Frank Y. Wei, M.D., PLLC

Physical Medicine and Rehabilitation

non-operative care of spinal and musculoskeletal disorders
electrodiagnosis

Southdale Office Centre
6600 France Avenue South, Suite 615
Edina, MN 55435

tel: (952) 926-8925

fax: (952) 920-6338

Office Policies and Procedures:

Appointments: Due to the increasing number of failed/missed appointments by patients, our office has been forced to adopt the following policy. ***Two*** *missed appointments without notification of cancellation will result in a $50 penalty fee.* No further appointments can be made until such fee is paid. Once a penalty has been incurred, there will be a $50 penalty for each failed appointment thereafter and it will be billed directly to you.

Copayments: Copayments are expected at the time of service. Patients who are unable to pay their co-pay/coinsurance after *two* notices will not be able to schedule future appointments until payment has been paid.

Coverage: Due to the variety of insurance plans, patients are ultimately responsible for calling their insurance plan to verify their coverage for any recommended treatment such as physical therapy or MRI scans.

Medication Requests: Please allow a 3 business day response to your request for medication.

No Fault Claims/Liability Claims: If your claim is in litigation, the full amount of the account balance is due. There will be no negotiation.

Interpreter Services: If you are in need of an interpreter, we are contracted with an accredited service, ARCH language services. We will schedule an interpreter for you if one is needed. If you choose to use your own interpreter, the patient will be financially responsible for the charges of those services. Please let us know within 24 hours of your appointment if you will need an interpreter. <u>If you no-show to your appointment and have not called 24 hours ahead of time to cancel, you will be responsible for the ARCH language services fee.</u>

By signing this form, I have read and understand the Office Policies and Procedures.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Name of Patient or Legal Guardian Date

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New Patient Evaluations

If you are a new patient to this office, please bring in your latest **list of current medications** that you are on so that we can include them in your medical chart.

Also, if you have any **x-rays, MRI's or CT's** in the recent past that are related to the problem that you are coming to see us for, please have copies of those reports or CD's with you at the time of you initial visit. If you only have the name of the x-ray facility where you had your studies done that would be helpful as well.

Frank Y. Wei, M.D., PLLC

Patient Consent For Use and Disclosure Of Protected Health Information

I hereby give my consent for **Frank Y. Wei, M.D., PLLC** to use and disclose Protected Health Information (PHI) for performing any activity for Treatment-providing, coordinating, & managing quality patient care, payment-ensuring that the practice gets paid for services, and Operations of the Practice-internal management activities (TPO).

Frank Y. Wei, M.D., PLLC's Notice Of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice Of Privacy Practices prior to signing this consent.

With this consent **Frank Y. Wei, M.D., PLLC's** office:

1. May call my home or other alternative location and leave a message on the recorder or in person in reference to any items that assist the practice in carrying out TPO, such as insurance items and clinical care including laboratory results.
2. May mail to my home or other alternative location any items that assist the practice in carrying out TPO such as patient statements.
3. May release my PHI to related family members or friends involved in my care.

I have the right to request the **Frank Y. Wei, M.D., PLLC** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I was notified of the Privacy Practices and am consenting to **Frank Y. Wei, M.D., PLLC's** use and disclosure of my PHI to carry out treatment, payment, and operations.

Frank Y. Wei, M.D., PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Frank Y, Wei, M.D., PLLC** at 6600 France Avenue S., #615, Edina, MN 55435.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Print Name of Patient or Legal Guardian Date

_____

Signature of Patient or Legal Guardian

Frank Y. Wei, M.D., PLLC

Physical Medicine and Rehabilitation

Referring Doctor

Date:

I. Patient

Last: First: Middle:	Sex: M/F Marital Status: M S D W
Race: Caucasian Asian African American Other:	Ethnicity: Hispanic or Non-Hispanic
Date of Birth: Mo._____ Day_____ Yr._____	Primary Language:_____
Address:	SSN:_____
City: State: Zip:	Home Phone:
E-mail Address:	Business or Cell:
Would You Like Appointment Reminders? Yes No If Yes, ☐	Phone ☐ Email

II. Guarantor of Account (if not patient)

Last: First: Middle:	Sex: M/F Marital Status: M S D W
Date of Birth: Mo._____ Day_____ Yr._____	SSN:_____
Address:	Home:
City: State: Zip:	Business or Cell:
Employer's Name and Address:	

III. Patient's Primary Insurance

Ins. Company & Address:	
ID, Policy, or Claim Number:	Group Number:
Effective Date:	Policy Holder Name:

Work comp:_____ Auto:_____ Medical:_____ Date of Injury/illness:____/____/____

IV. Patient's Secondary insurance

Ins. Company & Address:	
ID/Policy Number:	Group Number:
Effective Date:	Policy Holder Name:

V. Notify in Case of Emergency

Last:	First:	Middle:
Phone:	Relationship:	

Credit information: I understand and agree that (regardless of my insurance status)
I am ultimately responsible for the balance of my account for professional services. I authorize
Direct payment of medical benefits to Frank Y. Wei, M.D., PLLC for services rendered. I also
Authorize release of information to my insurance companies, referring physician, or legal guardian any information concerning my past medical care.

Patient Signature:_____ Guarantor Signature:_____

(Office Use) Both pages signed: _____

Please turn over and read back.

FRANK Y. WEI, M.D., PLLC
6600 FRANCE AVENUE SOUTH, #615
EDINA, MN 55435

INTAKE FORM

DEMOGRAPHIC INFORMATION DATE: _____

Name:_____ Date of Birth: _____ Age: ____

Sex: M/F Are you Right or Left handed

Primary Physician:_____ Clinic Name:_____

HEALTH STATUS INFORMATION

1. **When did your health problem begin? _____**

2. **Which one of the following best describes the way your medical problem began? (please only check one)**

( ) Accident at work ( ) Following an Illness/Medical Illness
( ) Exposure at work ( ) Just began spontaneously
( ) Automobile Accident ( ) Accident someplace else
( ) Other _____

3. **Please tell us how your medical problem specifically began (date and place of injury; how it happened)**

4. **What are your current symptoms (what bothers you)?**

WORK SCHEDULE:

Your employer: _____

Your job title: _____

Length of the time worked at this employer: _____

Please describe your work schedule:

Fixed shift: _____ (day, night, swing) Rotating shift: _____

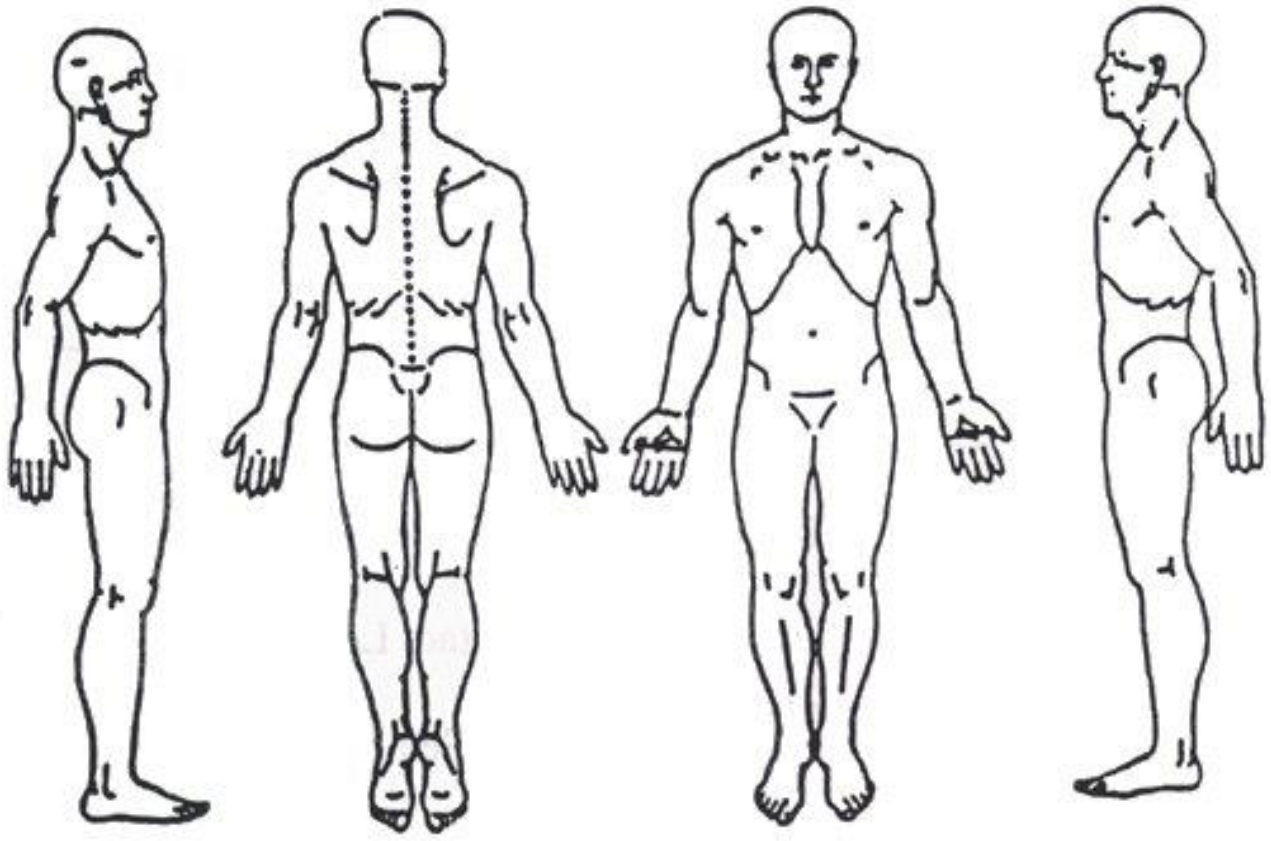
If you worked a rotating shift, how many days off did you get between rotations? _____

Are you being seen today for a work injury from this job? _____

REVIEW OF SYMPTOMS

The information you provide on this form will be very useful to the doctor you will be seeing today and will help your exam go as smoothly and quickly as possible. If you are being evaluated for a painful condition, mark the drawings below according to where you hurt (if it is the back of your neck, mark the drawing on the back of the neck, etc.) If you have any of the symptoms shown on the diagram, indicate where they are by drawing in the appropriate symbol on the affected body part

B = BURNING **A = ACHING** **P = PINS AND NEEDLES**
S = STABBING **N = NUMBNESS**



RIGHT **BACK SIDE** **FRONT SIDE** **LEFT**

NAME: _____ **DATE:_____**

MEDICAL HISTORY

Please list all major injuries you have had and the approximate date of them.

INJURIES	**YEAR**
_____	_____
_____	_____
_____	_____

Please list all major illnesses you have had or that you currently have.

ILLNESSES	**YEAR**
_____	_____
_____	_____
_____	_____

Please list all of the surgeries you have had and the approximate date of them.

Surgeries	**YEAR**
_____	_____
_____	_____
_____	_____

Please list all the times you have been hospitalized (except for surgeries) and their approximate dates.

Hospitalizations	**YEAR**
_____	_____
_____	_____
_____	_____

Please list any allergies that you have (medications, food, dust, etc.)

_____
_____

Please list any medications you are currently taking (or give front desk a copy of a medication list)

DRUG	**DOSE**	**WHEN TAKEN**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY: _____ **PHONE:**_____

FAMILY HISTORY

Do any medical problems run in your family? YES NO
IF YES PLEASE INDICATE:

_____
_____

SOCOECONOMIC HISTORY

Marital status: single, never married/ single, divorced/ single, widowed/ married/ living with significant other (please circle response)

Number of dependents: _____

Highest education level you attained (circle and complete answer)

1. **Completed _____th grade**
2. **Completed high school**
3. **Completed junior high**
4. **Some high school**
5. **Completed ____ year(s) of college**
6. **College graduate**
7. **Graduate school _____ degree**

Were you ever in the military? _____ If yes, which branch_____
Years of service____ type of discharge _____ any service-related disability? _____

Are you currently employed? _____ (if answered yes please fill out next 4 questions)
1. Are you currently working: full time or part time? _____
2. Is this the same job you had at the time of your injury?_____
3. If you have a different job now, what is your present job title? _____
4. If you have a different job now, who is your present employer?_____

Are you receiving time loss compensation? Yes No

PERSONAL HABITS

1. Do you smoke? Yes No; if yes how many packs per day? _____
2. Do you drink alcohol? Yes No; if yes, what type and how much per week? _____
3. Do you use any illegal drugs? Yes No; if yes, what kind _____
4. On most days, how active would you say you are? (Please check one)

- **( ) Very inactive (I spend all of my day sitting or lying down)**
- **( ) Inactive (I spend most of the day sitting or lying down)**
- **( ) Neither active or inactive (I'm up and around for a few hours each day)**
- **( ) Active (I spend most of the day doing things around the house or at work)**
- **( ) Very Active (I spend very little time resting because I have so much to do)**

5. Do you get regular aerobic exercise (exercise that gets you out of breath) Yes No

For each of the following categories, please CIRCLE any symptoms or conditions you have EVER HAD in your life; then please place a CHECK by the symptoms you are CURRENTLY experiencing:

EYES/VISION
loss or change of vision
eye pain or redness
excess watering
double or blurred vision
other: _____

EARS/HEARING
loss of hearing
buzzing or noise in ear
ear infection or drainage
other:_____

NOSE/THROAT
hoarseness
excessive sneezing
blocked nasal passages
nose bleeds
frequent runny nose
difficulty swallowing
other: _____

RESPIRATORY
Wheezing
large quantity of sputum
excessive cough
shortness of breath
night sweats
pain with breathing
allergy or cold symptoms
pneumonia
emphysema
asthma
TB
other: _____

NEUROLOGICAL
severe or frequent headaches
unusual head or neck tension
dizziness
fainting spells
seizures or convulsions
paralysis of limbs
numbness or tingling body parts
other:_____

CARDIOVASCULAR
chest pain
abnormal or fast heartbeat
high blood pressure
low blood pressure
calf "cramps" with walking
sensitivity of finger/toes to cold
varicose veins
frequent and marked swelling of ankles and feet
heart murmur
rheumatic fever
other: _____

GASTROINTESTINAL
digestion difficulties
frequent nausea or vomiting
bloody vomitus
loss of appetite
stomach or abdominal pain
frequent loose bowel movements
recurring diarrhea
blood in the stools
hemorrhoids
frequent or severe constipation
diabetes
gall bladder disease
inguinal, diaphragmatic hernia
loss of bowel control
other: _____

GENITOURINARY
urinary incontinence or dribbling
bloody urine
increased frequency or urination
chronic urgency of urination
difficulty starting or passing urine
painful urination
narrowing of urinary stream
flank pain
other: _____

GENITAL/FEMALE
breast pain
uterine fibroids or tumors
tubal infections
painful menses or excess bleeding
difficulty in sexual function

GENITAL/MALE
penile pain
abnormality of testicles
scrotal swelling
varicocele
difficulty in sexual function

MUSCULOSKELETAL
arthritis
polio
joint infection, swelling, pain or loss of motion
neck or back pain
sciatica
spine abnormality
brittle or soft bones
bone cyst or infection
bursitis
torn muscles or tendons
tendinitis
other: _____

PSYCHOLOGICAL/ EMOTIONAL
emotional illness
depression
recurrent feelings of loneliness/hopelessness
excessive worry/anxiety
severe tension
feelings of worthlessness
recurrent fear
abuse: emotional, sexual, physical
nervous exhaustion
frequent nightmares
hysterical attacks
constant unhappiness
difficulty sleeping
other: _____