HOW DID YOU HEAR ABOUT US?

Let us know how you found us!

Please select one option

Word of Mouth: ☐ **Friends** ☐ **Family**

Please Specify Name:

Physician Referral:

Please Specify Name:

- ☐ **TV Commercial**
- ☐ **Dallas Morning News**
- ☐ **Fort Worth Star-Telegram**
- ☐ **Frisco Style**
- ☐ **Celebration Magazine**
- ☐ **Denton Record-Chronicle**
- ☐ **FYI 50+**
- ☐ **Community Impact**
- ☐ **FYI 50+**
- ☐ **Pioneer Press**
- ☐ **Facebook**
- ☐ **Google**
- ☐ **Yelp**
- ☐ **Other:** *Please specify*

Name: _____

DFW Neuropathy Centers

Demographic/Insurance Verification form

(Please fill this form out completely)

Please hand your medication list and insurance cards to the receptionist so we can make a copy for you chart.

Date:_____

Patient Full Name: _____ Male / Female

Address: _____ DOB: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ -_____- _____Email address: _____

Employer: _____ Work Phone: _____

Spouse / Emergency contact information:

Name: _____ DOB: _____ M or F

Home phone: _____ Work Phone: _____ Relationship to pt: _____

Primary Care Doctor *:*

_____ **Phone:** _____

Referring Doctor *:*

_____ **Phone:** _____

Ethnicity:

Hispanic [ ]yes [ ]no Primary Language _____ Additional Language _____

Race:

[ ]American Indian/Alaska Native [ ]Asain [ ]Black or African American

[ ]Native Hawaiian or other Pacific Islander [ ]White [ ]Other Race_____

DFW Neuropathy-HIPAA Form

Consent for Treatment and Payment Agreement

I hereby authorize DFW Neuropathy to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare providers of DFW Neuropathy may refuse to treat me. I authorize the physicians to administer such treatment as they deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, PA (physician assistant) or NP (nurse practitioner) and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered valid as original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you may be responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain referral forms from your primary care physician when and if required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred. I have fully read and understand the above payment policy. I agree to forward to DFW Neuropathy, all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I request this authorization also apply to all other insurance.

***Patient Signature**_____**Date**_____

RELEASE OF MEDICAL INFORMATION

Please let us know the names of which we may release health information to or may be allowed to enter the exam room during discussion regarding health information. I understand that at any time a physician, PA, NP and/or a medical assistant will be present in the exam room for training purposes and I may request individuals to leave the exam room at any time.

Authorized persons	(Information)		(Exam Room)	
_____	Y	N	Y	N
_____	Y	N	Y	N
_____	Y	N	Y	N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

What information may we release?

_____All PHI (Personal Health Information)
_____Office notes
_____Lab/ Diagnostic test results
_____Appointment information
_____Prescription
_____Billing information
_____Other

This information may be released by:

_____Phone#_____
_____Fax #_____
_____Mail: Address_____
_____Other (please be specific)_____

***Patient Signature**_____**Date**_____

Notice of Privacy Practices

I hereby acknowledge that I have received or been provided the opportunity to receive a copy of the HIPAA privacy policies and understand that any questions or complaints may be addressed to the Privacy Office (Office Manager) without penalty.

***Patient Signature**_____**Date**_____

DFW Neuropathy

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____Date of Birth: _____
Phone: H) _____ Phone: W) _____
Address: _____ City/State/Zip: _____

Above listed patient authorizes the following healthcare facility to make record disclosure:
Facility Name: _____ Facility Phone: _____
Facility Address: _____ Facility Fax: _____
City, ST, Zip: _____

Release To: _DFW Neuropathy_____
Address: _2435 W. Oak St. Ste 101_____
City, State, Zip: _Denton, TX 76201_____ □ **Please mail records**
Phone: (940) 320-0022____Fax: (940) 320-0023_____ □ **Please fax records**

Dates and Type of information to disclose:
- □ 2 years prior from last date seen
- □ Dates Other: _____
- □ Specific Information Requested:

_____

The purpose of disclosure is:
- □ Change of Insurance or Physician
  - □ Continuation of Care
- □ Referral
- □ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:
I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

New Knee Patient Questionnaire Form

Name: _____
Date: _____
Time: _____
PCP: _____
PCP number: _____
Referred by: _____

CHIEF COMPLAINT: What are you here to see the doctor for? _____

TIMING OF PAIN/ ALLEVIATING AND AGGRAVATING FACTORS

When did you first notice pain or problems with the knees? _____

What were the symptoms (pain, numbness, popping, etc,) _____

When did this current pain begin? _____

What kinds of things make your pain feel better?_____

What kinds of things make your pain feel worse? _____

DURATION OF PAIN

How long have you had the pain problem you are currently experiencing (in months and years)? _____

What caused your current pain to start? _____

How often do you have your pain?

____a. Constantly (80-100% of time) ____c. Intermittently (25-81% of time)

____b. Nearly constant (50-80% of time) ____d. Occasionally (less than 25% of time

Past Treatment	Did it give you relief? For how long?	When and why did you discontinue?

MEDICATIONS: Please provide our office with a list of any and all medications, dosages, how many times per day and for how long you have been taking them. Your physician will go over this list with you.

Please circle **YES** or NO to the following questions. This will aid us in completing your medical history.

1. Do your knees crack, pop, or give you pain? □ Yes □ No – Details _____
2. Do you suffer from weakness in your back or neck? □ Yes □ No – Details _____
3. Do you have weakness in your in your arms or hands? □ Yes □ No – Details _____
4. Do you suffer from burning in your legs or feet? □ Yes □ No – Details _____
5. Do your legs or knees buckle or ever give away? □ Yes □ No – Details _____
6. Have you ever had any knee injections? □ Yes □ No – How often_____
7. Have you ever had any knee surgery? □ Yes □ No – How often_____
8. Do you frequently trip or catch your toe when walking? □ Yes □ No – Details _____
9. Have you ever been diagnosed with Arthritis? □ Yes □ No – Details _____
10. Do you ever suffer from dizziness? □ Yes □ No – Details _____

Hyalgan Osteoarthritis Knee Treatment Program

Medical Necessity and Prescription –Initial

Patient Name _____ Date of Birth: _____ Date: _____

Please complete the following information about your knee(s) pain/stiffness:

Circle the number that best describes how your pain has interfered with your:

a. a. **Walking ability:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

b. **Sitting:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

c. **Standing:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

d. **Normal Daily Activities:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

e. **Mood:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

f. **Normal Work (includes both work outside the home and housework):**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

g. **Sleep:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

h. **Family Relationship:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

i. **Relationship with your spouse/partner:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

j. **Social activities with other people:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

k. **Enjoyment of life:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Meaning = Impairment score: 0-20 = Mild; 21-40 = Moderate; 41-60 = Severe; 61-100 = Very severe

INITIAL TREATMENT GOALS: Please list specific goals you would like to achieve by your treatment.

Example: Return to previous employment, to be able to play golf, to be able to walk my dog, to be able to dress myself, etc.

Comments:_____

Stop here – Please turn your paper(s) into a staff member.

11. Do you have difficulty maintaining your balance? □ Yes □ No – Details _____
12. Do you frequently trip or catch your toe when walking? □ Yes □ No – Details _____

Scarlet Fever	Yes	No	Diabetes	Yes	No	Skin Disorders	Yes	No
Measles	Yes	No	High Blood Pressure	Yes	No	Tumor, Cancer, Cysts	Yes	No
German Measles	Yes	No	High cholesterol	Yes	No	Venereal Diseases	Yes	No
Rheumatic Fever	Yes	No	Dizziness/Fainting	Yes	No	HIV +	Yes	No
Mumps	Yes	No	Weakness/Paralysis	Yes	No	Hepatitis	Yes	No
Chicken Pox	Yes	No	Insomnia	Yes	No	Problems with Urination	Yes	No
Malaria	Yes	No	Frequent Anxiety or	Yes	No	**FEMALES ONLY**		
Tuberculosis	Yes	No	Depression	Yes	No	No. Of Pregnancies	Yes	No
Gum or Tooth Problems	Yes	No	Recurrent Headaches	Yes	No	Irregular Periods	Yes	No
Sinusitis	Yes	No	Recurrent Colds	Yes	No	Severe Cramps	Yes	No
Eye Trouble	Yes	No	Gallbladder Disease	Yes	No	Excessive flow	Yes	No
Ear, Nose, Throat	Yes	No	Bloody Stools	Yes	No	**IMMUNIZATIONS**		
Head Injury	Yes	No	Recurrent Diarrhea	Yes	No	MMR-Measles/Mumps	Yes	No
Hay Fever/Allergies	Yes	No	Jaundice/Hepatitis	Yes	No	Polio	Yes	No
Asthma	Yes	No	Stomach Problems/Ulcers	Yes	No	DPT	Yes	No
Shortness of Breath	Yes	No	Recent Weight Gain or loss	Yes	No	Tetanus	Yes	No
Emphysema	Yes	No	Joint Disease	Yes	No	Flu Shot	Yes	No
Chest Pain/Pressure	Yes	No	Back Problems	Yes	No	Pneumovax	Yes	No
Chronic Cough	Yes	No	Sciatica	Yes	No	Mammogram	Yes	No
Rapid Heart Beat	Yes	No	Neck Pain	Yes	No	Flexible Sigmoidoscopy	Yes	No
Heart murmur	Yes	No	Do you take any blood thinners	Yes	No	Colonoscopy, rectal Exam	Yes	No

1) List Hospitalizations & Surgery Dates: (Exact dates are not necessary; your doctor will discuss this with you).

Hospitalizations	Dates	Surgeries	

2) Do you smoke, or have you ever smoked? ____Y ____N
   a. If so, how much? _____cig/day, ____packs/day, and for how long? _____months, ____years
   b. If you quit, when? ____ how much? ___cig/day, ___packs/day, for how long? ___months, ___years
   c. Any significant alcohol use? ____Y ____N Any Illicit Drug use? ____Y ____N
   d. Please provide the receptionist with a list of all your medications, Rx and non-Rx.
   e. Are you Allergic to any Medications?

3) FAMILY MEDICAL HISTORY:
   a. Father: _____Alive? _____ State of Health_____
   Deceased? ____Age at Death _____ Cause of Death:_____
   b. Mother: _____Alive? _____ State of Health_____
   Deceased? ____Age at Death _____ Cause of Death:_____

_____ _____
Patient Signature Date

DFW Neuropathy

Patient Name:	DOB:
Allergies:	

Medication List

Name of Medicine / Dose(mg)		Directions	Used for	Notes
ex.		*1 tablet twice a day*	*Diabetes, type 2*	

Patient Scheduling Compliance Agreement

In treating your Peripheral Neuropathy ("PN"), there are some very important aspects for you to acknowledge. First, to achieve success it is critical that you plan for the time commitment needed to successfully treat your condition. The length of time needed can vary greatly depending on the causes of your condition, the extent of PN, and the ability of your body to respond to the treatment protocol. **Once you have started the treatment regimen, it is extremely important to adhere to your treatment schedule.**

Missed appointments can dramatically affect the treatment outcome and your overall long term progress. The treatment process and its improvements is diminished if you have a pattern of starting and then missing successive appointments. In addition, insurance payers may review your treatment process based on medical necessity. If they detect a pattern of starting and stopping treatments, they may question coverage. **You do not want to jeopardize your coverage by repeatedly missing appointments.**

Treatment times can range from eight (8) weeks to as much as sixteen (16) weeks depending on the severity of your PN, your body's healing ability, and the outcomes achieved during your treatments. Since continuity of treatment is critical, please choose a time frame where you are confident you can adhere to within your treatment schedule. We realize that from time to time "emergencies", holidays, and vacations do arise that may prohibit you from meeting your treatment schedule.

Please carefully consider the impact of treating your PN when making the decision to cancel a treatment.

We want the very best possible outcome for you and would like you to acknowledge the importance of following your treatment schedule by signing the following commitment.

I _____, am committed to adhering to the minimal time required to allow The DFW Neuropathy Professional and Medical Support Staff to treat me for my Peripheral Neuropathy. A member of the staff has reviewed the approximate treatment schedule with me. I understand that the actual time could be less or more depending on my response to the treatments and my medical necessity after the initial Evaluation and each Re-Evaluation. I also acknowledge that should an emergency situation arise, I will try to give at least a **48 hour advance notice** to reschedule my treatment. I also acknowledge that my adherence or absence to my treatments also effects the availability of the overall treatment to other patients with Peripheral Neuropathy; therefore, for all other reasons of missing my treatments I will reschedule my treatment days at the time of calling and cancelling my current treatment.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

_____

Title

DFW Neuropathy Knee Permit Consent Form

Written Consent: Consent to do procedure, anesthetics, and other medical services.

1. I, _____authorize the performance for the following procedure(s): Hyalgan knee injection(s) of the lower extremities to be performed under the direction of the DFW Neuropathy physician and/or medical staff including any additional indicated procedures such as knee aspiration(s).
2. I consent to the performance of procedures in addition to or different from those completed, whether or not arising from presently unforeseen conditions, which the above named doctor or his associate or assistants may consider necessary or advisable in the course of the procedure.
3. I consent to the administration of such medications or anesthetics as may be considered necessary or advisable by the physician responsible for the service including similar subsequent procedures.
4. I consent to the photographing or television of the procedures to be performed, including appropriate portions of my body for medical, scientific or educational purposes.
5. For the purpose of advancing medical education, I consent to the admittance of observers to the procedure room.
6. The nature and purpose of the procedure, benefits, alternative methods of treatment, risks involved, the possible consequences and the possibility of complications have been explained to me by the physician and/or medical staff. This explanation has been explained to me in a non-medical language in which I understand. I further acknowledge that the procedure is an elective, non-emergency type of therapy/surgery and that I have thought over all the information that the physician and/or medical staff has given me.
7. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained. Although an excellent result is expected, the possibility of complications could arise. They may or could include although not limited to:

A. Knee Swelling/effusion	B. Local bleeding	C. Condition no better	D. Joint swelling
E. Local skin reaction	F. Injection site pain	G. Delayed healing	H. Joint infection
I. Gastrointestinal complaints	J. Headache	K. Medication reaction	L. Joint stiffness

The above has been explained to me in non-medical terms and I acknowledge that all the underlined spaces on this document have been completed and explained to me prior to signing.

_____ _____

Patient signature Date

_____ _____

Physician signature Date