MEDICAL REGISTRATION AND HISTORY

Last name:_____ **First name:**_____ **Middle Initial:**_____
Address:_____
City:_____ **State:**_____ **Zip code:**_____
Phone number:_____ **SSN:**_____
E-mail:_____ **Date of Birth:**_____

Emergency contact name:_____ **Phone Number:**_____

Date of last physical examination:_____ **Reason for visit:**_____

MEDICAL HISTORY

(Check symptoms you currently have or have had in the past year.)

General:

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fever
- ☐ Headache
- ☐ Loss of weight
- ☐ Forgetfulness

Gastrointestinal:

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting

Cardiovascular:

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

Muscle/Joint/Bone Pain:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulder

Eye/Ear/Nose/Throat:

- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Loss of hearing
- ☐ Nose bleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

Skin:

- ☐ Hives
- ☐ Itching/Rash
- ☐ Scars
- ☐ Bruise easily
- ☐ Sore that does not heal

Men only:

- ☐ Erectile dysfunction
- ☐ Lump in testicles
- ☐ Penile discharge
- ☐ Sores on penis
- ☐ Other

Women only:

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot Flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Genitourinary:

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Check conditions you have or have had in the past.

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart
- ☐ Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ AIDS

***Current medications:** _____

_____

_____

***List allergies to medications/substances:** _____

_____

***Preferred Pharmacy name and phone number:** _____

_____

***Signature of Patient:** _____ **Date:** _____

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II

Health Information I would like to give the above healthcare organization permission to:

Mark as appropriate:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information Other
- ☐ (Specify) _____

Section III – Who Can Receive My Health Information:

I give authorization for the health information detailed in Section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section IV – Duration of Authorization

This authorization to share my health information is valid:

Mark as appropriate:

☐ From _____ to _____

Or

☐ All past, present, and future periods

Printed name:_____ Signature:_____

Date:_____

Controlled Substances Contract
Ronnie Mandal DO SC

Controlled substances medications (i.e. Narcotics, tranquilizers and barbiturates) are very useful, but have a high potential for misuse and are therefore closely controlled by the local, state and federal government. They are intended to relieve pain, improve function and/or the ability to work, NOT simply to feel good. Because my physician is prescribing such medication to help manage my pain or improve my functioning, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If a prescription or medication is lost, misplaced or stolen, or if I finish sooner than prescribed, I understand that it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while receiving such medications from Dr. Mandal. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted as a patient in a hospital,
3. Refills of controlled substances: **a)** Will only be made during regular office hours. **b)** Will not be made if "I run out early", "spill or misplace the medication". I am responsible for taking the medication in the dose prescribed and keeping track of the amount remaining. I accept that I must be seen for a follow up office visit at least every three months.
4. It may be deemed necessary by my doctor for me to see a medication use (addition) specialist at any time while I am receiving controlled substances. I understand that if I do not attend this appointment that my medications may not be continued or refilled. I understand that if this specialist feels I am at risk for psychological dependence (addiction) my medications will no longer be refilled.
5. I agree to comply with random drug screen, blood, mouth swab or random call in pill counts, documenting the proper use of my medications as well as confirming compliance.
6. I understand that if I violate any of the above conditions, my controlled substance medications and my treatment with Dr. Mandal may be terminated immediately. If the violation involves obtaining controlled substances for another individual or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to my other physicians, medical facilities, and the appropriate authorities.
7. I understand that the main treatment goal is to improve my ability to function and/or reduce pain. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by the following better health habits: exercise, weight control, avoiding the use of tobacco and alcohol. I must comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle, I can hope to have the most successful outcome to my treatment.
8. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be determined and that treatment may change throughout my time as a patient of Dr. Mandal. I understand and accept and agree that there may be unknown risks associated with long-term use of controlled substances, and that my physician will advise me as knowledge and training advances and will make appropriate treatment changes.

I have been fully informed in this contract by Dr. Mandal regarding psychological dependence (addiction) of a controlled substance. I know some people develop a tolerance and need to increase the dosage to achieve the desired effect and I know that I may become physically dependent on the medication. This will occur if I am on medication for several months. When I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

Date_____ Print Name_____ Signature_____

Drug Screening Policy
Ronnie Mandal DO SC

Dear Patient,

Should you be prescribed a controlled medication, please understand that you are a subject to our drug screen policy via a urine or saliva test. The goal of drug screening is to optimize patient care and safety and to reduce the risk of opiate therapy. In addition, we hope to identify patients who are at high risk for abuse and diversion of their controlled substance prescription.

It is essential to have a policy regarding the indications and frequency of drug testing. This will aid in making sure all patients are approached equally and that the drug test is administered effectively and objectively. Testing objectives are as follows:

- Identifies the presence of prescribed medications and potential for abuse, misuse and diversion.
- Identifies undisclosed substances, such as alcohol, unsanctioned prescription medication or illicit substances.
- Identifies substances that contribute to adverse events or drug-drug interactions.
- Provides objectivity to the treatment plan.
- Reinforces therapeutic compliance with the patient.
- Provides additional documentation demonstrating compliance with patient evaluation and monitoring.
- Provides diagnostic information to help assess individual patient response to medications (e.g. metabolism, side effects, drug-drug interaction etc.) over time for ongoing management of prescribed medications.

We adhere to the following federal recommendations:

1. **Chronic Opioid Baseline Testing:** Patients prescribed a controlled medication will be subject to baseline testing. The expected test results may include positive results from their medications prescribed by another provider and negative results for other controlled substances and illicit drugs.
2. **Periodic Monitoring/Testing:** Patients prescribed a controlled medication will be subject to periodic testing at a minimum of twice yearly. It is necessary to document compliance and/or identify abuse and diversion of controlled medications or abuse of illicit drugs.
3. **Miscellaneous Testing Reasons:**

    - Patient response to prescribed medications suddenly changes
    - Patient side effect profile changes
    - To assess possible drug-drug interactions
    - Patient admits to use of illicit or non-prescribed controlled substance
    - Assess patient prior to a major or minor surgical procedure

Please note that if, during the course of your treatment on controlled medication, you are referred to a Pain Management doctor, you will be subject to said doctor's drug screen policy.

I have read the above drug screen policy and understand that refusal to comply may result in being discharged from the practice as well as discontinuation of any controlled medication that has been prescribed.

Date	Print Name	Patient's Signature

Office Financial and Billing Policy

Below you will find a list of our office billing policies. These are NON- NEGOTIABLE policies and apply to every patient account.

1. You are responsible for notifying our office if your insurance, address, phone number, or any other pertinent information has changed in any way. We need this information in order to properly write orders for your medications, labs, radiology tests and referrals.

2. Co-payments are expected at the time of check-in. We offer numerous methods of payment including cash, credit card, and check. If you are unable to provide your co-payment at the time services are rendered, you will be asked to reschedule your appointment.

3. We participate in most insurance plans, including Medicare. If you are not insured by a plan that we accept, payment in full is expected at each visit.

4. Billing statements are sent out on the first of every month (30-day cycle). Contained within is a breakdown of the payment(s) received from the insurance company for services rendered, and your balance due on the claim.

5. If your balance is over 90 days past due, you will receive a letter stating that you have 30 days to pay your balance in full. Partial payments will not be accepted unless otherwise negotiated.

6. Failure to comply will result in your account being sent to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

7. There is a $25.00 fee for missed appointments or same day appointment cancellations. These charges will be your responsibility and will be billed directly to you.

By signing below, I acknowledge that I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**