

UNITED CARE MEDICAL, PLLC

PATIENT INFORMATION

Name: _____ Today's Date _____

Address: _____ City _____ State _____

ZIP: _____ Phone # _____ Work # _____ Cell # _____

SS# _____ Birthdate _____ Age _____ E-mail _____

Gender: M / F Marital Status: Single Married Divorced Widow(er)

What doctor will you be seeing today: _____

Referring: Doctor, Attorney, Therapist, Case Worker, Friend/Family, Advertisement, Other

Name: _____ Address: _____ Phone: _____

Family Physician Or Other Treating Physicians:

Name: _____ Address: _____ Phone: _____

Have you been seen for this injury before? ____ (If Yes) When? _____ How long? _____

And by whom? _____

HISTORY OF PAIN/PROBLEM ONSET

When did this current Episode of pain/problem begin?

Did the pain/problem begin: gradually suddenly

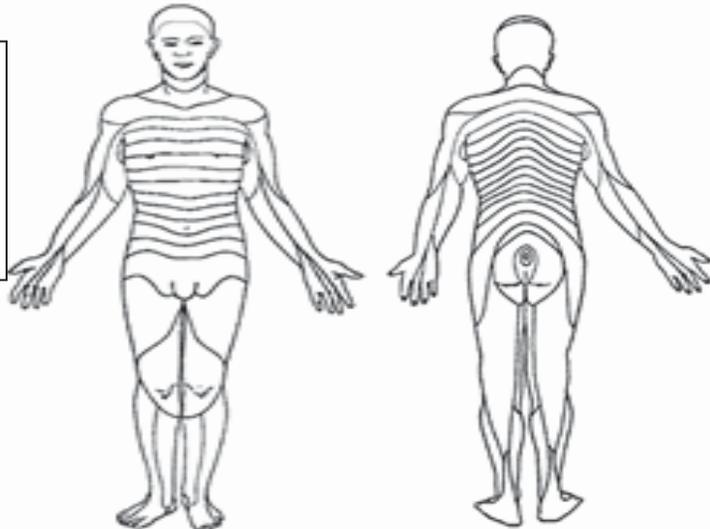
Part of the body being seen for today?

If your pain is due to an injury, briefly describe the events that led to the injury.

Please indicate the location of your pain on the diagram. → → → → →

What is your pain level?

0 _____ 10



PATIENT INFORMATION

Handedness: R / L

PAST MEDICAL HISTORY

Medical Illnesses / Problems

Check if you have had or are currently having problems with any of these illnesses / problems.

- Diabetes
- High Blood Pressure
- Heart Disease
- Stroke
- Other _____
- Hypothyroid
- Osteoporosis
- Osteoarthritis
- Rheumatoid / Lupus / Gout or other connective tissue disorder
- Depression
- Anxiety Disorder
- Head Injury

Surgical History

Check if you have had any of the following surgeries

- Cardiac Bypass or Stent
- Tonsillectomy
- Joint Surgery _____
- Spine Surgery _____
- Gallbladder surgery
- Appendectomy
- C - section
- Hysterectomy
- Other:

Family History

Check if any one in your immediate family has problems with any of these illnesses / problems.

- Diabetes
- High Blood Pressure
- Heart Disease
- Stroke
- Hypothyroid
- Osteoporosis
- Osteoarthritis
- Rheumatoid / Lupus / Gout or other connective tissue disorder
- Depression/Anxiety
- Back pain
- Other _____

ALLERGIES: _____

Medications: _____

Review of Systems: During the past 6 months, have you had any of the following?

- Fevers/Chills
- Night Sweats
- Weight Loss
- Excessive Fatigue
- Stiffness in Joints
- Joint Swelling / Warmth
- Unusual Rashes
- Easy Bruising
- Chest Pain or Tightness
- Trouble Breathing
- Swollen Ankles/Legs
- Hoarseness
- Difficulty Swallowing
- Numbness/Tingling
- Anxiety/Depression
- Difficulty Sleeping
- Headaches
- Loss of Bowel Control
- Black or Bloody Stools
- Urinary Incontinence
- Menstrual Problems
- Memory Problems
- Dizziness

Do you smoke? Y / N _____ packs/day _____ years

Do you consume alcohol beverages? Y / N _____ drinks per day _____ per week.

Current Height _____ **Current Weight** _____

Occupation: _____

UNITED CARE MEDICAL, PLLC

PATIENT INFORMATION

Is this injury work related Yes / No Is this injury motor vehicle related Yes / No

If workers comp or MVA please fill out insurance information below:

Insurance Company: _____ Adjuster/Case Worker: _____
Phone# _____ Address: _____
Claim# _____ Attorney: _____ Employer: _____

In the event that your motor vehicle insurance either denies payment for or does not authorize treatment provided by UNITED CARE MEDICAL, PLLC, I authorize charges to be submitted to my private health insurance. I will then be personally responsible for any unpaid charges. In the event that I have no other health insurance coverage, I am aware that I am personally responsible for all charges for my care.

Patient Signature

PRIMARY INSURANCE COVERAGE

Type of coverage PPO, Medicare, Self Pay, School, Other

Name of insurance plan: _____

Claim Address: _____

City: _____ State _____ ZIP _____ Phone# _____

Subscriber's Name: _____ Date of birth: _____

Subscriber's SS#: _____ Gender: M / F Relationship to Patient: _____

Subscriber's Employer Name: _____

Is the insurance coverage through the subscriber's Employer? Yes / No

SECONDARY INSURANCE COVERAGE

Type of coverage PPO, Medicare, Self Pay, School, Other

Name of insurance plan: _____

Claim Address: _____

City: _____ State _____ ZIP _____ Phone# _____

Subscriber's Name: _____ Date of birth: _____

Subscriber's SS#: _____ Gender: M / F Relationship to Patient: _____

Subscriber's Employer Name: _____

Is the insurance coverage through the subscriber's Employer? Yes / No

**ASSIGNMENT, RELEASE AND
ACKNOWLEDGEMENT**

I, the undersigned, certify that for I (or my dependent) have insurance coverage with the above listed company and assign directly to the providers of **UNITED CARE MEDICAL, PLLC** all insurance benefits, if any, otherwise payable to me for services rendered. I

understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure payment of benefits and related to my direct care to my insurance company, attorney, school or any treating specialist. I authorize the use of this signature on all insurance submissions.

_____, ____/____/____
Signature of Responsible Party Date

_____, ____/____/____
Signature of Patient Date

MEDICATION POLICY

Medication prescriptions or refills will not be called in on weeknights, Fridays, weekends or holidays under any circumstances. It is your responsibility to monitor the amount of medication you have. Therefore, you cannot expect the physicians to call in refills on the same day of your request. You must allow the doctors at least 2 days to call in your refill of your current medication.

_____, ____/____/____
Signature of Responsible Party Date

_____, ____/____/____
Signature of Patient Date

PLEASE READ AND SIGN. PLEASE BE ADVISED THAT IF YOUR INSURANCE COMPANY DOES NOT PAY YOU WILL BE RESPONSIBLE FOR YOUR BILL.

1. Patients with no insurance: payment is expected at the time of service. A specific payment plan acceptable between you and billing office may be arranged.
2. Patients with insurance: Your co-payment is an amount, which is not covered by your insurance and is not always and exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility.
3. If a patients account balance remains unpaid for more than 120 days, and no response has been made to our office billing department, the patient's account may be turned over to our attorney for collection.

INSURANCE POLICY

We extend to our patients, the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out of pocket expenses. Please also note the following:

1. Since we do not own your insurance policy we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.
2. It is the goal of this office to provide you with the finest quality care available. If you have any questions regarding your health care or any of our office policies, please do not hesitate to let us know.

PLEASE SIGN BELOW

- I have reviewed and am aware of the payment policies of **UNITED CARE MEDICAL, PLLC**
- I authorize my insurance company to make payment for my unpaid balance directly to: **UNITED CARE MEDICAL, PLLC**

_____, ____/____/____
Signature of Responsible Party Date

_____, ____/____/____
Signature of Patient Date

OUT OF NETWORK

I HAVE BEEN MADE FULLY AWARE THAT **UNITED CARE MEDICAL, PLLC** AND THEIR PROVIDERS DO NOT PARTICIPATE WITH MY INSURANCE. I AGREE THAT I WILL BE HELD RESPONSIBLE FOR ANY AND ALL REMAINING BALANCES THAT MY INSURANCE WILL NOT PAY.

_____, ____/____/____
Signature of Responsible Party Date

_____, ____/____/____
Signature of Patient Date