Regenerative Ortho Med

Dear new patient,

My staff and I would like to welcome you to Regenerative Ortho Med. Our office has integrated high-tech business solutions into the practice of medical care. We utilize solutions such as electronic medical record keeping, automated text and email appointment reminders.

We are better prepared for your first visit when you fill out the attached new patient forms and return them to our office at least **one (1) business day** before your appointment. Having your forms in our office the day before your appointment allows my staff ample time to enter your medical history, pharmacy info and other data into our computer system before your first appointment with me. Here are three ways to return the forms.

1. You may fax the forms to us at 281-888-3886
2. You may email the forms to my medical assistants at www.houstonsportsdoctor.com (drop link-Under patient info.)
3. If time permits you may mail the forms to:
   6750 West Loop South, Suite 520
   Bellaire, Texas 77401

If you return the attached forms at least one business day before your appointment then I recommend that you arrive 10 minutes before your scheduled appointment.

If you **cannot return the forms one (1) business day prior to your appointment** then I ask that you **arrive one 15 minutes early** with your forms already filled out. This gives my staff ample time to enter your information and prepare for your appointment.

If you have questions please call my office at 281-888-3416. I look forward to meeting you.

Your future partner in health,

Dr. Adam Weglein

Regenerative Ortho Med
6750 West Loop South, Ste. 520 Bellaire, TX 77401 • 281.888.3416 Phone • 281.888.3886 Fax

PATIENT INFORMATION (Section I)

Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Email Address: _____
Date Of Birth: _____ **Sex:** ☐ Male ☐ Female
Social Security Number: _____
Home Phone #: _____ **Cell Phone #:** _____
Work Phone #: _____ **Alt Phone #:** _____
Employer: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Drivers License#: _____ **State Of Issue:** _____

Marital Status:
☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Widowed

Student:
☐ Yes ☐ No

Retired:
☐ Yes ☐ No

FINANCIAL RESPONSIBILITY (Section II)
(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)

☐ **CHECK HERE IF "SELF" & PROCEED TO SECTION 3**

Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Email Address: _____
Date Of Birth: _____ **Sex:** ☐ Male ☐ Female
Social Security Number: _____
Home Phone #: _____ **Cell Phone #:** _____
Work Phone #: _____ **Alt Phone #:** _____
Employer: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Drivers License#: _____ **State Of Issue:** _____

Relationship:
☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Other (Specify)

EMERGENCY CONTACT (Section III)

Contact Name: _____
Relationship: _____
Contact Phone #(s): _____

FOR OFFICE USE ONLY:
Appointment Date:_____ Demos Rec'vd On:_____ ☐ Insurance Setup ☐ Patient History Entered

PHARMACY INFORMATION (Section IV)

Name Of Pharmacy:	Zip Code or Street Address:	Pharmacy Phone:	Pharmacy Fax:

HOW DID YOU HEAR ABOUT US? (Section VII)

☐ Referred by Physician - Physician's Name: _____

Phone: _____

Fax: _____

☐ Internet Website or Search Engine – Which site did you initially find us on? _____

☐ Newspaper/Magazine Article Or Ad – Which publication? _____

☐ Insurance Plan (Check here if you found us thru your insurance plan's website or in their provider directory.)

☐ Friend or Family Member: _____

☐ Other – Please describe: _____

OTHER PHYSICIANS (Section VIII)

Physician Name:	Physician Phone:	Physician Fax:

Current Medications (Please Attach Another Page If Needed)

Name, Dose and Frequency:	Reason For Medication:	Prescribing Physician:

Drugs <u>Previously</u> Tried For Principal Complaint But <u>Not Currently Taking</u>

Name, Dose and Frequency:	Reason For Stopping:	Prescribing Physician:

Drug Allergies And Adverse Reactions (Please Attach Page If Needed)	
Name and Dose:	**Description of Adverse Reaction:**

PAST MEDICAL HISTORY

(Section X)

(ATTACH ADDITIONAL PAGE IF NEEDED)

Other Medical Conditions:	Date Of Onset:	Treating Physician:

Past Surgeries:	Date Performed:	Operating Physician:

PATIENT HISTORY (Section IX)

Principal reason for seeing Dr. Weglein? _____

How long have you had this problem? _____

Any other musculoskeletal issues? _____

Please check either yes or no to the following questions:	**Yes**	**No**
Do you have HIV (AIDS), Hepatitis, or immune compromising disorder?	☐	☐
Have you had a recent change in weight?	☐	☐
Have you had a recent fever?	☐	☐
Do you have headaches?	☐	☐
Do you have double vision or a change in your vision?	☐	☐
Do you have shortness of breath at rest?	☐	☐
Do you have shortness of breath with exercise?	☐	☐
Do you have a regular exercise routine?	☐	☐
Do you have chest pain at rest (not exercise related?)	☐	☐
Do you have chest pain with exercise?	☐	☐
Have you been diagnosed with cardiac disease?	☐	☐
Do you have problems with nausea?	☐	☐
Do you have problems with inability to control stools (incontinence)?	☐	☐
Do you have problems with inability to control urine (incontinence)?	☐	☐
Do you have problems with sexual activity (if currently sexually active)?	☐	☐
Do you have problems with neck pain or arm pain?	☐	☐
Do you have problems with low back pain or leg pain?	☐	☐
Do you feel that you are depressed?	☐	☐
Do you feel that you are overly anxious?	☐	☐
Do you wake up feeling refreshed?	☐	☐
Do you snore?	☐	☐
If female, do you have regular menstrual cycles?	☐	☐
Do you currently smoke or use any tobacco product?	☐	☐
Have you smoked greater than 100 cigarettes in your lifetime?	☐	☐
Have you used, or currently use, any illegal substances?	☐	☐

How much alcohol do you typically drink? _____

How much caffeine do you typically drink? _____

List any diseases that run in your immediate family (Parents, Brother, Sisters, Children):

_____

_____

_____

Does anyone in your immediate or extended family have the same condition or symptoms for which you are seeing Dr. Weglein? If so, who?

_____

_____

Is there any other information you would like to tell us?

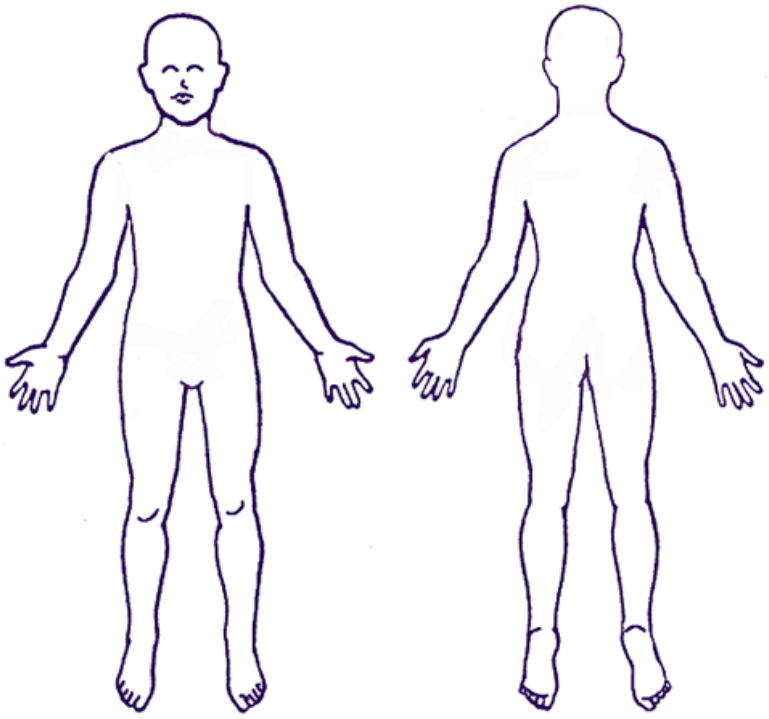
_____

_____

_____

_____

Problem Diagram: (Please mark the areas on the diagram where you are experiencing difficulty.)



PLEASE LEAVE THIS AREA BLANK

If you have pain, please describe the pain sensation. _____

When during the day do you have your pain? _____

What makes your pain worse? _____

What makes your pain better? _____

What daily activities does this problem affect? _____

Have you received any special testing or procedures for this problem? (Circle below)

CT Scan MRI EMG X-Rays Injections Surgery

(Please bring your test results in CD form or written results with you to your appointment for Dr. Weglein to review.)

Appointment Policy

We do not over-schedule or over-book our patients. Your appointment time is reserved specifically for you. If you show up late for your appointment, you are simply cutting down your time with the Doctor. If you miss your appointment, we do show grace on the first incident, but you will be required to pay a "No-Show" fee for any others. We request a 24-hour notice on all appointment Cancellations and Reschedules; any less than a 24-hour notice will be assessed a fee. Thank you for respecting our time, we will be respectful of yours!

* **I have Read, Understand, and Accept the "Appointment Policy")**

Signature _____Date_____

Financial Policy

We are a "Fee for Service" clinic, which means we collect all fees for our services from you at time the service is delivered. We do not check with, bill, communicate or receive any reimbursements from your insurance company. We will, however, give you what you need to submit for reimbursement to your insurance company. This does not guarantee reimbursement of our services from your insurance company. We will not change any clinical procedures, notes, diagnostic codes, procedure codes or prices for insurance reimbursement purposes. We also do not work with or accept Medicare, Medicaid, Workers Compensation or Automobile Accident Insurance., active legal cases.

Patient-Clinic Agreement : I acknowledge that I am financially responsible for all charges, whether or not I receive reimbursement from any insurance company. All payments are due at the time of service paid in full.

Signature _____Date _____

Acknowledgement of Review of Notice of Privacy Practice

I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature _____Date _____

Authorized Contacts

Often family members will call our office to ask for or give medical information about the patient. So that we may properly protect your privacy, please identify any person by name and relationship to you with whom you authorize us to share or discuss your private medical information.

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

Medical Records

A copy of the patient's medical record is available for a fee of $25 for the first 20 pages And $0.50 per page for each additional page. Records will be made available 15 business days after the date of receipt of the request and fees for furnishing the information.

Other Charges:

If an affidavit is requested to accompany the medical record copy, certifying that the information s a true and correct copy of the records a reasonable fee of up to $15 may be charged for executing the affidavit.

There are separate fees for medical and billing records and affidavits.

Records to other providers: Requests for recent office visit notes will be sent to other physicians for no charge as a courtesy but requests for complete charts or extensive records will be charged at the rates listed above. The patient will be responsible for any charges incurred for their medical records.

E-mail Message & Text Message Authorization

Practice and procedure:
Established patients may e-mail **non-urgent** medical questions to Dr. Weglein. You must include your full name and birthday in every e-mail message that you send Dr. Weglein. This information is required so Dr. Weglein can establish that the patient requesting medical advice is in fact the person the sender claims to be. Without this information, Dr. Weglein will not be able to address your questions. The subject of the e-mail should include the purpose of the e-mail, for example: Prescription Refill Request. If you do not provide this information, Dr. Weglein will not be able to respond.

Acknowledgement and Authorization: I would like to take advantage of this e-mail service. I understand and agree that Dr.Weglein may forward e-mails as appropriate for diagnosis, treatment and other related reasons. As such, I authorize Regenerative Ortho Med staff other than Dr.Weglein to have access to e-mails that I send. I understand that Dr. Weglein's incoming e-mail is not encrypted and I request that Dr. Weglein respond to my e-mail directly, in the same unencrypted manner that my e-mail was sent to him. I will not send or request very sensitive information, because Dr. Weglein and Regenerative Ortho Med cannot and do not guarantee the privacy or security of any messages being sent over the internet. I acknowledge that there is the potential that e-mail sent over the Internet can be intercepted and read by others. I am aware that if I use e-mail provided by my employer any e-mail sent on my employer's system may be viewed by my employer. Regenerative Ortho Med also sends appointment reminders via e-mail and/or cell phone text messages. Regenerative Ortho Med also sends patient satisfaction surveys via e-mail about every 6 months. These messages are not encrypted and do not contain any personal medical information. I will immediately notify Regenerative Ortho Med if my contact information changes.

If I do not receive a response from Dr. Weglein or Regenerative Ortho Med within two business days of my sending the e-mail, I will call the office directly.

I have been informed of and understand the risk and procedures involved with using e-mail. I understand that the confidentiality of my individually identifiable health information may be compromised when my individually identifiable health information is sent through electronic transmission via e-mail, I agree to the terms listed above and I hereby voluntarily request the use of e-mail as one form of communication with my physician, and his/her associates, technicians and other health care providers. By signing below and providing my e-mail and/or cell phone number, I agree to receive these messages.

Signature _____Date _____

Treatment Authorization

PATIENT NAME _____

I voluntarily request Regenerative Ortho Med to examine, diagnose and treat: _____ (Name of patient). I authorize and give Regenerative Ortho Med consent to submit specimens (blood, urine, tissue, etc.) to any laboratory for analysis and study.

Signature _____Date _____

Legal Guardian _____

Authorization for the Release of Medical Information

I authorize Regenerative Ortho Med to release any medical information requested by insurance companies with whom I have coverage or any public agency or third party payor that may be assisting in payment of medical care. I authorize the release of any medical information necessary to process any claim associated with Regenerative Ortho Med with respect to my medical care. I permit a copy of this authorization to be used in place of the original.

Signature _____Date _____

Patient Legal Guardian _____