Patient Information Sheet

Today's Date:_____

Patient:

*Last, First, MI*_____*M / F*
*Address*_____
*City, State, Zip*_____
Telephone: Home( )_____*Cell*( )_____
*Email*_____
*Marital Status*_____*Birthdate*_____*Age*_____
*Social Security #*_____*Driver's License#*_____
*Employer*_____*How Long?*_____*Occupation*_____
*Employer Address*_____
*City, State, Zip*_____
Employer Phone( )_____*Fax*( )_____

Spouse or Guardian:

*Last, First, MI*_____*M / F*
*Address*_____
*City, State, Zip*_____
Telephone: Home( )_____*Cell*( )_____
*Email*_____
*Marital Status*_____*Birthdate*_____*Age*_____
*Social Security #*_____*Driver's License#*_____
*Employer*_____*How Long?*_____*Occupation*_____
*Employer Address*_____
*City, State, Zip*_____
Employer Phone( )_____*Fax*( )_____

Emergency Contact:

*Last, First, MI*_____*M / F*
*Address*_____
*City, State, Zip*_____
Telephone: Home( )_____*Cell*( )_____
*Relationship*_____

How Did You Hear About Dr. Fino?

*( ) Physician*_____ *( ) Friend/Relative*_____
( ) Radio ( ) Television ( ) Newspaper ( ) Yellow Pages ( ) Magazine

Remon A. Fino, M.D.
1602 Rock Prairie Road Suite 4600
College Station, Texas 77845
Phone (979) 693-8263 Fax (979) 693-5139

Patient Information Sheet

Primary Insurance Coverage

*Insurance Company*_____
*Primary Subscriber*_____ *Birthdate* _____
*Social Security#*_____*Relationship to Patient*_____
*Group #*_____ *Effective Date of Insurance*_____
*Employer*_____ *Employer Phone*(____)_____
*Insurance Company Address*_____
*Insurance Company City, State, Zip*_____
Insurance Company Phone(____)_____*Fax*(____)_____

Secondary Insurance Coverage *(If Applicable)*

*Insurance Company*_____
*Primary Subscriber*_____ *Birthdate* _____
*Social Security#*_____*Relationship to Patient*_____
*Group #*_____ *Effective Date of Insurance*_____
*Employer*_____ *Employer Phone*(____)_____
*Insurance Company Address*_____
*Insurance Company City, State, Zip*_____
Insurance Company Phone(____)_____*Fax*(____)_____

Additional Insurance Coverage *(If Applicable)*

*Insurance Company*_____
*Primary Subscriber*_____ *Birthdate* _____
*Social Security#*_____*Relationship to Patient*_____
*Group #*_____ *Effective Date of Insurance*_____
*Employer*_____ *Employer Phone*(____)_____
*Insurance Company Address*_____
*Insurance Company City, State, Zip*_____
Insurance Company Phone(____)_____*Fax*(____)_____

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Patient Evaluation - Initial Questionnaire

Name_____ Date _____

Primary Physician_____

Referring Physician_____

1. When did you first get injured OR first notice your symptoms?_____

   Briefly describe your injury OR your symptoms?_____

   How did your problem start? ( )Gradually ( )Suddenly

2. What makes your pain **WORSE**?_____

3. What makes your pain **BETTER**?_____

4. What treatments have you had? (ex. P.T., Chiro, Injections)_____

5. Are you currently working? ( )Yes ( )No. If yes, ( )Full Duty ( )Light Duty

   Describe your work duties?_____

6. What tests have you had performed? (ex. X-Ray, MRI, NCS) When/Where?_____

* 7. **Please list ALL MEDICATIONS you are currently taking.**_____

* 8. **Are you ALLERGIC to any medications? ( )Yes ( )No If yes, please list.** _____

* 9. **Do you have any significant MEDICAL HISTORY such as heart disease, high blood pressure, previous spine, nerve or joint problems, OR ANY OTHER TYPE OF MEDICAL CONDITION? ( )Yes ( )No**

   If yes, please explain._____

* 10. **Are there any MEDICAL CONDITIONS (ex. arthritis, diabetes) that run in your FAMILY? ( )Yes ( )No**
   If yes, please list._____

11. Do you smoke? ( )Yes ( )No If yes, how many packs per day?_____

12. Do you drink? ( )Yes ( )No If yes, how many drinks per day?_____

13. Have you ever been treated for drug addiction? ( )Yes ( )No

14. Have you had ANY surgeries? ( )Yes ( )No If yes, please list._____

15. What is the last grade you completed?_____

16. Are you married? ( )Yes ( )No Please list the ages of any children._____

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Patient Evaluation - Review of Symptoms

(Check All That Apply)

1. **Constitutional:** ( )Fever ( )Chills ( )Unexplained Weight Loss ( )Loss of Appetite
2. **Eyes:** ( )Glasses ( )Blurred Vision ( )Double Vision
3. **ENT:** ( )Dizziness ( )Headaches ( )Sore Throat ( )Ringing in the Ears
4. **Cardiovascular:** ( )Chest Pain ( )Shortness of Breath ( )Irregular Heartbeat
5. **GU/GI:** ( )Bladder Incontinence ( )Bladder Retention ( )Jaundice
   ( )Bowel Incontinence ( )Abdominal Pain ( )Sexual Dysfunction
6. **Musculoskeletal:** ( )Joint swelling ( )Joint stiffness
7. **Skin:** ( )Rash ( )Dermatitis
8. **Psychological:** ( )Depression ( )Anxiety ( )Suicidal thoughts
   History of physical abuse? ( )Yes ( )No When_____
   History of mental abuse? ( )Yes ( )No When_____

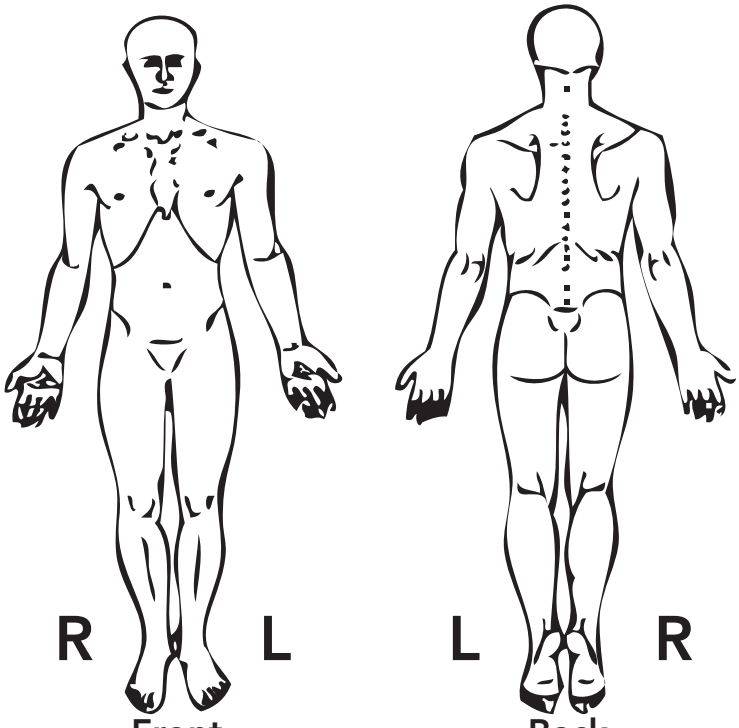
Patient Evaluation - Location of Pain

Instructions:

*Use **XX's** to indicate pain.*

*Use **///'s** to indicate numbness.*

Draw in where your pain and numbness are located on the figures to the right.



Patient Evaluation - Severity of Pain

(Circle the Number That Best Describes Your Pain)

0 1 2 3 4 5 6 7 8 9 10

No Pain — *Today* — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

No Pain — *Last 2 Weeks* — Worst Pain

Notice of Prescription Policies

The following procedures will be strictly enforced regarding ***ALL*** *prescriptions issued or refilled by this office.*

1. You are only allowed to receive narcotic or pain medication from ***one physician.***

2. You are required to contact your pharmacy for refills. Only one pharmacy is allowed for refills.

_____

Pharmacy Name ***Address*** ***Telephone #***

3. Refills and medication questions are handled ***ONLY*** Monday-Thursday from 8:00am-12:00pm and 1:00pm-3:00pm, and on Fridays from 8:00am-12:00pm. ***No refills will be processed on Friday afternoons, after hours or on weekends.***

4. Triplicate prescriptions require a minimum of 48-72 hours to be processed before pickup. These prescriptions will not be called in, and must be picked at the office.

5. ***YOU MUST GIVE 24-HOUR NOTICE ON REGULAR REFILL REQUESTS!***

6. Prescriptions are generally written for a 30-day supply. No prescriptions will be refilled before the 30-day allotted time. If you do not keep your regularly scheuled appointments, or cancel after receiving a refill and are seeing Dr. Fino for medication management, you run the risk of not receiving future refills.

7. You are required to take medication prescribed by your doctor(s). Failure to do so could result in the immediate termination of the physician-patient relationship. You may only adjust the way you take medications with orders from your doctor(s).

8. You are required to bring all medications prescribed by Dr. Fino to all follow-up visits to be counted.

9. Replacements for lost or stolen medications are strictly prohibited. It is your responsibility for the safekeeping of your medications.

10. Dr. Fino reserves the right to request periodic urine/blood drug screenings at the expense of the patient, or patient's insurance company. It is mandatory that these screenings be performed the same day of the request. ***ANY*** illegal drugs found in the drug screen, is grounds for immediate termination of the physician-patient relationship.

I have read, and agree to, the above prescription policies.

_____ _____

Patient Signature ***Date***

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Request for Release of Medical Records

To:_____

Address:_____

City, State, Zip_____

Phone_____ Fax_____

I hereby request that my medical records be released to:

Dr. Remon A. Fino
4600 Rock Prairie Road, Suite 4600
College Station, Texas 77845

Patient Name_____

Patient Signature_____ Date_____

Address_____

City, State, Zip_____

Date of Birth_____

Social Security #_____

Phone_____

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Notice of Cancellation/Termination Policies

Cancellation

Consistency of treatment by following a plan of care, as outlined by your physician, is critical in order to achieve a successful outcome.

A $25.00 FEE WILL BE CHARGED FOR ALL MISSED APPOINTMENTS, UNLESS YOU CALL THE OFFICE AT LEAST 24-HOURS IN ADVANCE TO CANCEL THE APPOINTMENT.

1st Missed Appointment.....No Charge

2nd Missed Appointment.....$25.00 Charge

3rd Missed Appointment.....$25.00 Charge

Termination

THE PHYSICIAN-PATIENT RELATIONSHIP MAY BE TERMINATED FOR ANY ONE, OR COMBINATION OF, THE FOLLOWING:

1. Three (3) **NO-SHOWS** within a six month period.
2. Three (3) **CANCELLATIONS** within a 6-month period without 24-hour notice.
3. Three (3) **RESCHEDULES** within a 6-month period without 24-hour notice.
4. Failure to strictly adhere to all prescription policies.
5. Failure to comply with request for blood/urine drug screenings.

I have read, and agree to, the above cancellation and termination policies.

_____ _____

Patient Signature ***Date***

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Notice of Financial Policies

Thank you for choosing Dr. Fino as your healthcare provider. We are committed to the successful treatment of your condition. Please understand that the timely payment of your bill is considered part of your treatment. The following is our FINANCIAL POLICY, which we require that you read, agree to and sign, prior to any treatment.

Our office will file insurance claims for you. However, your share of the cost of our services is due at the time of service.

1. We accept cash, checks or credit card payments.
2. The adult/guardian bringing a minor for treatment is the responsible party for payment of our services.
3. **INSURANCE** - All HMO's, PCCM's and some PPO's require prior authorization (i.e. referral #) from your Primary Care Physician for your office visit. ***If you do not have this referral number at the time of your appointment, your benefits may be paid at a reduced rate, or not paid at all.*** You generally have a deductible every year, and are expected to meet and pay this deductible as contracted with your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract.
4. **MEDICARE** - We accept Medicare assignments, but be aware that at the beginning of each calendar year, you will have a deductible amount that you are responsible for.
5. **WORKER'S COMPENSATION** - We accept Worker's Compensation when properly verified in advance of the appointment. If your Worker's Compensation claim is later found to be non-compensible and is fully adjudicated by DWC, you will be responsible for your bill in full. If your employer is self-insured and fails to pay your Worker's Compensation bill in full, you are responsible for the balance of the bill.
6. **CO-PAYS** - Your co-pays and deductibles are due at the tme of service. In order to be eligible participators, we must sign contracts agreeing to collect co-payments at the time service is rendered. Therefore, we must collect your co-pay at the close of your appointment.
7. **USUAL & CUSTOMARY CHARGES** - Our practice is committed to providing the best treatment possible for our patients. We charge what we believe to be the usual and customary fees for our area. You are responsible for paying the contracted portion of our bill when there is a balance remaining after any insurance payment(s).
8. **MISSED APPOINTMENTS** - We reserve the right to charge for missed appointments at the rate of a normal office visit, if you do not cancel or reschedule the appointment at least 24 hours in advance. We confirm appointments ahead of time as a courtesy only. It is your responsibility to remember your appointments.
9. **INVESTMENT INTERESTS** - Please be aware Dr. Fino may have investment interests in other healthcare facilities within the community. Dr. Fino may or may not choose one of those facilites to perform diagnostic testing or surgery. Please feel free to ask Dr. Fino, or his staff, if you have any questions or concerns. You have the right to request your procedure be performed at another facility.

I have read, and agree to, the above financial policies.

_____ _____

Patient Signature ***Date***

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Notice of Privacy Practices

Please read this notice carefully. It concerns your individual, private healthcare information and how it may be used and disclosed by this office. After reviewing this notice, you will be asked to consent to the use of this information as described below. This consent is voluntary on your part.

1. We have a legal, ethical and moral obligation to protect your confidentiality. Any information about you and/or your family will be held strictly confidential by all employees. No discussions about you, outside of the patient care framework, will be allowed, and any conversations between staff members pertaining to delivering you quality care will be held in a confidential and professional manner.

2. In order to provide quality care to you, and operate this office in an efficient manner, we will need to access your private healthcare information for purposes of treatment, payment, and operations such as quality assurance. In using this information, this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act (HIPAA).

3. Specifically, we will need to disclose your private information under the following circumstances:

   A) Sharing Information for Purposes of Treatment
   We will share information with all members of your treatment team, both within this office and with other providers (personal and institutional) in order to provide you with quality care and the educationalor wellness programs specified in your insurance plan.

   B) Sharing Information for Purposes of Payment
   We will share all necessary information with your insurer(s), payor(s), governmental agencies (Medicare, Medicaid etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as our representatives involved in the billing process (including, but not limited to claims representatives, data warehouses and billing companies).

   C) Sharing Information for Purposes of Operations
   We will share all information necessary for ongoing operations of this office. Including, but not limited to, credentialling processes, peer review, accreditation, and compliance with all state and federal laws.

4. Your consent for use and disclosure of information as described herein, may be revolked in writing at any time. Please notify our office/Privacy Officer if you decide to revolk your consent.

5. Your specific authorization will be required for the release of any information not included above. Written authorization will be required, and must be specific to the disclosure requested. Incidences which may require your authorization under HIPAA regulations include (but are not limited to) some marketing purposes, disclosure of any psychotherapy records in our possession and disclosures for fundraising by any entity.

6. This office will not release any information other than those incidences described above, unless disclosure is required by law, a court, a legal process or governmental agencies.

7. This office has policies and procedures in place to facilitate compliance with law, as well as assure that this office consistently treats you with respect for you and your privacy and confidentiality. These policies and procedures are available for you to review. If you would like to read them, please notify the Privacy Officer.

8. The Privacy Officer is the person in the office responsible for your privacy and the security of your information. Any complaints you or your family may have in this area, should be directed to the Privacy Officer. The front office staff will be happy to assist you in contacting them.

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Consent for Treatment
&
Acknowledgement of Forms

Patient Name _____ Date _____

1. **I hereby grant permission to Remon A. Fino, M.D., P.A., physician in charge of the case of the above named patient to provide medical services to him/her as he deems necessary.**

   Print Name _____ Date of Birth _____

   Signature _____ Date _____

2. **I have received the Notice of Privacy Practices (HIPAA) and I have been provided an opportunity to review the form.**

   Signature _____ Date _____

3. **I have received the Notice of Financial Policies and I have been provided an opportunity to review the form.**

   Signature _____ Date _____

4. **I have received the Notice of Prescription Policies and I have been provided an opportunity to review the form.**

   Signature _____ Date _____

5. **I have received the Notice of Cancellation/Termination Policies and I have been provided an opportunity to review the form.**

   Signature _____ Date _____

6. **I authorize the Release of Medical Information pertaining to this illness/injury and direct payment of insurance benefit to Remon A. Fino, M.D. A photocopy of this authorization shall be valid as the original.**

   Signature _____ Date _____

7. **I give the office of Remon A. Fino, M.D. authorization to discuss or release information regarding my illness/injury, and release prescriptions to the person(s) listed below.**

   Name(s) _____

   Signature _____ Date _____

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