Advanced Pain Management
5848 Highway 6 North
Houston, Texas 77084
(281) 463-4321
(281) 463-8555 Fax

Physical Medicine and Rehab
25404 Highway 59 North Suite 102
Porter, Texas 77365
(281) 354-4000
(281) 354-8128 Fax

PATIENT INFORMATION

DATE: _____

LAST NAME: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: _____ DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

DRIVERS LIC #: _____ HOME PH: _____ WORK PH: _____

CELL: _____ EMERGENCY CONTACT: _____

EMPLOYER: _____ MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

E-MAIL: _____ REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____

INSURANCE INFORMATION

INSURED'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____

DOB: _____ SSN# _____

EMPLOYER: _____

PATIENT'S RELATIONSHIP TO INSURED: _____

IS INSURED EMPLOYED AND COVERED BY EMPLOYER'S HEALTH PLAN: _____ (Y/N)

PRIMARY INSURANCE NAME: _____

POLICY OR ID #: _____ GROUP: _____

How can we help you? _____

What is primary complaint? _____

Are you here as a result of an accident? _____ (Y/N) Work Injury: _____ (Y/N) Accident Date: _____

Job Related: _____(Y/N) Workers Comp: _____ (Y/N)

Accident Type: _____ (A) uto (W) ork (H) ome (R) ecreation (S) ports

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OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies:

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept cash, personal checks, Visa and Mastercard.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. You must agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept as assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit. We will file with up to two (2) insurance companies. It is your responsibility as a patient to provide this office with current insurance information.
4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
5. We will bill your insurance company for all services. You are responsible for any balance due.

_____ _____

Signature of patient (or responsible party if minor) Date

_____

Please print the name of the patient

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that se patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see yu: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable

anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

HIPPA
PRIVACY PRACTICES ACKNOWLEDGEMENT

To be filed in patient chart

I have received the HIPPA Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name: _____ Birthdate: _____

Signature: _____ Today's Date: _____

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PATIENT CONSENT TO TREAT

I, _____, consent to allow the doctors, associates and designated staff of this clinic to treat me with physical medicine modalities and manual spinal manipulation.

_____
Initials

I, _____, consent to allow the doctors, associates, And designated staff of this clinic to treat my child or ward, _____ with physical medicine and manual spinal manipulation. The patient is a minor, _____years of age. My relationship to this minor is _____.

_____
Initials

I acknowledge there is a risk associated with such care and it could result in stroke, paralysis, dislocation, fractures or otherwise could worsen a condition. I hereby acknowledge and understand this risk and permit treatment to begin and follow through to the end of care at this facility

_____
Initials

CONSENT TO X-RAY

I, _____, authorize the performance of diagnostic x-ray examination of myself which the above doctor or associates may consider necessary or advisable in the course of my examination and treatment.

_____
Initials

I, _____, authorize the performance of diagnostic x-ray examination of my above mentioned child or ward which the above doctor or associates may consider necessary or advisable in the course of examination and treatment.

_____
Initials

VERIFICATION OF NON-PREGNANCY

This is to certify that, to the best of my knowledge, I am not (or the above mentioned child or ward is not), pregnant and the above doctor/or associates have my permission to perform said diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

_____
Initials

_____
Signature of Patient
(or parent of minor)

_____
Date

Physical Medicine & Rehab
25404 Highway 59N, Suite 102
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Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to **Jennifer Langeland**, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me for treatment rendered by **Jennifer Langeland** within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to **Jennifer Langeland** and send any and all checks to **25404 Highway 59N, Suite 102 Porter, Texas 77365.**

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to **Jennifer Langeland,** and to send any and all checks to **25404 Highway 59N, Suite 102 Porter, Texas 77365.**

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered to **Jennifer Langeland** , in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant **Jennifer Langeland** power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by **Physical Medicine & Rehab.** I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to **Jennifer Langeland**

REJECTION IN WRITING: I hereby authorize **Jennifer Langeland** to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by **Jennifer Langeland**, he has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from ay other doctor, I will notify **Jennifer Langeland** immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:

_____ Date:_____

Physical Medicine & Rehab
Authorization for Release of Information

Patient Information:

Last Name:	First Name:	Middle:
Date of Birth:	Social Security Number (optional):	

Health Information may be released to: *(required)*

Name:			
Address:		Telephone Number:	
City:	State:	Zip:	Fax Number:

Purpose of the Disclosure: *(required)*

☐ Continued Care ☐ Attorney/Litigation ☐ Disability Services ☐ Other_____

I hereby authorize the use or disclosure of protected health information as described below:

DATES OF SERVICES: *(required)* _____

☐ History & Physical Exam ☐ Emergency Department Records ☐ Laboratory Reports ☐ Discharge summary
☐ Operative Reports ☐ Radiology Report ☐ Consultation Reports ☐ Cardiology Reports ☐ Pathology Reports
☐ All Pertinent Records for Continued Care
☐ Other: _____
(Fill in other document type)

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires within 60 days. Otherwise, you may select either of the following expiration events:
☐ 1 year from the date in which I, or my legal representative signs this authorization
☐ Upon the happening of the following event: _____
(Example: "Upon release of the above records")

I understand that:

1. I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care.
2. My revocation will not have any effect on any actions taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.
3. The organization will not condition my treatment, payment, enrollment in a health, or eligibility for benefits on my signing this authorization.
4. I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient (or Patient's Representative) Date

_____
Print Name of Patient) (or Patient's Representative)

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:
☐ Power of Attorney ☐ Legal Guardian
☐ Executor or Personal Representative ☐ Parent ☐ Other

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TELEPHONE POLICY

In our continuing effort to protect the privacy and provide a quiet atmosphere to all of our patients **NO CELL PHONES** will be allowed in the treatment area or Dr. office.

We ask that your cell phone be on silent mode and left in your pocket or purse.

Should you have any questions please speak with a staff member or ask to speak to the manager.

Patient _____ Date _____