PATIENT REGISTRATION SHEET

Please complete the ENTIRE form and sign where indicated.
Please provide the receptionist with your insurance card.

Last Name: ______________________ First Name: ______________________ MI: ________

Address: ______________________ City: ________________ State: ______ Zip: ________

Date of Birth: _____/_____/_____ Age: ______ Social Security #: _____ - _____ - _____ Marital Status: __________

Home #: (______) ______ - ________ Cell. #: (______) ______ - ________ Email Address: ______________________

Employer Name: ______________________ Employer Address: ______________________

Primary Care Physician: ______________________ Phone: (______) ______ - ________

Fax: (______) ______ - ________

Referring Physician: ______________________ Phone: (______) ______ - ________

Fax: (______) ______ - ________

If you were not referred by a physician, how did you hear about us? ______________________

Name of Insurance Company: ______________________ Phone: (______) ______ - ________

Insurance ID Number: ______________________ Group Number: ______________________

Address: ______________________ City: ________________ State: ______ Zip: ________

Name of Policy Holder: ______________________ Date of Birth: _____/_____/_____

Name of Secondary Insurance: ______________________ Phone: (______) ______ - ________

Insurance ID Number: ______________________ Group Number: ______________________

Address: ______________________ City: ________________ State: ______ Zip: ________

Name of Policy Holder: ______________________ Date of Birth: _____/_____/_____

Person responsible for payment: ______________________ Relationship to patient: ______________________

Date of Birth: _____/_____/_____ Phone: (______) ______ - ________

Emergency Notification: ______________________ Phone: (______) ______ - ________

Signature of Responsible Party: ______________________ **Date**: ______________

Revised 01/01/2020

NOBLE
PAIN MANAGEMENT
& SPORTS MEDICINE

Patient Name: ______________________________

Date of Birth: ______________________________

Meaningful Use Patient Questionnaire

In an effort to improve the quality of care or patients receive, Noble Pain Management and Sports Medicine has implemented an electronic health record and is participating in the Meaningful Use Initiative. The data we are collecting below will help Noble efficiently and safely care for you, reduce health disparities, and improve care coordination between Noble, your primary care physician and local hospitals. Please take a moment to answer the following very important questions regarding you and your overall healthcare. Thank you for choosing Noble.

Please circle your race:

American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander

Black or African American White Other Race Other Pacific Islander

Declined to Specify Other: ____________________

Please circle your ethnic background:

Hispanic or Latino Not Hispanic or Latino Declined to Specify Other: ____________________

What is your preferred language? ____________________________

Patient/Guardian Signature________________________________ **Date:** ______________________

NOBLE
PAIN MANAGEMENT
& SPORTS MEDICINE

Patient Name: ______________________

Date of Birth: ______________________

CONSENT TO TREAT: I consent to the administration of health care by Noble Pain and sports Medicine (Noble). I understand that I may set conditions or limitations on my treatment and care and that if I wish to provide such conditions, I will be given the opportunity to write those in a separate document. I have been informed and acknowledge that I may withdraw my consent at any time upon written notice to Noble. I am giving my consent to the administration of health care by Noble voluntarily, and that hereby knowingly and voluntarily enter into this Health Care Consent for Treatment. Noble is an interventional Pain Management and Sports Medicine clinic only. Noble encourages all patients to obtain a Primary Care Physician.

AGREEMENT FOR BENEFIT ASSIGNMENT AND FINANCIAL RESPONSIBILTY: I agree to pay for all services rendered to me by a Noble Pain and Sports Medicine (Noble) physician and/or other qualified healthcare provider employed by Noble. I agree that I am responsible to provide timely information about my insurance coverage and changes in coverage as they occur. **I am responsible for keeping any required insurance referrals current and up to date**. I agree to respond promptly to requests for information from my insurance company as they occur. I assign Noble Pain and Sports management (Noble) benefits due to me or become due to me as a result of the medical services I shall receive from a Noble physician or other qualified healthcare provider. I further authorize the payments to be paid directly to Noble. I also understand that I am responsible to Noble for any payments made directly to me for services Noble provided to me. If this account is not paid in accordance with Noble's policies, I agree and guarantee to pay collection costs, including reasonable attorney fees, collection agency fees and interest from the date of demand. We also can arrange payment plans.

IF MEDICARE, MEDICAID, or other similar government program should determine that I am not eligible for coverage or that the treatment is not covered, I will be responsible for payment, unless prohibited by law.

IF NO INSURANCE, THIRD-PARTY INSURANCE, or MOTOR VEHICLE ACCIDENTS you will be responsible for all charges associated with your care. Any balance on your account is your responsibility to pay in full at the beginning of the office visit. Likewise, any associated medical procedure will require a prepayment of 100% of the physician's fee and any balance from additional services will be billed to the patient. We do not file insurance to third-parties or insurance carriers and do not accept liens. You will be responsible for all charges as well as billing appropriate carriers as you like. For the patients without insurance, we are able to offer a self-pay discount due to required payment in full at the time of service. There are no discounts for third-party carriers.

ACKNOWLEDGEMENT OF PRIVACY POLICIES / HIPAA: I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changes at any time and I have the right to request new copies at any Noble location during regular business hours.

☐ ACCEPTED ☐ DECLINIED ______ Patient's Initials

By my signature below, I am acknowledging receipt of this document and agree to the terms under all five sections of this document. Agreement Consent to Treat, Benefit Assignment and Financial Responsibility and receipt of Privacy Policies / HIPAA.

______________________________ ________
Name of Patient/Guardian Date

______________________________ ________
Signature of Patient/Guardian Date

______________________________ ________
Relationship to Patient if signed by someone other than patient Date

Summary of HIPAA Notice of Privacy Practices
Effective March 1, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A full version of this Privacy Notice is available to you at the front desk of our locations.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, a revised notice will be made available to you within 60 days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (817) 518-1112.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written consent or authorization and you may revoke such authorization in writing at any time.

Treatment: We may use or disclose your health information to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record and that record may be shared with other providers involved in your care.

Payment: We may use or disclose your health information in order for services you receive at our office to be paid by your insurance carrier. For example, we may disclose appropriate information for reimbursement, collection or payment purposes.

Health Care Operations: We may use or disclose your health information for health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

Business Associates: There may be instances where services are provided to our office through contracts with third party "Business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

Communication with Family or Friends: Our professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. The office may also disclose your condition to family or friends who accompany you to our offices.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Patient Name: ______________________________

Date of Birth: ______________________________

HIPAA Policy

Noble Pain and Sports Medicine
431 E. State Highway 114
Southlake, TX 76092
(p)817-518-1112 (f)817-518-1113

According to the Texas State Law and per HIPPA policy, our practice is not allowed to release any of your information without your permission. Please list any individuals that you are giving permission to receive or to pick up any scripts written by the doctor. Please list any individuals that you are giving permission to receive information in regards to you as a patient at our practice.

Name: ______________________________ D.O.B.___/___/___
Phone: ____________________ Relationship: ____________________

Name: ______________________________ D.O.B.___/___/___
Phone: ____________________ Relationship: ____________________

CHECK ALL THAT APPLY

Home Phone

- ☐ Okay to leave a message with detailed information
- ☐ Leave message with call back number only

Cellular Phone

- ☐ Okay to leave a message with detailed information
- ☐ Leave message with call back number only

______________________________ ______________________________ ______________

Print Patient Name Patient/Guardian Signature Date

NOBLE
PAIN MANAGEMENT
& SPORTS MEDICINE

Office Policies

1. Cancellation / No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, or do so in a timely manner, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a thirty-five dollar ($35) fee; this will not be covered by your insurance company. Appointments must be cancelled during normal business hours.

2. Pain Contracts

As a condition of your pain contract, you will only receive controlled substances if you are under direct medical supervision. This means that you will need to keep your regularly scheduled appointments.

If you No Show or have two instances where you did not give at least a 24 hour notice then you will not receive medication refills. A third No Show/Less than 24 Hour Cancellation is grounds for dismissal from the practice. (These do not need to be consecutive, but in total).

3. Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least one day in advance, you may be charged a seventy-five dollar ($75) fee; this will not be covered by your insurance company.

4. Copays and Account Balances

Copays and balances will be collected prior to your appointment. Failure to comply will result in the appointment being rescheduled. Patients who have questions about their bills or who would like to discuss a payment plan option may call 972-792-5700 and ask to speak to a billing representative with whom they can review their account and concerns. To avoid missing your scheduled appointment, please have this completed prior to your appointment. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

5. Verbal and Physical Abuse

At Noble we value our patients as well as our staff. Verbal or physical abuse will not be tolerated and will result in termination of the relationship.

6. Phone Calls

Our office works hard to diligently assist the doctor in clinic as well as return phone calls in a timely manner. Many calls require consulting the doctor. Please refrain from multiple calls and voicemails as these take time to process and result in delaying the process. Please request refills of non-controlled substances through your pharmacy directly and they will send us the request for review. Will respond to the pharmacy directly and ask that you allow 24 to 48 hours for processing. An after-hours service is available for emergencies. Please do not call after hours for refill or appointment issues.

7. FMLA/Disability Paperwork

There is a $100 minimum fee for all paperwork. Please visit our front desk for our questionnaire and allow 14-21 days for processing.

____________________	____________________	__________
Print Patient Name	Patient/Guardian Signature	Date

Name:____ DOB: ____/____/______ Today's Date: ____/____/________

Brief History of Problem:____

Approximate Onset of Problem: Number (#) of: _____ days, _____ weeks, and/or _____ years?

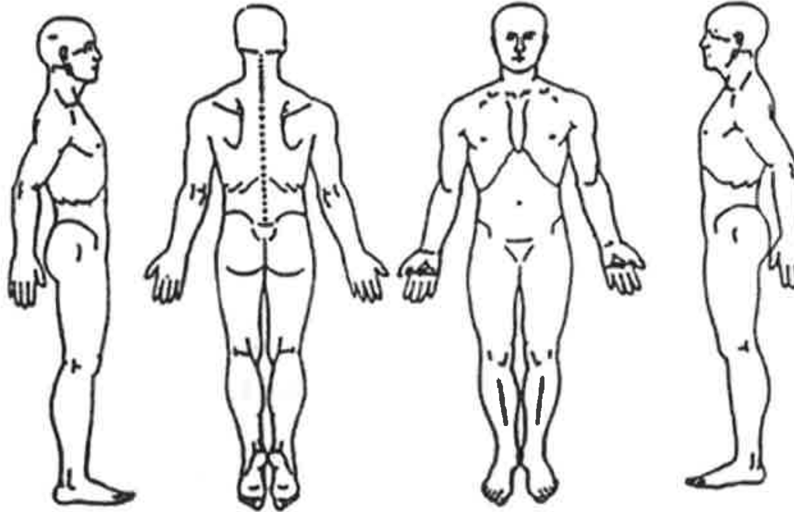
Did you have an injury? □ Yes □ No. If yes, did the injury occur at work? □ Yes □ No

(Please Note: We do not take Workman's Comp or accident injury)

Rate Severity of Pain from 0-10 (0=None, 10=Worst Possible): 0 1 2 3 4 5 6 7 8 9 10

Pain Diagram

Location of Pain: Mark or circle your location of pain



How often does your pain occur: □ Intermittent □ Continuously □ Activity Dependent □ At Rest

Relieves Pain: □ Rest □ Activity □ Other: ____

Increases Pain: □ Rest □ Activity □ Other: ____

How are you currently treating your pain? ____

Have you had pain management in the past? □ Yes □ No Do you have a letter of good standing? □ Yes □ No

Have you had tried any of these in the past for your current condition:

□ Injections What kind?____

□ Pain Medications What kind?____

□ Physical therapy For how long? ____

Review of Systems: [Check Any That Apply]

□ Weakness to __________ □ Fatigue □ Headaches □ Vision Changes □ Poor Balance
□ Numbness to __________ □ Nausea □ Vomiting □ Chills/Fever □ Persistent Cough
□ Tingling to __________ □ Depression □ Dependence □ Skin Problems □ Insomnia
□ Skin Problems__________ □ Chest Pain □ Shortness of Breath □ Loss of bowel/bladder function

Past Medical History: [Check Any That Apply]

□ Diabetes □ Fibromyalgia □ Stroke/TIA □ Liver Disease

□ Hypertension □ COPD □ Previous Heart Attack □ Lupus

□ High Cholesterol □ Cancer □ Sleep Apnea □ Implanted Devices____________________

□ Heart Disease □ Mental Illness □ Renal Disease (Kidneys) □ Other:____________________

Please list **any medications** you currently take, including anything over the counter (OTC):

Medication Name:	**Dosage:**	**Directions:**

Have you had problems with addiction or medication dependence? ☐ Yes ☐ No

Please list any known allergies:

☐ No Known Drug Allergies ☐ Food Allergies ☐ Medication Allergies ☐ Other:

____

Have you had any recent Hospitalizations? ☐ Yes ☐ No

If so, when and what for? ____

Please list ANY past surgical procedures and the date they occurred:

____

____

Have you had any recent images? ☐ MRI ☐ CT ☐ XRAY ☐ EMG ☐ Bone Scan

Family History:

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Substance Abuse	Medication Dependence
Father							
Mother							
Maternal Grandfather							
Maternal Grandmother							
Paternal Grandfather							
Paternal Grandmother							

Social History: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you smoke: ☐Yes ☐No If so, how often:________________________________

Do you drink: ☐Yes ☐ No If so, how often:________________________________

Print Name	Signature	Date