PAUL BECK, M.D.

Patient Registration Information

Appointment Date: ____________________ Referring Physician: ______________________________

Reason for today's visit: ____

Name: ____

Mailing Address: ____

City/State: ______________________________ Zip Code: ______________

Home Phone: ______________ Cell: ______________ Work: ______________

Email Address: ____

SS# ______________________ Date of Birth: ______________ Age: ________

Sex: Male / Female • Ethnicity: Hispanic or Non-Hispanic • Race: ____________________

Preferred Language: ____

Employer Name & Address: ____

Spouse's Name: ____

If patient is a minor, name of Parent/Guardian: ______________________________

Policy Holder's Name & Relationship to patient: ______________________________

Policy Holder's SS# ____

Primary Insurance: ______________________ Secondary Insurance: ______________________

Is your condition a result of a work injury: Yes / No • Date of injury: ______________________

Pharmacy you prefer: ____

Pharmacy Location (street name) ____

Emergency Contact *(That does not live with you)*

Name & Relationship to patient: ____

Mailing Address: ____

Home Phone: ______________________________ Cell: ______________________________

Date:______________________ **PAUL BECK, M.D.**

Patient Name:______________________________________DOB:______________

Hospital you prefer:________________________Pharmacy________________________

Family physician:________________________Cardiologist________________________

Height:__________ Weight: __________

~ PAST HISTORY ~

Major events, illnesses, surgeries, and hospitalizations (*continue on back of this page if needed*)

I.______________________________ 2.______________________________

3.______________________________ 4.______________________________

Please check if any apply: ❑ High Blood Pressure ❑ Diabetes

❑ Implantable devices: Yes / No (*If yes, please provide front desk with your device card.*)

~ MEDICATIONS ~

Please list current **Medication(s)**, **Dosage** and **Frequency** (*continue on back of this page if needed*)

1.______________________________Dosage__________Frequency__________

2.______________________________Dosage__________Frequency__________

3.______________________________Dosage__________Frequency__________

4.______________________________Dosage__________Frequency__________

Are you currently taking blood thinners?______________________________

ALLERGIES

Please list allergies and your reaction to them:

1.______________________________Reaction______________________________

2.______________________________Reaction______________________________

3.______________________________Reaction______________________________

~ FAMILY MEDICAL HISTORY ~

Mother: Alive______or Age of death: ________Cause of death:______________________

Father: Alive______or Age of death: ________Cause of death:______________________

Please check the following illness(es) that run in your family:

❑ Diabetes: Type:______________________ ❑ Cancer: Type:______________________

❑ Heart Disease ❑ Stroke ❑ Arthritis ❑ Anemia ❑ High Blood Pressure ❑ Kidney Disease

~ SOCIAL HISTORY ~

Do you smoke?__________How much?______________________________

Did you previously smoke? __________When and how much?______________________________

Drink Alcohol?__________ How much & How often:______________________________

Use street drugs?______________________________

What is your occupation?______________________________

Any religious beliefs that affects your medical care?______________________________

Any other information you would like your Doctor to know?______________________________

____

POST-OPERATIVE PAIN MEDICATION CONTRACT

This is an agreement between__________________________________(the patient) and the surgeon concerning the use of narcotic pain-killers for the treatment of **POST-OPERATIVE PAIN.**

PLEASE INITIAL BELOW THAT YOU UNDERSTAND

__________ These medications are to be used to decrease my pain but they will not take away my pain completely. I understand that narcotic pain-killers are strong medications and have been informed of the risks and side effects involved with taking them.

__________ I agree to take this medication as prescribed and not to change the amount or frequency of the medication.

Refill Requests can take up to **48** hrs to process, **DO NOT** wait until you run out!!

__________I understand that there is a "**30** day policy" in which pain medication will be prescribed. Pain exceeding the 30 day post operative period will be referred out to Pain Management.

__________It is my responsibility to tell my provider if I am currently taking any pain medication from another doctor. If so, **Please list prescribing Doctor/Facility that you are currently receiving pain medication from:**

____

__________I will fill my prescriptions at one pharmacy of my choice; pharmacy name and location:

____

__________I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know the doctor may discontinue writing (narcotic pain-killers) prescriptions for me.

X____

Patient signature   Date

X____

Printed name of patient

In the event that you need surgery we will be asking you to identify which hospital is contracted with your insurance company. If your surgery is scheduled at a non-contracting facility, it could result in a reduction of payment or possibility non-payment. If you aren't sure, contact your insurance company directly for that information.

We will contact your insurance company prior to surgery to pre-certify the procedure. This is not a guarantee of payment. It is your responsibility as the patient to know and/or check your benefits with your insurance carrier.

ASSIGNMENT OF BENEFITS - FINANCIAL AGREEMENT

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO *PAUL BECK, MD* and any assisting physicians for services rendered. I understand that I am financially responsible for all charges weather or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and if necessary reasonable attorneys fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; I further agree that a photocopy of this agreement shall be valid as the original.

Signature: ____ Date: ___________________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

Please sign indicating that you have read and understand our notice of privacy practices.

Signature: ____ Date: _____________________________

Relationship (if not signed by patient): ____

Internal use only

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time): __________________

By (name and title): ___________________________

AUTHORIZATION FORM

Patient's Full Name	Patient's Social Security Number/Medical Record Number
Address	Patient's Date of Birth
City, State, Zip Code	Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me: ______________________________

2. The following person (or class of persons) may receive disclosure of protected health information about me:

Name ______________________________

Address ______________________________

City, State, Zip Code ______________________________

3. The specific information that should be disclosed is (please give dates of service if possible):

____

____

____

UNLESS YOU SIGN HERE,
NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

❑ **YES** - Disclose this information ______________________________

❑ **NO** - Do not disclose this information______________________________

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying______________________________ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. My purpose/use of the information is for______________________________

7. This authorization expires on______________________20____, OR upon occurrence of the following event that relates to me or to the purpose or the intended use or disclosure of information about me:____________________

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING - note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

~ OR, if applicable ~

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signature.

Official Use Only

Received	**Processed By**	**Log #**

Patient Authorization for Practice to Release Protected Health Information

Practice: Paul Beck, MD

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

In an effort to protect your healthcare information. please list any/all names and relation of those whom we have your permission to discuss appointments, billing, medical information, etc. (Example: spouse, significant other, parents, physicians, caretaker, etc.)

Name Relation ______________________________

Name Relation ______________________________

Name Relation ______________________________

Name Relation ______________________________

Name Relation ______________________________

Name Relation ______________________________

I have reviewed this consent form and am giving my permission to **Paul Beck, MD** to use and disclose my health information in accordance. This authorization shall expire on____________________ or in 5 years from the date signed if left blank.

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

____

Signature of Patient or Guardian

____

Relationship if other than Parent

____

Printed name of patient

____

Date Signed