Terren D. Klein M.D., P.A

1300 Murchison Dr. Ste 310-B El Paso, TX 79902

Ph (915) 706-2500 Fax 915-444-5907

DATE: _____ **MRN:** _____

PATIENT REGISTRATION

Patient's Last Name _____First Name_____MI_____

Date of Birth _____Age _____Sex □ Female □ Male

SSN: (required for billing) _____ Driver's License_____

Race: □ African American/ Black □ American Indian/ Alaskan Native □Asian

□ Caucasian/ White □ Nat. Hawaiian Islander □ Other

Ethnicity: □ Hispanic Latino □ Not Hispanic Latino □ Other _____

Primary Language: □ English □ Spanish □ Other_____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Other_____

Address_____

City_____ State_____ ZIP Code_____

Please check Primary- □ **Home** □ **Cell** □ **Work**

Home _____Cell _____Work_____

Email Address_____

Primary Doctor _____ Address _____

Occupation_____ Employer_____

Employment Information:

□ Employed □ Unemployed □ Self Employed □ Disabled □ Retired □ Active/ Military □

Homemaker/ Housewife □ Student □ Minor/ Child □ Other

Employer:_____Address_____

City _____State _____Zip Code_____ Number_____

Who may we thank for your referral?_____

Guarantor Information:

Relationship to Patient: □ Self □ Spouse □ Parent □ Other_____

Last Name_____ First Name_____MI_____

DOB_____SSN (required for billing) _____

This office complies with HIPPA and you may have a copy of the Notice of Privacy Practice that is posted in the office.

☐ I want a copy ☐ Do not want a copy

Workmans Compensation Insurance Information

Insurance_____ Date of Injury_____ Body Part_____

Claim#_____Adjuster_____

Address_____ City_____State_____ ZIP_____

Phone #_____ Extension_____Fax_____

Health Insurance Information

Primary Insurance_____ Policy #_____

Insured Name_____Last Name_____DOB_____

Insured SS# (required for billing) _____

Secondary Insurance (if applicable)

Secondary Insurance_____ Policy #_____

Insured Name_____Last Name_____DOB_____

Insured SS# (required for billing) _____

Attorney insurance information

Date of Accident_____ Injured Body Part_____

Attorney Name_____ Case Manager_____

Address _____City, State & Zip_____

Phone_____Extension_____Fax_____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:
- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

Terren D. Klein M.D., P.A. **MRN:** _____

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AGREEMENT OF FINANCIAL RESPONSIBILITY

We are committed to provide quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, Care Credit and pre-approved insurance for which are contracted providers. There will be a $30 service charge on all returned checks.
- It is your responsibility to know your own insurance benefits, including whether we are contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we bill your insurance company first, less any co-payment(s) or deductible(s) any patient responsibility is due prior to treatment any amount not covered by your insurance will be your responsibility.
- If we are not contracted with your insurance company, you will be expected to pay for all services rendered prior to your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Please understand some insurance coverage have Out-of-Network benefits that have co-insurance charges, higher co-payments, higher deductibles and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the Insurance Network rate.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance care for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Workers Compensation Case patients we will attempt to verify information for your workers compensation claim prior to treatment. It is your responsibility to update us of any insurance changes, multiple workers compensation injury claims and disputes to your case or any other financial changes to your claim.
- We will bill all workers compensation bills to the workers compensation insurance for payment. If your claim was closed or denied in its entirety you will be financially responsible. You must provide your new insurance information or you will be expected to pay for all services rendered at the end of your visit.

- Attorney Cases must provide $300 AND L.O.P. (letter of protection) from your attorney for the first appointment. All follow-ups are covered by the L.O.P. for the date of injury and body part specified in the L.O.P. until you are discharge by you physician.
- We will bill all attorney cases to your attorney for payment. You or your attorney will be expected to pay in full for all services rendered once your case has settled or closed.
- If you are under an Attorney case and your case is no longer being handled by them any outstanding balance will be a patient responsibility any outstanding balance will need to be paid in full prior to scheduling any visits or releasing any medical records.
- **NO SHOW POLICY**: If you fail to show to your appointment you will be asked to pay a **"NO-SHOW FEE"** of $25 which will be due prior or on your next appointment date. This does not include any other fees due for services rendered i.e. any co-payment(s) deductible(s) and any amount determined to be your responsibility. The "no-show-fee" will not be applied if you call us to cancel or re-schedule your appointment 24 hours prior to your visit.

I have read the financial policies contained above and my signature below serves as acknowledgement of a clear understanding of my financial. I understand that if my insurance company denies coverage and/ or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/ Responsible Party _____ Date_____

Print Name of Patient / Responsible Party _____Date_____

Relationship to Patient_____

MRN _____

Terren D. Klein M.D., P.A.

Arrived: _____ Scheduled: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Referring Doctor: _____ ☐**Right Handed** ☐**Left Handed**

Occupation: _____ **Marital Status:** ☐ **Single** ☐ **Married** ☐**Widowed** ☐ **Divorced**

Please complete this medical questionnaire to inform your physician. Please circle or mark the appropriate response(s) where applicable:

Chief Complaint (example: I fell down and hurt my knee) Date of Injury/Onset: _____

Body Part: _____

_____

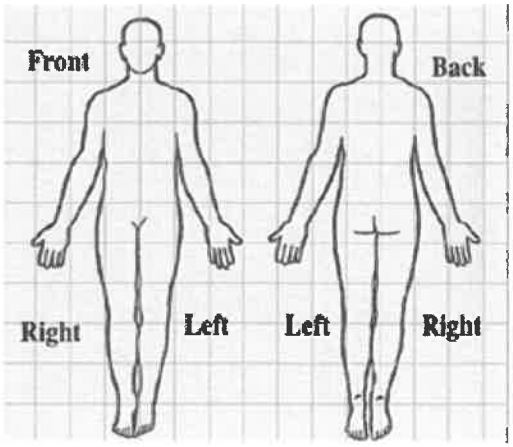
Duration (How long have you had this problem?)

_____

☐ Mild

☐ Moderate

☐ Severe 0,1,2,3,4,5,6,7,8,9,10



Please mark "X" where you are now having problems.

Modifying Factor:

What makes it better? _____

What makes it feel worse? _____

When were you first seen for this problem? _____

Doctor's Name? _____

Please list any tests that have been performed for this injury:

☐X-ray(s) ☐MRI ☐EMG ☐CAT scan ☐Ultrasound ☐Bone Scan ☐Other_____

Please list any treatments that have been performed for this injury:

☐Chiropractic Adjustments ☐Work Hardening ☐Pain Clinic ☐Physical Therapy How Long? _____

Please list medication or types of medicines you have been given to treat this condition: How Long? ____

_____

_____

MRN _____

Have you ever injured this area of your body before?

☐Yes, approximate Date: _____ ☐No

Medical History – X appropriate History responses:

□ Diabetes □ Heart Disease □ Hypertension □ Rheum Arthritis

□ Cancer □ High Cholesterol □ Thyroid Disease □ Arthritis

□Other _____ _____ _____

Surgeries:

_____

Family History – X appropriate History responses:

□ Anesthesia Problems □ TB □ Cancer
□ Bleeding Disorder □ Arthritis □ HTN
□ Diabetes □ Blood Clots □ Stroke
□ Osteoporosis □ Heart Disease □ Asthma
□ Rheum Arthritis
□ Other _____ _____ _____

Smoker: □Current □Former □Never
Do you drink alcoholic beverages? □ Yes Frequency per week _____ □ No

List of Medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to medications:

_____