understand that I cannot restrict information that may have already been shared based on this authorization.

Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation. Unless revoked or otherwise indicated this HIPauthorization will be valid

Signature of Patient or Legal Representative _____ Date:_____

Description of Legal Representatives Authority _____

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HIPAA RELEASE OF PROTECTED HEALTH INFORMATION

_____

Patient or Patient Legal Representative Signature Date

Please provide us with a list of names of who you would allow our office to release medical information to and to pick up scripts.

Name _____

Relationship _____

Phone Number _____

Name _____

Relationship _____

Phone Number _____

Name _____

Relationship _____

Phone Number _____

Name _____

Relationship _____

Phone Number _____

Name _____

Relationship _____

Phone Number _____