**Drew A. Stein, MD**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: MALE FEMALE Marital Status: SINGLE MARRIED DIVORCED WIDOWED

**Preferred method of communication with office (Please circle all that apply)**: Phone: **W**ork **C**ell **H**ome **E**-Mail

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax# \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

**Primary Care Physician:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If different from referring M.D.)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

**Is your visit here due to an auto accident or worker’s compensation case? YES NO** If yes, date of accident: \_\_\_\_\_\_\_

**Health Insurance Carrier**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Receptionist will copy your card)**

**Insured’s Information if not the same as the patient:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Secondary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Receptionist will copy your card)**

**Insured’s Information if not the same as the patient:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| ASSIGNMENT OF BENEFITS  I authorize payment of medical benefits to Drew Stein MD PLLC. for services described. I accept full responsibility for total amount of bill. I understand that if anything above is untrue, I am responsible for the full bill. If payment is not made on time I am responsible for a finance charge.  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MEDICARE INFORMATION  I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or their intermediaries or carriers, or to the billing agent of this practice, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. In addition, I authorize release of my medical information as necessary to other health care providers, including physicians, pharmacies and physical/occupational therapists.  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Acknowledgment of Receipt of**

## **HIPAA Notice of Privacy Practices**

HIPPA PRIVACY NOTICE

HIPPA PRIVACY LAWS EXPLAIN HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By signing below, I acknowledge that I have been provided a copy of this notice of privacy practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may separate written explanations of special privacy protections that apply to HIV-related information and mental health information.

ACKNOWLEDGEMENT

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF PATIENT DATE

Acknowledge that I have been provided with a copy of HIPPA Privacy Notice and have been given the opportunity to read and ask questions about this practice. A copy of the full HIPPA notice can be found on my web site.

**Protecting patients from identity theft**

We recognize that identity theft is a crisis in our country, exposing victims to financial loss credit destruction, business disruption, and confusion of personal information. Medical identity theft also may lead to false patient information that could jeopardize the delivery of safe, quality health care.

We will comply with all federal and state Laws pertaining to identify theft of “Red Flag Rules” such as those pursuant of the Fair and Accurate Credit Transaction Act of 2003.

In order to do so, it is REQUIRED to scan a copy of your photo license or state issued ID.

Thank you for understanding.

PATIENT INFORMATION SHEET

### INJURY INFORMATION

### 

Date of Injury: \_ \_ / \_ \_ / \_ \_ If no injury, then how long have you had symptoms? \_\_\_\_\_\_\_

Body Part Injured:

Type of Pain: Dull Sharp Burning Constant Radiating

Intensity of Pain: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

*Low Pain Moderate Pain Intense Pain*

Pain at night? Yes No *describe the pain*

What makes it worse?

What makes it better?

Previous treatment for this problem?

# MEDICAL INFORMATION Height \_\_\_\_\_\_ Weight \_\_\_\_\_\_ Handed: R or L

Current Medical History:

Previous Surgical History:

Current Medications:

Allergies to Medications:

Family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke Cigarettes?

Current every day smoker Current some day smoker Former smoker

E-cig smoker Cigar smoker Chewing Tobacco

Do you drink Alcohol?

Daily Weekly Monthly Occasional

In the past year, have you had any falls?

None One Two More than two

**Review of Body Systems**

***Please Circle all That Apply***

**Constitutional:**

Fever Weight loss Malaise Night sweats

**Eyes:**

Glasses Double Vision Blurring

**Ear/Nose/Throat:**

Vertigo Sinusitis Hearing loss

**Cardiovascular:**

Chest pain High Blood Pressure Palpitations High Cholesterol

**Respiratory:**

Shortness of Breath Cough Asthma COPD

**Gastrointestinal:**

Constipation Diarrhea Abdominal pain Reflux

**Genitourinary:**

Incontinence Kidney stone Menstrual issues Impotence

**Skin:**

Rashes Scars Eczema

**Neurologic:**

Seizures Balance issues Memory issues Stroke

**Rheumatologic:**

Autoimmune disease

**Psychiatric:**

Depression Sleep Disturbance Anxiety

**Endocrine:**

Obesity Hair loss Menopause Low Testosterone

**Financial Policy Agreement**

It is our sincere desire to provide you with the best possible medical care. This involves mutual understanding among the patients, healthcare providers and staff. We encourage you, to discuss any questions you may have regarding our professional fees, this financial policy and your responsibility.

It is also your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and/or co-insurance. The same responsibility exists for HMO and PPO insurance.

Payment is expected at the time of your visit for services not covered by your insurance plan. We accept cash, check, and credit cards.

Please be advised that:

1. Your insurance is a contact between you, your employer and insurance company.
2. Most plans require a referral and/or co-payment. It is expected that you provide this at the time of service.
3. Any unmet patient responsibility (i.e., deductible or coinsurance) may be secured by a credit card.
4. Any ancillary services provided may have an associated co-pay/co-insurance once your insurance company has processed the claim. This includes x-rays, injectables and durable medical equipment (DME).
5. If you are scheduled for surgery, our practice may be required to utilize the services of an assistant surgeon or physician assistant. This service may not be covered by your plan and therefore, you may be financially responsible for such service pursuant to your plan.
6. We will become involved in disputes between you and your insurance company regarding deductibles, coinsurance, covered benefits, secondary insurance, “usual, customary and responsible charges”, etc., other than to supply information as necessary.
7. In situations where a claim is pending for more than 60 days, you will be billed for unpaid charges filed with your primary carrier.
8. If you fail to inform this office of your secondary coverage, you may be responsible for any unpaid charges for deductibles and/or coinsurance.
9. If you neglect to report to your carrier who is primary and who is secondary regarding your coverage (known as Coordination of Benefits), you may be responsible for all unpaid medical charges filed with your primary insurance carrier.
10. It is unethical and prohibited by law for the healthcare provider to change diagnosis codes and/or procedure codes to meet the reimbursement requirements of your plan for a medical service specifically excluded by your policy.
11. All returned checks will be subject to $25.00 return reprocessing and administrative fee.

I authorize payment of benefits be made on my behalf of Drew Stein, MD for any services furnished to me by the provider. Additionally, I authorize Drew Stein, MD information from my medical records pertaining to my treatment as requested by other healthcare providers for my continued care and treatment.

I have been presented with a copy of Drew Stein, MD Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I have read the above and agree that I am ultimately responsible for the balance on my account for any services.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_