Integrity Pain Management, PLLC

Patient Registration Form

Appointment Date: Time:

SS#	DATE OF BIRTH Month-Day-Year	SEX M___ F ___	MR, MRS, MS, DR (Circle One)
PATIENT LAST NAME	FIRST NAME		MIDDLE NAME
JR, SR,III, MD (Circle one if applicable)	HOME PHONE#	WORK PHONE#	CELL #
ADDRESS	APARTMENT / LOT #	E-MAIL ADDRESS	
CITY	STATE / ZIP CODE		
DIABETIC Y N	EMERGENCY CONTACT NAME	EMERGENCY PHONE #	
MARITAL STATUS: S___ M___ D___ W___	HEIGHT _____ WEIGHT _____ lbs		
LMP DATE: / /	PREGNANT Y N	REFERRING PHYSICIAN NAME	PHYSICIAN PHONE #
CHIEF COMPLAINT:			
DATE OF ACCIDENT: / /	TYPE OF ACCIDENT: Auto / Employment / Other		
ATTORNEY REPRESENTATION			Phone #
PATIENT EMPLOYER	EMPLOYER ADDRESS		
CITY / STATE / ZIP CODE	PHONE #		
PRIMARY INSURANCE COMPANY	ADDRESS		
CITY	STATE / ZIP CODE	PHONE#	
POLICY #	GROUP # OR NAME	POLICY HOLDER NAME	DOB
POLICY HOLDER SS #	POLICY HOLDER EMPLOYER	EMPLOYER ADDRESS	
EMPLOYER CITY / STATE / ZIP CODE	EMPLOYER PHONE#	PATIENT RELATION TO INSURED: Self Spouse Child Other	
SECONDARY INSURANCE COMPANY	ADDRESS		
CITY	STATE / ZIP CODE	PHONE #	
POLICY #	GROUP # OR NAME	POLICY HOLDER NAME	DOB
POLICY HOLDER SS #	POLICY HOLDER EMPLOYER	EMPLOYER ADDRESS	
EMPLOYER CITY / STATE / ZIP CODE	EMPLOYER PHONE#	PATIENT RELATION TO INSURED: Self Spouse Child Other	

INTEGRITY PAIN MANAGEMENT CENTER

KERRY C. LATCH, M.D. / SAL S. SANDOVAL, M.D.

☐ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to INTEGRITY PAIN MANAGEMENT CENTER of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to INTEGRITY PAIN MANAGEMENT CENTER for charges not covered by this assignment. I understand that should I bill my managed care insurance directly, I am not entitled to any further discounts.

☐ **RELEASE OF INFORMATION:** I hereby authorize INTEGRITY PAIN MANAGEMENT CENTER to furnish my insurance company or companies, or their representatives with any and all information that may be contained in their medical records.

☐ **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of INTEGRITY PAIN MANAGEMENT CENTER any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used on place of the original, and request payment of medical benefits be made to the holder of the assignment of my behalf. I understand that I am responsible for any health deductibles and coinsurance.

☐ **LIABILITY / INSURANCE WAIVER:** I hereby state that I wish INTEGRITY PAIN MANAGEMENT CENTER to submit my claim for medical services to _____for services rendered for the accident date of: _____. I am not filing this claim with any other liability insurance and will not be making any claim to any other general liability insurance or company. I also understand that if I do submit this to any other general liability insurance or company that _____ will have to be refunded immediately and the total amount originally charged for the services rendered will become due and payable by me. Filing your liability insurance does not constitute and assignment. If this is a legal case, we do not accept assignment pending the outcome of your case. You are responsible for your bill in its entirety.

☐ **LIABILITY / ATTORNEY - MEDICAL RECORDS RELEASE:** I authorize INTEGRITY PAIN MANAGEMENT CENTER to release my medical records to my attorney: (name) _____ phone #: _____

☐ **WORKER'S COMPENSATION:** This authorizes my physician to furnish written reports and communicate orally with any representative, attorney for, or investigator from my Worker's Compensation carrier _____ regarding my examination, diagnosis, treatment, and prognosis concerning injuries sustained as a result of an accident occurring on the _____ day of _____, 19___.

☐ **IF PATIENT IS UNDER 18:** I hereby give my permission for _____ to be treated by Dr. _____.
Patient Name

_____ _____ _____
Signature / Telephone Verification Witness Date

I have reviewed the **Notice of Privacy Practices** from **Integrity Pain Management Center** concerning how the use or disclosure of **Protected Health Information** will be handled by the practice. I give **Integrity Pain Management Center** consent to use or disclose my **Protected Health Information** for purposes of treatment, payment, and restrictions and to revoke this consent.

THESE AUTHORIZATIONS MUST BE SIGNED IN ORDER TO EXPEDITE THE FILING OF YOUR INSURANCE CLAIM

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian (Please Print): _____

Parent/Guardian's Signature: _____ Date: _____

Witness: _____ Date: _____

INTEGRITY PAIN MANAGEMENT

Kerry C. Latch, M.D. / Sal S. Sandoval, M.D.

We thank you for choosing our office for your medical care. In order to better serve you we kindly ask that you review our office policies. Our professional relationship will be enhanced by your clear understanding of our office policies. Thank you for your review and acceptance of these policies.

____ **PAYMENT FOR SERVICE:** All applicable fees such as: deductible, co-insurance and co-pays must be paid at the time services are rendered. Our office accepts cash , checks, debit and MasterCard or Visa. Payments returned to our office for insufficient funds, closure of account and/or credit card contestment will result in an assessment of $35. **Each office visit and procedure accrues it own fees.**

____**HMO/REFERRALS:** If your insurance policy requires a written authorization/referral from our office, you must notify us in advance to ensure that the authorization/referral is received prior to your visit with the specialist.

____ **INSURANCE VERIFICATION:** As the policy holder, it is your responsibility to call your insurance and verify that Kerry C. Latch, MD., Sal S. Sandoval, M.D. are participating providers with your insurance. Our office makes every attempt to obtain current benefit information from your insurance carrier at your initial appointment; **however as the insured member, you are ultimately responsible for understanding your benefits structure**. At the time of your initial visit and each year, our office will request a copy of your current medical card and updated patient information form. Please notify our office immediately of any changes to your medical insurance policy so that we may take the necessary steps to assist you in obtaining your maximum level of benefits.

____ **MEDICATION REFILL:** When requesting a prescription refill, please contract your pharmacy first and they will contact us with the required information. Refills are handled by the end of the clinic day and your request for such may be delayed due to your insurance, holidays or weekends. Please plan appropriate advance notice of your refill requests. Prescriptions for narcotic medications will not be filled after clinic hours, weekends and/or holidays.

____**URINE DRUG SCREENING**: The best treatment plan often includes urine screening, an essential tool that enables us to manage your pain and reduce medication cross-reactions. We do these randomly as needed for care. All results are fully confidential.

_____ **CANCELLATIONS:** If you must cancel or reschedule your appointment, please notify our office at least 24 hours in advance. You may call after hours and leave a message on the receptionist voicemail box. **Cancellations or no shows within 24 hours of the scheduled appointment time will result in a $50 cancellation fee.** Your insurance will not cover this charge. All fees must be paid in full prior to or on the day of your next appointment. This allows us adequate time for other patients to be assisted.

_____ **FORMS:** Our office charges for letters and forms which need to be filled out and signed. The minimum charge will be $50 per form/letter. There is a $25 charge for patients who want copies of their medical records.

_____ **NOTE TO PATIENT:** Please understand that the insurance carriers/attorneys do not guarantee any payments for services rendered. Payment is not made until the claim is reviewed and accepted; therefore, you will be responsible for the total balance if no payment is made by your insurance/attorney. Any and all payments received from your insurance/ attorney will be credited to your account

_____ _____

Patient Signature **Date**

PHYSICIAN LIEN, PARTIAL ASSIGNEMENT OF CAUSE OF ACTION, ASSIGNMENT OR PROCEEDS, CONTRACTUAL LIEN AND AUTHORIZATION ("Agreement")

I hereby direct any and all insurance carriers, attorneys, agencies , governmental departments, companies, individual, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, for which medical treatment or medical services were rendered hereunder ("condition") to pay directly to and exclusively in the name of, Kerry C. Latch, M.D. (Dr. Latch, Dr. Sandoval and or Office) such sums as my be owing to Kerry C. Latch, M.D. and Sal S. Sandoval, M.D. for charges incurred by me at their office relating to my condition and pay directly to and exclusively in the name of Kerry C. Latch, M.D. and Sal S. Sandoval, M.D. such sums as may be owing to the doctors for charges incurred by me, including charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges").

I further grant a contractual lien to Kerry C. Latch, M.D. and Sal S. Sandoval, M.D. in accordance with the definitions, rights and remedies of Texas Law including specifically, but not limited to, Texas Business & Commerce Code 9.102 and the comments there under, with respect to my charges, and outstanding medical balance. This lien shall apply to all payers and to the full extent of Texas law for the purpose of the Agreement/ medical assignment and medical lien benefits shall include, but shall not be limited to, proceeds for any settlement judgment or verdict, as well as any proceeds or recovery relating to commercial health or services benefits, no fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposed stated herein, regardless of whether such proceeds are related to my charges or not.

In addition I hereby assign to the Office, insofar as permitted by law, the following:
All of my rights, remedies, and benefits to Kerry C. Latch, M.D. and Sal S. Sandoval, M.D. as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this manner, I hereby direct each attorney(s) to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of the office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds and to provide a full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to Kerry C. Latch, M.D.and Sal S. Sandoval, M.D. any information regarding any coverage or benefits which I may have including, but not limited to the amount of the coverage, the amount paid thus far and the amount of any outstanding claims.

I authorize the Office to release any information regarding my treatment or pertinent to my case to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement together with any applicable charges with any or all payers regardless of whether a claim has been established with said payers. I hereby authorize Kerry C. Latch, M.D. and Sal S. Sandoval, M.D. to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse or any of my dependents. I further authorize Kerry C. Latch, M.D. and Sal S. Sandoval, M.D. to apply my credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse or my dependents, regardless of whether these other charges are related to my condition. In the event that I retain one or more attorneys to represent me for a recovery for injuries sustained which were the basis of the condition which I sought medical treatment, I direct each and every attorney to issue a letter of protection for Kerry C. Latch, M.D. or Sal S. Sandoval, M.D. to protect the outstanding medical balance of Kerry C. Latch, M.D. or Sal S. Sandoval, M.D. Upon issuance I hereby agree that such letters of protection cannot be revoked or modified without the express written consent of Kerry C. Latch, M.D. or Sal S. Sandoval, M.D.

I understand that I remain personally responsible for the total amounts due to Kerry C. Latch, M.D. or Sal S. Sandoval, M.D. for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services as its option. If this Office must take any action to collect and outstanding balance on my account, I will be responsible for payment and will reimburse Kerry C. Latch, M.D. or Sal S. Sandoval, M.D. for all costs of such collection effort, including, but no limited to all court costs and attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of Kerry C. Latch, M.D. or Sal S. Sandoval, M.D. and myself. I hereby revoke any previously signed authorizations whether executed at this office or any other office to the extent that the terms of those authorizations conflict wit the terms of this Agreement.

I agree that each and every provision of the Agreement is reasonably necessary for the protection of the rights and interests of Kerry C. Latch, M.D., Sal S. Sandoval, M.D. and myself. However, should any provision of the Agreement be found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall nevertheless remain in full force and effect.

Patient Name (Please Print) : _____ Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian (Please Print): _____

Parent/Guardian's Signature : _____ Date: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize_____ to use and/or disclose the
[Name of Health Care Provider]
protected health information described below to _____.
[Name of Individual]

2. Authorization for Release of Information. Covering the period of health care from
□ _____ to _____ **OR** □ all past, present and future periods:

a. □ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. □ I hereby **authorize the release of my complete health record with the exception of the following information**:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____.

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until_____, at which time this authorization expires. [Date or Event]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

INTEGRITY PAIN MANAGEMENT

Kerry C. Latch, M.D./ Sal S. Sandoval, M.D.

PATIENT SERVICE AGREEMENT

Guarantor Statement:

I hereby agree to assume financial responsibility for any and all reasonable charges in accordance with service provided me or my dependent(s) at this facility.

In the event my account becomes delinquent, I will assume total responsibility for any reasonable collection expenses or attorney's fee associated with the collection effort.

Assignment of Benefits:

I hereby agree to the authorization and assignment for payment to be made to the facility named above, by any and all insurance claims regarding all professional services rendered. In the event that my insurance company pays me directly, I will upon receipt, remit the entire amount to the facility named above. It is understood that my account will not be considered closed until all remaining balances are paid, regardless of the amount of percent of insurance coverage.

Disclosure of Information:

I hereby authorized and consent to the disclosure or release of any all medical records and films relative to my condition, care or treatment either by or to the facility named above, my referring physician and all other physicians participating in my care.

I agree that the conditions set forth in the above agreements have been explained to me and that I agree to and understand its contents.

_____ _____

Signature Date

_____ _____

Witness Date

INTEGRITY PAIN MANAGEMENT CENTER

KERRY C. LATCH, M.D. / SAL S. SANDOVAL, M.D.

PATIENT RIGHTS & ADVANCE DIRECTIVES

We recognize that you have the right to participate in and to make decisions regarding your health care, including the right to refuse medical treatment as provided by state law and regulations.

You have the right to express your wishes related to your care through "Advanced Directives" as provided by state law and regulations. "Advanced Directives"are written statements which specify what kind of treatment you want or do not want under special and serious circumstances when you may not be able to tell your doctor or other caregiver how you want to be treated.

"Advanced Directives" may be in the form of a "living will" and/or by designating a third party (relative, friend, etc.) to make decisions on your behalf using a durable power of attorney or other forms allowed by the state.

Integrity Pain Management Center does not discriminate against clients in admissions to care or services offered on the basis of the presence or absence of advanced directives and will comply with state law. However, it is important that we know if you have formulated an advanced directive so your wishes can be honored. It is also important that you provide a copy of your advanced directive to your physician so that the appropriate care can be ordered.

If you have already formulated an advanced directive, if you execute an advanced directive in the future, or if you change or revoke and advanced directive, it is important that your physician and the surgery center be informed.

If you indicate below that you have an advanced directive, the facility will retain the information in your clinical record, will contact your clinical record, will contact your attending physician for orders to comply with the terms of your instructions, and will notify Integrity Pain Management Center staff who provides your care. Likewise, if you formulate, change or revoke an advanced directive later, you must notify us and your physician. We will include the information in your clinical record, contact your physician for orders, and notify us and your physician. We will include the information in your clinical record, contact your physician for orders, and notify Integrity Pain Management Center staff of the changes.

☐ I have prepared and advanced directive regarding my health care.

☐ I have not prepared an advanced directive regarding my healthcare.

☐ I have received written information regarding my right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advanced directives under state law.

Patient Signature:_____ Date: _____

INTEGRITY PAIN MANAGEMENT
KERRY C. LATCH, M.D. / SAL S. SANDOVAL, M.D.

NAME: _____
DOB: _____

PERSONAL HISTORY

HEIGHT: _____ WEIGHT_____

DO YOU HAVE CHILDREN? _____ IF SO, HOW MANY _____

HAVE YOU HAD AN MRI X-RAYS EMG

1. Are you allergic to any medications: NO YES
List medications and type of reaction:
_____
_____
_____

4. Do you take any prescription medication? NO YES

LIST MEDICATIONS	DOSE	FREQUENCY	LAST DOSE	DO YOU TAKE ANY OTHER MEDICATION?
				NO YES (*IF YES, LIST BELOW*)

WORK HISTORY

WHO WAS YOUR EMPLOYER AT THE TIME OF THE INJURY
_____

WHAT WAS YOUR JOB DESCRIPTION _____

ARE YOU STILL EMPLOYED WITH THEM? YES OR NO

IF NOT ARE YOU CURRENTLY EMPLOYED? YES OR NO

I understand that I have been referred to Integrity Pain Management Center for the purposes of determining my present status. Any information obtained during my visit will be used to determine that status. I, therefore, will give the most complete and honest answers possible. I understand that physical testing is necessary and will give my best efforts during the tests.

SIGNATURE _____DATE: _____

INTEGRITY PAIN MANAGEMENT CENTER

PATIENT INFORMATION

Please fill out the following information. This will make admission process quicker and will prevent answering the same questions repeatedly.

PLEASE PROVIDE THE MOST APPROPRIATE ANSWER

PATIENT NAME:_____

Religious Preference: _____

Language: _____ **Are you able to read?** _____ **Are you able to write?**_____

Information obtained from: SELF OTHER (SPECIFY): _____

1. List all previous surgeries, major illnesses and or major injuries:

_____

_____

2. Have you or a member of your family ever had complications from an anesthetic: NO YES
Explain if yes,

_____

_____

3. Have you ever had any of the following illnesses?

PLEASE CHECK YES OR NO

	YES	NO		YES	NO
Angina (Chest Pain)	____	____	**HIV Positive**	____	____
Heart Attack	____	____	**Kidney Problems**	____	____
Stroke	____	____	**High Blood Pressure**	____	____
Asthma	____	____	**Bleeding Problems**	____	____
Emphysema	____	____	**Head Injury**	____	____
Tuberculosis	____	____	**Muscle Weakness**	____	____
Diabetes	____	____	**Sleep Apnea**	____	____
Hepatitis	____	____	**Liver Damage**	____	____
Vision Problems	____	____	**Nerve Disease**	____	____
Contacts	____	____	**Seizures**	____	____
Glasses	____	____	**Dentures**	____	____
Hearing Problems	____	____	**Hearing Aids**	____	____

List any other illnesses:

_____

_____

SUBSTANCE USE	HOW MUCH?	HOW LONG?	LAST USED?
Alcohol NO YES			
Tobacco NO YES			

INTEGRITY PAIN MANAGEMENT CENTER

INFORMACION DE PACIENTE

Favor de llenar la informacion.

Favor de contester lo que se le aplica

Nombre:_____

Religion Preferida: _____

Idioma preferido: _____ **Puedes leer?** _____ **Puedes escribir?**_____

Informacion obtenida de: **DE UNO MISMO** **OTRA PERSONA:** _____

1. Lista de cirugias:

_____

_____

_____

2. Usted o algun familiar a tenido problema con anestheticos: **NO** **SI**

_____

_____

3. A tenido algun problema de la lista de abajo?

FAVOR DE MARCAR SI O NO

	SI	NO		SI	NO
Dolores de pecho	____	____	Positivo VIH	____	____
Ataque de corazon	____	____	Problemas de rinon	____	____
Carrera	____	____	Alta precion	____	____
Asma	____	____	Problemas de sangrado	____	____
Enfisena	____	____	Lesion craneal	____	____
Tuberculosis	____	____	Debilidad muscular	____	____
Diabetes	____	____	Apnea del sueno	____	____
Hepatitis	____	____	Dano hepatico	____	____
Problemas con vision	____	____	Enfermedad de los nervios	____	____
Contactos	____	____	Ataques	____	____
Antionjos	____	____	Dentadura postiza	____	____
Problemas escuchando	____	____	Audifinos	____	____

Antecedentes Psiquiatricos? Si se le aplica favor de expliquar:

_____

_____

Otras enfermedades:

_____

_____

Substancias usadas	Cuanto?	Cuanto Tiempo?	Ultima vez?
Tomas NO SI			
Fumas NO SI			

INTEGRITY PAIN MANAGEMENT
KERRY C. LATCH, M.D. / MICHAEL E. KRUCZEK, M.D.

NOMBRE: _____
FECHA DE NACIMIENTO: _____

HISTORIA PERSONAL

ALTURA: _____ PESO_____

TIENE HIJOS? _____ SI CUANTOS _____

HAS TENIDO RESONANCIA MAGNETICA RAYOS X ELECTROMIOGRAMA

1. Es alergico a medicamentos: SI NO
Lista de medicamentos y tipos de reaccion:

_____
_____
_____

4. **Tomas medicamentos recetados**? NO SI

Lista de medicamentos	Dosificacion	Frequencia	Ultima dosificacion	TOMA USTED OTROS MEDICAMENTOS
				NO SI LISTADO ABAJO

HISTORIAL DE TRABAJO

QUIEN ERA SU EMPLEADOR EN EL TIEMPO DE LA LESION

_____

DESCIPCION DE TRABAJO _____

ESTA USTED TODAVIA EMPLEADO CON ELLOS? SI O NO

SI NO USTED ACTUALMENTE EMPLEADO? SI O NO

Yo entiendo que ha cido referido a Integrity Pain Management Center con el proposito de determinar mi estado presente. Informacion obtenida durante mi visita sera usada para determinar mi estado. Yo, llenare las formas lo mas apropiado que pueda. Yo entiendo que un examen physico es necesario y voy a dar mis mejores esfuerzos para responder.

FIRMA _____FECHA: _____