ADVANCED PHYSICAL MEDICINE
AT BELL DISTRICT

Welcome to Advanced Physical Medicine at Bell District

We welcome you to our clinic and look forward to helping you with any health issues you have. We will make sure to address any questions or concerns you may have. Our team is committed to helping patients recover from injuries and resolve health concerns so that they can enjoy an active, healthy lifestyle.

Physical Medicine and rehab are most effective when you are committed to your health and follow the recommended treatment plan. Frequency and consistency are key to resolving your issues. Recovery and healing are a process, not a quick fix, and will have long lasting benefits.

Please acknowledge that while in our clinic, you will receive the best care if we have your undivided attention and your cell phone is not in use during your entire visit.

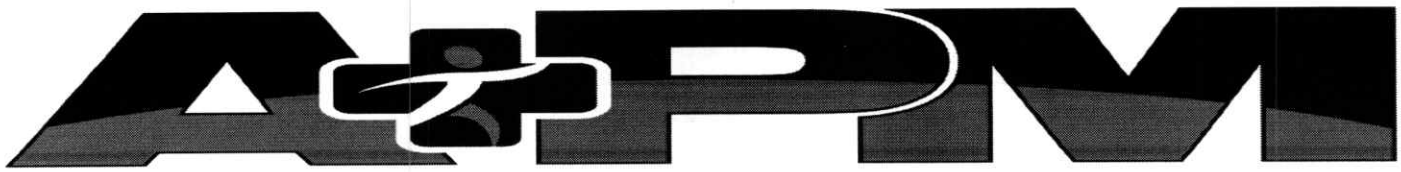
We love kids and your children are always welcome to join you in our clinic. For their safety and the well-being of all patients, please supervise your children while they are here. Please do not allow them to touch any of the fitness or treatment equipment.

We maintain a busy schedule and we really strive to stay on time. We respect your time and ask that you make every effort to be punctual so that you and fellow patients do not have to wait. If you need to cancel or reschedule and appointment, please know that we require a 24 hour notice. Failure to provide a 24 hour notice will result in a $50 fee. Please know that consideration will be given for illness or true emergencies.

If we are in network with your insurance provider, we will file insurance claims for you as a courtesy. Please know that this is not a guarantee of payment and that it is the patient's responsibility to communicate with the insurance company regarding any coverage disputes. Any unsettled accounts over 90 days past due will be sent to our collection agency unless acceptable payment arrangements have been made.

We are so glad you found us today. The majority of our patients come to us through referrals. We appreciate you passing on our information to your friends and family. We would also appreciate if you would take the time to post a review online. We understand that you have many options when it comes to your healthcare and we thank you for choosing Advanced Physical Medicine at Bell District.

PLEASE RETAIN FOR YOUR RECORDS



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New Patient Information and History

Date: _____ How did you learn about our office? _____

Name: _____ Date of birth: ____ / ____ /_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

SSN:_____-_____-_____ TXDL:_____

Person responsible for payment:_____ Relationship to patient:_____

Responsible party's date of birth: ____ / ____ /_____ Responsible party's SSN:_____-____-_____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____

I authorize doctors and/or staff to provide medical treatment to my minor son/daughter.

Parent's Printed Name:_____ Parent's Signature _____

Primary Care Physician:_____ Phone:_____

May we share information with your primary care physician in regards to your case? YES or NO

Have you been treated for other health conditions within the past year? If yes, please explain. _____

_____

Do you have any concerns about your visit today? _____

What is your primary reason for coming in today? _____

When did your problem begin? _____

Have you been treated for this condition in the past? _____ If yes, who was your provider? _____

If yes, what was your previous treatment? _____

Is there anything that makes this condition better? _____

Is there anything that makes this condition worse? _____

On a scale of 0-10, how would you rate your pain? (0=no pain to 10=unbearable pain) _____

Describe how your pain feels: _____

Describe where your primary pain is: _____

Is there a time of day when the condition is worse? _____

Do you have pain anywhere else? _____ If yes, where? _____

Advanced Physical Medicine at Bell District

Patient Name: _____ Today's Date: _____

Have you had any other injuries? _____ If yes, explain: _____

_____

Have you ever been hospitalized? _____ If yes, when and for what? _____

List medications you are currently taking: _____

_____

List vitamins and supplements you are currently taking: _____

_____

Are you Married? _____ Do you have children? _____

Do you use tobacco products or vape? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you use recreational drugs? _____

What is your Occupation? _____ Do you sit a lot? _____ Do you stand a lot? _____

Do you exercise? _____ If yes, what do you do and how often? _____

Do you eat a healthy diet? _____ What did you eat for your last meal? _____

Women: Are you pregnant? YES or NO Are you planning pregnancy? YES or NO

*If you have had a breast augmentation, please inform your doctor during the exam so that you can discuss alternative adjustment options.

Check all that apply:

- ☐ Allergy to Adhesive
- ☐ Artificial Heart Valve
- ☐ History of Accutane
- ☐ Recent Surgery (within 6 months)
- ☐ Artificial Implantable Device (cochlear implant, nerve stimulator, etc.)
- ☐ Active Cancer
- ☐ Blood Thinners
- ☐ Immunosuppressed
- ☐ Active Infection
- ☐ Defibrillator
- ☐ Pacemaker

Explain: _____

Family Medical History: Please mark if you or anyone in your family has a history of the following:

Arthritis	☐ Self	☐ Family	Cancer	☐ Self	☐ Family
Diabetes	☐ Self	☐ Family	Heart Disease	☐ Self	☐ Family
Stroke	☐ Self	☐ Family			

Other major health conditions we should be aware of: _____

Review of Systems

Patient Name: _____ Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

Advanced Physical Medicine at Bell District

Patient Name: _____ Today's Date: _____

Possible Non-Covered Services Declaration

While the vast majority of services performed at Advanced Physical Medicine at Bell District are covered by insurance, there are certain cutting edge treatments and products that some insurance policies do not recognize and therefore do not cover.

If you choose to receive non-covered services, you may be responsible for the full cost.

I understand that my health insurance coverage has certain restrictions and limitations and may not pay for the all of the services offered by Advanced Physical Medicine at Bell District. By choosing to obtain the services, I hereby consent and agree to be financially responsible for any and all related charges, if they are not covered by insurance.

Printed Name of Patient:_____

Signature of Patient or Authorized Representative: _____ Date: _____

Cancellation and Late Arrival Policy

24 hour notice is required for any appointment changes or cancellations. Failure to contact the office at least 24 hours prior to your appointment for any changes or cancellations will result in a $50 missed appointment fee. Consideration will be given in the cases of true emergencies. If we have availability to reschedule you for another time within the same day, the $50 fee will be waived. Appointments may be cancelled or changed through our online scheduling system or by calling the office.
Please do not email the office regarding appointment changes.
Please arrive promptly for your appointments so we can keep doctors and patients on time. Please allow yourself time to change clothes, if necessary, prior to your appointment time. Please call the office if you are running late for your appointment. We will always do our best to accommodate you, but if you arrive 15 minutes or more after your scheduled time we may need to reschedule you for another day or time.

I understand the above stated Cancellation and Late Arrival Policy. _____ patients initials

Please read the following carefully:

I have answered the information to the best of my ability. I have not purposely omitted information or represented false information about myself. If I become aware of new information, I will notify the doctor or staff immediately.
I understand that insurance billing is a service provided as a courtesy and that I am financially responsible to Advanced Physical Medicine at Bell District and/or its affiliated entities for any charges not covered by health insurance benefits. It is my responsibility to notify Advanced Physical Medicine at Bell District of any changes in my health insurance coverage. In some cases exact insurance benefits cannot be determined until the insurance company processes the claim. I am responsible for the entire bill or the balance of the bill as determined by Advanced Physical Medicine at Bell District and/or my health insurance carrier if any part of the submitted claims are denied for payment. Account balances that remain unpaid for more than 90 days will be forwarded to a collection agency.

With my signature I hereby authorize direct remittance of payment of all insurance benefits, including Medicare if applicable, to Advanced Physical Medicine at Bell for all covered medical services and supplies provided to me during the course of treatment.

Signature of Patient or Authorized Representative: _____ Date: _____

Advanced Physical Medicine at Bell District

Patient Name: _____ Today's Date: _____

Use and Disclosure of Protected Health Information

Advanced Physical Medicine at Bell District may use my protected health information and may disclose such information to others for the purpose of treatment, determining insurance benefits, obtaining payment, or supporting the day-to-day healthcare operations of this office. You should review the attached Notice of Patient Privacy Policy for a more complete description of how your protected health information may be used or disclosed.

I have received the **Notice of Patient Privacy Policy**. _____ patients initials

Notice of Treatment in Open or Common Areas

Open/common areas are used for some treatments and therapies. Private areas are always available to discuss your health information upon request.

Appointment Reminders

Appointment confirmations and reminders will be automatically sent via secure, encrypted email. In addition, patients have the option of receiving reminders via text message. Text messages are not encrypted and therefore should not be considered a secure form of communication. Appointment reminders contain the patient's name and details about the scheduled appointment, but not personal health information.

With my signature I hereby acknowledge the privacy practices of this office and consent to the use and disclosure of my health information as outlined in the Notice of Patient Privacy Policy.

Signature of Patient or Authorized Representative: _____ Date: _____

Protected Health Information (PHI) Communication Authorization

I authorize Advanced Physical Medicine at Bell to disclose any and all details of my diagnoses and treatment, billing information, and/or appointment information to the named individuals as indicated below. This authorization is voluntary and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my **protected health information (PHI)** may be disclosed to additional individuals based on my written authorization or as indicated in our *Notice of Patient Privacy Policy*. This authorization shall remain in effect indefinitely unless revoked in writing by me.

☐ **I elect not to authorize disclosure to any individuals at this time.** _____ patients initials

Check all that apply	**First and Last Name**	**Relationship**	**Phone Number**
☐ Medical ☐ Billing ☐ Appointments			
☐ Medical ☐ Billing ☐ Appointments			
☐ Medical ☐ Billing ☐ Appointments			
☐ Medical ☐ Billing ☐ Appointments			