COLLEGE PARK
MEDICINE

Today's Date _____

Patient name_____ DOB: _____ Sex: ☐ Male ☐ Female

Mailing Address_____ City _____ State _____ Zip _____

Primary phone # _____Secondary phone # _____

Email _____ SS#_____

Employer_____Occupation_____

How did you find our office?_____Name, if referred by a friend or family_____

Parents/Guardians (if minor) _____

PREFERRED PHARMACY

Name:_____Address/Phone number:_____

Would you like to receive a text message or automated phone call from the clinic once medications are called into the pharmacy. Standard text rates apply. ☐ Yes ☐ No

Emergency Contact Information:

Name_____Relationship_____Phone_____

Primary Insurance

Insurance Co._____

Policy Holder's name _____. Policy Holder's DOB _____ Relationship to Patient _____

Policy holder's phone number _____ Policy holder's ss# _____

We ask that all patients show their insurance card and allow us to make a copy for our records.

Financial Policy

Any out-of-pocket expense for the patient such as co-pays, deductibles, or co-insurances must be paid at the time of the clinic visit including services that are not covered under the patient's benefit plan.

Authorization and Release (please sign below)

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payments of benefits be made to College Park Medicine. I acknowledge that I am financially responsible for payment of services not covered by insurance.

Signature:_____Date: _____

COLLEGE PARK MEDICINE

Office and Financial Policies

Welcome and thank you for choosing College Park Medicine for your medical care. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that by providing our patients with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____Insurance: The patient is responsible for knowing their insurance benefits including their deductible and out- of-pocket expenses. Copay, deductibles, and patient's financial portion including any balance will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials:_____Cancellations/No Show Fee: Please call our office at least 24 hours in advance if you are unable to keep a scheduled appointment. You will be charged a No-Show Fee of $50 for failure to keep the appointment as scheduled.

Initials:_____PCP Assignment: Patients with an HMO policy need to choose one of our doctors as their PCP to be seen at College Park Medicine. Please note that when changing your PCP, it may not get updated within 24 hours. You may be asked to reschedule if insurance still shows another physician as a PCP.

Initials:_____Patient Balances: Please be prepared to pay for the current visit as well as any past balances on your account. Copay, deductible, out-of-pocket expenses, and non-covered services must be paid at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____Late Arrivals: We do our best to reduce patient wait time but when a patient arrives late, it is impossible to stay on schedule. If you arrive 15 minutes or more after your scheduled appointment time, you will need to reschedule your appointment.

Initials _____ Dishonored Checks: A $30 Return Check Fee will be assessed on all dishonored checks. If you have dishonored checks on file, check payment will no longer be a payment option for you, but we will gladly accept cash or credit card payments at your future visits.

Initials:_____Collections: You will be receiving at least 3 statements from our office for balances owed before it gets referred to collections. Please make payment arrangements, if necessary, to keep your account current. If your address changes, it is your responsibility to inform College Park Medicine to update our records. Your account will be turned over to collections when your statement returned due to a bad address. When your account is already in collections, you may not be seen until the account is paid in full at the collection agency.

Initials:_____Prescriptions Refills: It is the patient's responsibility to notify the office 3 business days prior to running out of medication.

Initials:_____ Medication Prior Authorization: Any medication that is not covered under your insurance as preferred and needs additional information from the office will require a $25 fee. The patient has the right to call the insurance to find out what medication may be covered before paying the fee.

I have read understand and agree to the above office and Financial/Office policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing by signing this statement.

Signature:_____Date:_____

Patient Name: _____

DOB: _____

COLLEGE PARK MEDICINE

PATIENT HEALTH HISTORY

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notesyouthink areimportant.

Date of Last: **Colonoscopy** (mm/yr) _____ ☐ Normal ☐ Abnormal
Date of Last: **Mammogram** (mm/yr) _____ ☐ Normal ☐ Abnormal
Date of Last: **PAP** (mm/yr) _____ ☐ Normal ☐ Abnormal

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION	☐**NO ALLERGIES**
1. _____	_____	
2. _____	_____	
3. _____	_____	

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over the counter drugs, such as vitamins and inhalers.

	DRUG NAME	DOSE / STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

IMMUNIZATION HISTORY

Immunizations and most recent date given:

Flu shot	Date: _____	Tetanus	Date: _____
Pneumonia (Pneumovax)	Date: _____	Tdap	Date _____
Pneumonia (Prevnar 13)	Date: _____	MMR	Date:_____
Shingles (Zostavax / Shingrix)	Date: _____	Meningitis	Date:_____
Hepatitis B	Date:_____	Gardasil (HPV)	Date:_____
Hepatitis A	Date: _____	Varicella (chicken pox):	Date:_____

COLLEGE PARK MEDICINE

PAST MEDICAL HISTORY

Patient Name: _____

DOB: _____

Please check all that apply:

- ☐ Acne
- ☐ ADHD/ADD
- ☐ Autoimmune Disorders
- ☐ Anxiety Disorder
- ☐ Arrythmia
- ☐ Anemia
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots (DVT, PE)
- ☐ Blood transfusion
  Reason: _____
- ☐ Cancer _____
- ☐ COPD/Emphysema
- ☐ Chronic Pain
- ☐ Chemical dependency/Alcoholism
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Epilepsy/Seizure disorder
- ☐ Fibromialgia
- ☐ GERD
- ☐ Gout
- ☐ HIV
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Irritable Bowel Disorder
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lower extremity edema
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Pacemaker
- ☐ History of Pneumonia
- ☐ Prostate Disease
- ☐ Psoriasis
- ☐ Osteoporosis/Osteopenia
- ☐ Recurrent UTI
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid
- ☐ Tremors
- ☐ Other _____

PAST SURGICAL HISTORY / HOSPITALIZATIONS

SURGERY AND REASON	YEAR
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

SOCIAL HISTORY

OCCUPATION:_____

EDUCATION:

☐ Less than 8th grade ☐ High school
☐ Some college ☐ Bachelor's degree
☐ Advanced Degree

EXERCISE LEVEL: ☐ None (No exercise)
☐ 1-2 days per week ☐ 3-4 days per week
☐ 5 + days per week

MARITAL STATUS: ☐ Married ☐ Single
☐ Widowed ☐ Domestic partner

TOBACCO:

Do you use tobacco? ☐ Yes ☐ No
How often: ☐ Occasionally
Cigarettes pks./day _____
If not currently, did you ever use tobacco? ☐ Yes ☐ No
# of years ____ Or year quit _____
☐ Chew_____/day ☐ Cigars/day

ALCOHOL:

Do you drink alcohol? ☐ Yes ☐ No
☐ Occasionally
☐ < 3 times week ☐ > 3 times week

DRUGS:

Do you currently use recreational or street drugs? ☐ Yes ☐ No
If Yes:_____

Patient name:_____
DOB:_____

COLLEGE PARK MEDICINE

FAMILY MEDICAL HISTORY

Please check all that apply:

Mother:
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Depression/Mental Illness
- ☐ Cancer If yes, please specify _____
- ☐ Other Please specify _____

Father:
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Depression/Mental Illness
- ☐ Cancer If yes, please specify _____
- ☐ Other Please specify _____

Siblings:
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Depression/Mental Illness
- ☐ Cancer If yes, please specify _____
- ☐ Other Please specify _____

Grandparents:
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Depression/Mental Illness
- ☐ Cancer If yes, please specify _____
- ☐ Other Please specify _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

NAME: _____

TODAY'S DATE: _____

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

CHIROPRACTIC HISTORY

Patient Name _____ D.O.B. _____

WHERE is your pain today? (Please circle) NECK UPPER BACK HIP ANKLE

SHOULDER LOWER BACK KNEE OTHER _____

WHEN did this pain begin? ____/____/_____
Have you had a history of this pain or any similar pain? YES NO
If yes, explain _____
WHAT were you doing when this pain began? (Please Explain)
_____

_____

Have you seen another doctor(s) for your current pain? YES NO
If yes, who _____
Are you currently taking medication for this pain? YES NO
If yes, list. _____
Have you had an X-Ray or MRI? YES NO
X-RAY Date: _____ MRI Date: _____ Other: _____
What makes this pain WORSE?
_____

_____

What makes this pain BETTER?
_____

_____

DESCRIBE your pain (Please circle & explain)
DULL/ACHY SHARP THROBBING STABBING NUMB/TINGLE TIGHT OTHER
EXPLAIN: _____
Rate your pain (Please circle 0-10)
0 1 2 3 4 5 6 7 8 9 10
NO PAIN SOME PAIN PAIN AFFECTS LIVING ER
How often do you feel this pain? (Please circle percentage)
0 10 20 30 40 50 60 70 80 90 100
When is the pain worse? (Please circle)
MORNING NIGHTTIME PROGRESSIVELY WORSE AS THE DAY GOES ON

DAYTIME SLEEP
Do you exercise? YES NO Do you smoke? YES
NO
If yes, how often and how much? If Yes, How much?____pks/day
_____days/week _____minutes/day

Dr Signature_____Date____/_____/____

Health Insurance Portability and Accountability Act (HIPAA)

A. Inspection and copies of protected health information – you may inspect and / or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that a request for copies be made in writing and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: The information is psychotherapy notes; the information reveals the identity of a person who provided information under a promise of confidentiality; the information is subject to the Clinical Laboratory Improvements Amendments of 1988; the information has been compiled in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for review of our decision to deny access. Texas law requires us to be ready to provide copies or a narrative report within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based-fee.

B. Amendments of Medical Information – you may request an amendment of your medical information in the designated records set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons: The information was not created by this practice or physicians in this practice; the information is not part of the designated records set; the information is not available for inspection because of an appropriate denial; the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical records. If we refuse to allow an amendment to be made and tell others that we now have the correct information.

C. Accounting of Certain Disclosures – HIPAA privacy regulations permit you to request,and us to provide, and accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by our or your representative. Please submit any request for an accounting to the person at the end of this document. You first accounting of disclosures (within a 12-month period) will be free. For additional request within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits – We may contact you by (telephone, mail or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints – If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filling a complaint with us or the government.

F. Our Promise to you – We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of your privacy practices with respect to protected health information, and to abide by the terms of notice of privacy practices in effect.

G. Questions and Contact Person for Requests - If you have any question or want to make a request pursuant to rights described above, please contact our office at **936-271-2555**.

I acknowledge that I have been given an opportunity to review **College Park Medicine** Notice of Privacy Policies and have been provided a copy if I desire one.

Signature of Patient or Legal Representative	Relationship to Patient	Date

Your Birthday AND address will be used to verify identity on your behalf

COLLEGE PARK
MEDICINE

Health Disclosure Consent Form

I,_____, DOB_____, will allow College Park Medicine, to disclose information to the following person(s) about my health. I have also reviewed and acknowledged the Notice of Privacy Practices.

I will allow disclosure to the following person(s):

Name:	Relationship:
1._____	_____
2. ._____	_____
3._____	_____
4._____	_____
5._____	_____

Can we leave a message to your voicemail? ☐ Yes ☐ No

If Yes, at what number? _____(I understand that I am the only person who can receive this message for privacy and security purposes)

_____ _____

Signature of Patient or Personal Representative Date