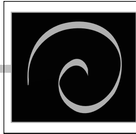


The Centeno-Schultz Clinic

Admission Form

PATIENT INFORMATION

Patient Name: ______________________________ Date Injured: ____________________

Address: ______________________________ SS#: ______________ Marital Status: S M D W O

City: ______________ State: ________ Zip: ________ Date of Birth: ______________ Sex: M F

Home Ph#: ____________ Work Ph#: ______________ Email: ______________________________

Employer Name: ______________________________ Workers Comp: Y N

Employer Address: ______________________________ Auto Accident Y N If yes, what State? ____________

City: ______________ State: ________ Zip: ________

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL ☐ **SELF**

Insured (**Responsible**) Party Name: __________________ Relationship to Patient: ______________________

Address: ______________________________ Date of Birth: ______________ SS#: ______________

City: ______________ State: ________ Zip: ________

Home Ph#: ______________ Work Ph#: __________

PHYSICIAN INFORMATION

Referring MD: ______________ Phone #: ____________ Primary Care MD: ____________ Return to MD: ______________

INSURANCE INFORMATION

*If you are being seen for an injury related to **workers compensation** or an **automobile accident**, please give us the name of your workers compensation /automobile carrier instead of your primary personal medical insurance carrier.*

Primary Insurance: ______________________________ Phone: ______________

Group #: ____________ Subscriber/SS#: ______________

Pt. Relation to insured: Self Spouse Child Other

Do you have Secondary Insurance? Y N

Adjuster: ____________ Claim #: ________________

Is your case in litigation? Y N

Name: ______________

Attorney's Name: __________________________

How did you hear about The Centeno-Schultz Clinic? *(check all that apply)*

□ Physician □ Insurance Company □ Attorney □ Friend □ Family Member □ Internet □ Yellow pages □Other____________________

I authorize the release of any private health information necessary to process this claim.

I, the undersigned agree, whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to The Centeno-Schultz Clinic, **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records.

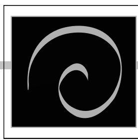
I have read, understand and signed Centeno-Schultz Clinic *Financial Policy* on the back of this page.

Signed: ______________________________ Dated: ______________________
Insured and/or Responsible Party

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my physician and/or provider, may be considered necessary or advisable while a patient at Centeno-Schultz Clinic. I also understand that Centeno-Schultz Clinic may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data

Signed: ______________________________ Dated: ______________________
Insured and/or Responsible Party



The Centeno-Schultz Clinic

Financial Policy

Welcome to the Centeno-Schultz Clinic. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The services that you receive and the bill, is an agreement between you and Centeno-Schultz Clinic. **It is ultimately your responsibility to see that your bill is paid in full**. Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Centeno-Schultz within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a $20.00 charge will be made to your account.

Many insurance companies require a referral from your Primary Care Physician (PCP) to a specialist prior to any appointment. **It is your responsibility to ensure that this referral is obtained prior to all scheduled appointments**. To obtain a referral you will need to contact your PCP and request one. Failure to have a referral on file in our office prior to your appointment will require a waiver and payment in full at the time of service, or for the appointment to be rescheduled.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph. If you receive payment made out to both The Centeno-Schultz Clinic and you, please endorse the check and forward to us.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with the business office at 303-429-6448

If we bill your insurance and reimbursement is 100% denied, we will bill you our Self Pay rates plus an 18% per annum service charge. If you are unsure of self pay rates, it is your responsibility to ask.

If you are a cash pay patient and you do not pay at the time of service or an arrangement to be billed by our billing department has not been set-up, you will be charged an 18% per annum service charge.

On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service.

Interest is charged on accounts due beyond the grace period. We allow a grace period for 2 months after receiving a final determination from your insurance company or date of service if you are a cash pay payment or have a Lien account. After the time, we will add a 1.5% per month to the total due beyond the grace period. Interest will be calculated on a cumulative basis. If your balance is over 180 days past due, you agree that if your balance is sent to collections you agree to pay the collections fee in addition to your original balance.

NO SHOW & LATE CANCELLATION

Our no show/late cancellation policy requires 24 hour notice if you are unable to make your appointment. If no notice or less than 24 hours notice is given, there will be a $50.00 fee.

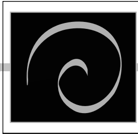
I have read the *Financial Policy*. I understand and agree to this *Financial Policy*.

HIPAA--I ACKNOWLEDGE THE RECEIPT OF THE CENTENO-SCHULTZ CLINIC'S *HIPAA NOTICE OF PRIVACY PRACTICES*.

Signed: ____ Dated: __________________________

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

☐ Yes ☐ No If Yes, person's name: ________________________ Relationship: ________________________



The Centeno-Schultz Clinic

Clinical Intake

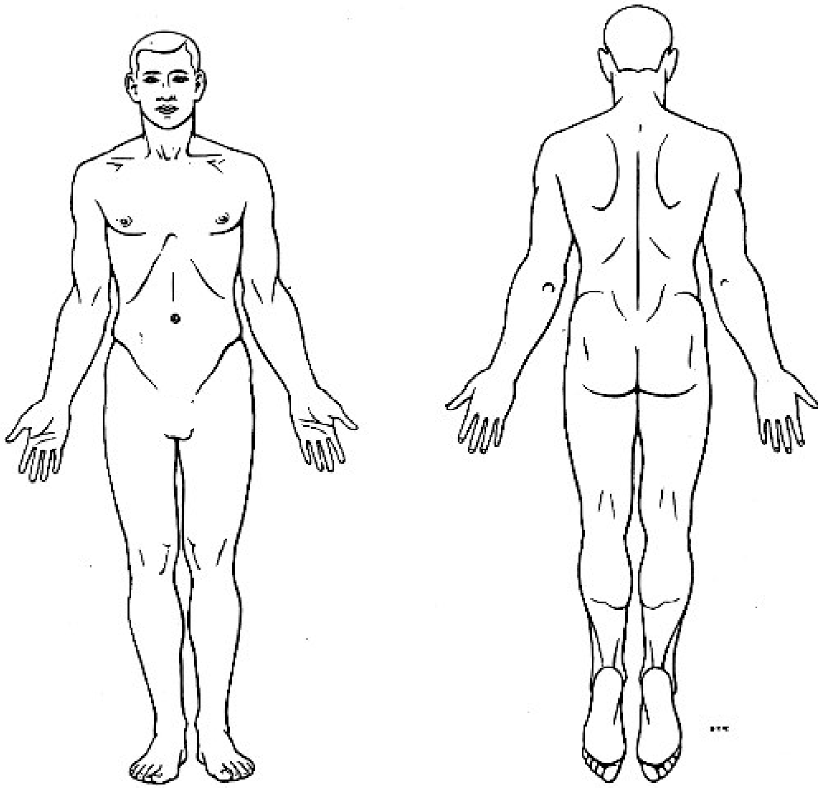
PATIENT NAME	AGE

Please fill this out before you come to your appointment.

INJURY OR ACCIDENT			
If you had a motor vehicle accident or injury, when did it occur?		*(Skip the following questions if you were not in an automobile accident. The following questions are for this claim only (one accident only).*	
Please describe your car accident, work injury, other injury, or how your illness began.		**Please describe work accident or how your illness or pain began.**	

CURRENTLY (Subjective)

The following questions are about how your illness is affecting you now. With a RED PEN, please indicate where your pain is on the drawing below. You may indicate it with X's or shades. Pay special attention to the directions with the arrows showing each part of the body.



List your pain and problems in order of severity (most severe first):

1.	
2.	
3.	
4.	
5.	
6.	

Is there anything that INCREASES your pain/symptoms?	**Is there anything that RELIEVES your pain/symptoms?**
Since the injury or when your problem began, your symptoms are	☐ Better ☐ Worse ☐ Unchanged

Patient Name____

CURRENTLY (Subjective)

At this time are your symptoms: ☐ Better ☐ Improving ☐ Getting Worse ☐ Unchanged

Check the box (X) that describes:	0 None	1-2 Mild	3-4 Uncomfortable	5-6 Distressing (fairly severe)	7-8 Very severe (horrible)	9-10 Unbearable (excruciating)
Your pain as it usually feels						
Your pain as it is right now						
Your pain at it's worst						
Your pain when it hurts the least						

How many days a week do you experience pain? ☐ Daily ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Intermittent

PRE-EXISTING STATUS**

The purpose of this section is to understand how you were prior to your injury or illness.

***Only fill out if you had an accident or injury*

Did you have any similar or previous problems? ☐ Yes ☐ No

Where you under a physician's care or in therapy prior to the injury? ☐ Yes ☐ No

Have you had any other significant disabling problems or accidents? ☐ Yes ☐ No

MEDICAL CARE	WORK HISTORY	ACTIVITIES OF DAILY LIVING / FUNCTIONAL STATUS
Please tell us which doctors or providers you have seen for this problem. Make sure to include the results of any diagnostic tests (i.e., x-rays, MRI's, CT scans, etc.)	**How does this problem impact your ability to do your job?**	**How does your problem impact your ability to do the daily activities you want (such as recreation or jobs around the house?)**

PAST / OTHER MEDICAL HISTORY

FAMILY MEMBER'S HISTORY

Similar problems to yours?	☐ Yes	☐ No	If yes, who?
Disability	☐ Yes	☐ No	If yes, who?
Arthritis	☐ Yes	☐ No	If yes, who?
Heart Disease	☐ Yes	☐ No	If yes, who?
Diabetes	☐ Yes	☐ No	If yes, who?
Drug Abuse	☐ Yes	☐ No	If yes, who?
Alcoholism	☐ Yes	☐ No	If yes, who?

Same problem as the one you are being seen for today? ☐ Yes ☐ No If yes, who?

HOSPITALIZATIONS

Year	Illness/Operation	Remaining problems

PREVIOUS TRAUMA
(Automobile accident, fractures, strains, any other)

Date	Injury/Accident	Remaining problems

ALLERGIES
(medications or environmental)

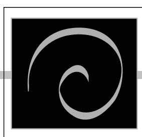
MEDICATIONS
(please all medications you take—even if only occasionally)

Medication	Dose	How Often	When Started	Why?

Patient Name______________________________

CURRENTLY (Subjective)							
The following is a record of any symptoms you may have had in the past or are ongoing. Please check the appropriate boxes for each	**Never**	**Occasional**	**Frequent**		**Never**	**Occasional**	**Frequent**
GENERAL				**EYES**			
Feeling hot				Glasses			
Feeling cold				Blurry vision			
Fatigue				Double vision			
Irritable				Eye pain			
Nervous				**EARS**			
Hot/cold				Ringing/buzzing			
Chills				Drainage			
Sweats				Motion sickness			
Tremors				Loss of hearing			
Weight gain				**FACE/THROAT**			
Weight loss				Sinusitis			
HEAD/NEUROLOGIC				Frequent colds			
Headaches				Hoarseness			
Head injury				Problems swallowing			
Neck injury				Pain in chewing			
Dizziness				Pain in your jaw(s)			
Convulsions				Dentures			
Slurred speech				Problems smelling			
Memory loss				**LUNGS**			
Concentration problems				Tuberculosis			
Weakness				Asthma			
Strokes				Pneumonia			
Heavy head				Shortness of breath			
BONES/JOINTS				Chronic cough			
Arthritis				Wheezing			
Bursitis				Blood clots			
Tendonitis				Rapid breathing			
Carpal Tunnel				**HEART**			
Cramps/spasms				Palpitations			
Swollen joints				Rapid heart rate			
Pain between shoulders				Chest pain			
Back pain				High blood pressure			
Chiropractic treatment				Shortness of breath:			
Dislocations				-with activity			
Gout				-lying down			
Stiffness				Leg cramps (walking)			
Osteoporosis				Swollen feet/ankles			
Pain or numbness in:				**CIRCULATION**			
-shoulders				Varicose veins			
-arms				Blood clots			
-elbows				Easy bleeding			
-wrists				Anemia			
-hands				SKIN			
-hips				Pain			
-legs				Itching			
-knees				Dryness			
-feet				Eczema			
Painful tailbone				Rashes			
Poor posture				**GASTROINTESTINAL**			
Sciatica				Painful swallowing			
Spinal curvature				Regurgitation			
KIDNEYS/BLADDER				Indigestion			
Bed-wetting				Antacid use			
Blood in urine				Ulcers			
Frequent urination				Abdominal pain			
Painful urination				Nausea			
Kidney stones				Vomiting			
Urinary infections				Diarrhea (frequent)			
Incontinence				Constipation			
FEMALES ONLY				Blood in stool			
Painful menstruation				Bloating			
Irregular periods				Hepatitis			
Hysterectomy				Pancreatitis			
Are you pregnant? ____yes ____no				Gall bladder			
Pelvic pap smear							
Breast exam							
Mammography							
Libido							
Hot flashes							

Height: ____________________ Weight: ________________ BP __________________ P __________________



The Centeno-Schultz Clinic

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MATTER (CHECK ALL THAT APPLY):

❒ Home Telephone: _____________________
- ❒ Okay to leave a detailed message
- ❒ Okay to leave message with call back number only

❒ Work Telephone: _____________________
- ❒ Okay to leave a detailed message
- ❒ Okay to leave message with call back number only

❒ Written Communication:
- ❒ Okay to mail to home address: ____
- ❒ Okay to email me at this email address: __________________________________
- ❒ Okay to fax to this number: __________________________________

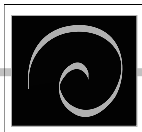
❒ Okay to leave info with specified people (i.e. attorney, spouse, friend):

____
____
____

Patient Signature ____ Date ____________________

Print Name ____ Date of Birth ______________

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.



The Centeno-Schultz Clinic

IMS/Trigger Point Injection Consent

Procedure: The procedure involves placing a needle into the muscle to break up "knots" and trigger points. With trigger point injections a small amount of lidocaine is injected.

Consent: Once you sign this form, you will only be verbally consented. That means that you will be asked if you give your permission to proceed. If you say yes, then you will not be given another written consent form.

Risks of the Procedure:
The biggest risk with any needle procedure is inadvertent puncture of a lung (pneumothorax). If this were to occur, it would likely only require a chest x-ray and no treatment. The symptoms of shortness of breath may last for several weeks.

A more severe lung puncture can require hospitalization and reinflation of the lung. We have never seen this complication. It has been reported only several times in world literature in the past 40 years.

Here is the risk of mild lung puncture (requiring no treatment) due IMS/TPI compared to everyday risks:

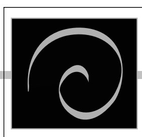
Activity	Risk
Dying on the road after 50 years of driving	1 in 85
Annual risk of death from smoking 10 cigarettes a day for 10 years	1 in 200
Death from taking Motrin type drugs for 2 months	1 in 1200
Death by an accident at home	1 in 7,100
Small Lung Puncture from IMS (no treatment needed)	1 in 15,000
Drowning in the bath in the next year	1 in 685,000
Being struck by lightning	1 in 10,000,000

Other possible risks include excessive bleeding, infection, and nerve injury. Clinically, we have only experienced 1 infection and 1 complication from a subdural hematoma in approximately 35,000 treatments. While rare, these complications can occur and are usually considered more uncommon than a mild lung puncture.

Consent to Procedure(s) and Treatment:
Having read this form and asked all questions, my signature below acknowledges that I voluntarily give my authorization and consent to the performance of the IMS procedure or trigger point injections described above by any Centeno-Schultz Clinic Staff, Physician, Physician Assistant, or IMS Practitioner.

Patient name, Printed: ______________________________________ Date of Birth: ______________________

Signed: ____ Dated: ______________________



The Centeno-Schultz Clinic

Referral Information

Tell us who referred you to our office:

- ☐ Internet – Internet Search Engine (i.e. Google, MSN)__________________
- ☐ Website – Website Name________________________
- ☐ Employer
- ☐ Physician
- ☐ Emergency Room
- ☐ Friend/Relative
- ☐ Self
- ☐ Magazine Article
- ☐ Other (specify)

Physician Information: Please provide information regarding your primary care physician and the physician who referred you to our practice.

Primary Care Information:

☐ No primary care physician

Practice Name: ____

Physician Name: ____

Address: ____

City: ___________________________________State:_____________________________Zip:__________

Telephone: _______________________________Fax:___________________________________

Referring Physician

☐ No referring physician

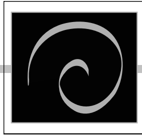
Practice Name: ____

Physician Name: ____

Address: ____

City: ___________________________________State:_____________________________Zip:__________

Telephone: _______________________________Fax:___________________________________



The Centeno-Schultz Clinic

Referral Information

Coordination of Care: Are you seeing any other Physicians, Physical Therapists, Chiropractors and/or Acupuncturists for this condition?

- ☐ Yes. If so, please provide information below
- ☐ No

1. Practice Name: ____

Physician/ProviderName: ____

Address: ____

City: ______________________State:__________________Zip:__________

Telephone: ______________________ Fax:______________________

2. Practice Name: ____

Physician/ProviderName: ____

Address: ____

City: ______________________State:__________________Zip:__________

Telephone: ______________________ Fax: ______________________

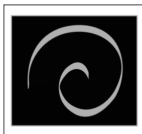
3. Practice Name: ____

Physician/ProviderName: ____

Address: ____

City: ______________________State: __________________Zip:__________

Telephone: ______________________ Fax: ______________________



The Centeno-Schultz Clinic

HIPAA Acknowledgement

Name of Patient: ________________________________ **Date of Birth:** _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 5/1/2011.

____________________________________ ______________________

Signature of Patient/Patient Representative Date

____

Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's
Notice of Privacy Practices

The patient presented to the office/hospital on ___/___/___ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

  ____

- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):

  ____

Signature of Employee Completing Form: ______________________________________

Date Signed: _____________________