DT MEDICAL CONSULTING
PATIENT REGISTRATION

Name:_____ Date of Birth: _____

Address: _____

City: _____ Zip: _____ Cell: _____

Social Security Number:_____E-mail Address: _____

Gender: Female ☐ Male ☐ Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

Attorney Name/Group: _____

Police Report: Yes ☐ No ☐ **(Please provide copy of the police report)**

Third Party Insurance:_____Phone: _____

Claim #:_____Adjuster Name: _____

Emergency Contact

Name:_____Relationship:_____Telephone: _____

PERMISSION TO DISCUSS MEDICAL INFORMATION/TEST RESULTS WITH:

1._____2._____3. _____

INSURANCE PAYMENT/FINANCIAL RESPONSIBILITY RELEASE

I request that payment insurance benefits be made to either me or on my behalf to DT Medical Consulting, PLLC for any services furnished to me by the Physician/Provider. I authorize any holder of medical information concerning me to be released to my insurance carrier or Health Care Financing, its agents; any information needed to determine these benefits or the benefits payable for related services. A photocopy of this authorization shall be considered effective and valid as the original. I understand that I am financially responsible for all charges not covered by my insurance company.

Signature:	Date:

Notice of Privacy

***To Our Patients*:** This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

- Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
- We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.

Your rights regarding your health information

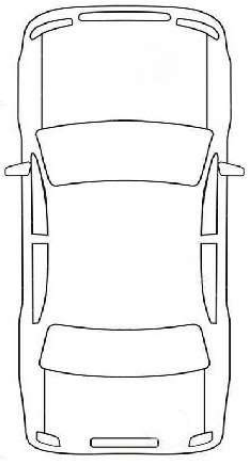
1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests
2. You can request a restriction of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing.
5. Right to copy this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
8. I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy

Print Name:_____Signature:_____Date: _____

Date of Accident:_____/_____/_____
To what was this injury related? ☐Auto ☐Work ☐Other
If work related, what is name of your employer: _____
Were you the: ☐Driver ☐ Passenger
If passenger, where were you sitting: ☐Front Seat ☐Back Seat _____
Seatbelt: ☐Yes ☐No
Airbag deployed: ☐Yes ☐No
Head Injury: ☐Yes ☐No If yes, what did your head hit? _____
Did you experience: ☐Shock ☐Loss of Consciousness ☐Whiplash ☐Other _____

Mark where your car was impacted:



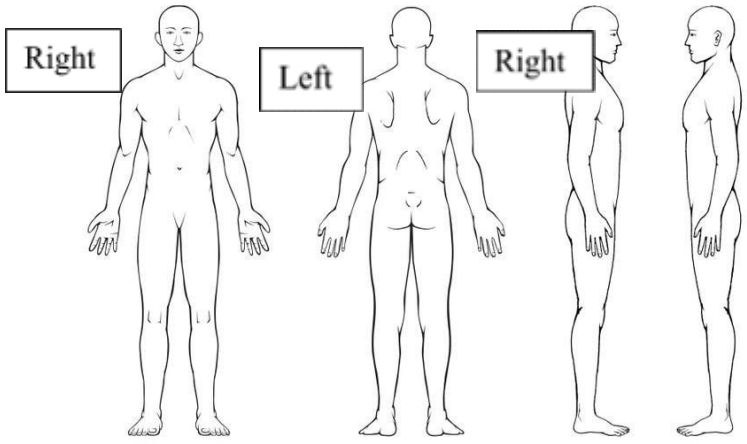
☐Rear-ended ☐Head-on ☐Broad-sided

Speed of your vehicle: _____ -or- ☐ Stopped
Approx. speed of other vehicle _____
Type/Size of vehicle that hit you _____
_____

Describe Accident:
_____
_____
_____
_____
_____
_____

Please mark the areas on the body where you are experiencing pain:
Stabbing/Cutting = ///// Tingling = ****** Burning = XXXX Cramping = ^^^^^ Numbness = NNNN Dull = ####

Front Back Right Left



The pain is located:
_____
_____
_____
_____
_____

Tingling/Numbness ☐No ☐Yes If so, where
_____

The pain is ☐Constant ☐Comes & goes

What makes pain worse _____
What makes pain better _____

PAIN RATING: On a scale of 0 –10, rate your pain:

No Pain Severe Pain
0 1 2 3 4 5 6 7 8 9 10

The pain is described as ☐Achy ☐Soreness ☐Throbbing ☐Tightness ☐Muscle spasms ☐ Stiffness ☐Burning ☐Sharp-shooting ☐Tingling ☐Numbness ☐ Stabbing ☐Deep-pressure

The pain impairs your ability to perform: ☐Household chores ☐Work ☐Drive ☐Walk ☐Run ☐Play sports

It has had a negative impact emotionally causing problems with: ☐Concentration ☐Depression ☐Anxiety ☐ Mood ☐ Appetite ☐ Sleep ☐ Relationships

OTHER DOCTORS SEEN for this injury:
☐Chiropractor ☐Orthopedist ☐Neurologist ☐Psychiatrist ☐General Practitioner ☐Other _____
☐Emergency Room (after accident)

Chiropractor Name: _____

Treatments you have had for this injury:
☐Trigger Point ☐Joint Injections ☐Epidural Injections ☐Acupuncture ☐Hot packs ☐TENS unit ☐Back Brace ☐Other: _____

List the types of Diagnostic Testing that has been performed for this problem:
☐ X-Rays ☐CT Scan ☐MRI Scan ☐EMG/NCS

SOCIAL HISTORY:
☐Non-Smoker ☐Smoker How many per day _____
☐Do not drink alcohol ☐ Drink alcohol How often _____
☐Do not take drugs ☐Take Drugs _____

MEDICAL HISTORY:

List any medications you are currently taking:

NAME OF MEDICATION	DOSAGE	WHEN DO YOU TAKE	HOW OFTEN

Allergies to medications: YES NO If yes please list: _____
Reaction: _____

MEDICALHISTORY:
Do you have or have you ever had any of the following:

Respiratory:		**Cardiovascular:**	
Bronchitis	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Emphysema	☐Yes ☐No	Chest Pain	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Attack	☐Yes ☐No
Chronic Cough	☐Yes ☐No	Heart Murmur	☐Yes ☐No
Morning Cough	☐Yes ☐No	Arrhythmia	☐Yes ☐No
Shortness of Breath	☐Yes ☐No	Phlebitis	☐Yes ☐No
Wheezing	☐Yes ☐No	Artificial Valve	☐Yes ☐No
		Pacemaker	☐Yes ☐No
Other Systemic:			
Hepatitis	☐Yes ☐No	Stomach absorptive disorder	☐Yes ☐No
Diabetes	☐Yes ☐No	Arthritis/joint Deformity	☐Yes ☐No
Thyroid Problems	☐Yes ☐No	Artificial Joint	☐Yes ☐No
Kidney Disease	☐Yes ☐No	Convulsions	☐Yes ☐No
Dialysis	☐Yes ☐No	Epilepsy, Seizures	☐Yes ☐No
Bladder Problems	☐Yes ☐No	Fainting	☐Yes ☐No
		Depression	☐Yes ☐No

OTHER: _____

List Past Surgeries:

_____

_____

List previous back, neck and musculoskeletal problems prior to this injury:

_____

_____

Family Medical History:
Mother's Medical Problem: _____
Father's Medical Problem: _____

Signature_____Date _____

ASSIGNMENT, LIEN, AUTHORIZATION OF INSURANCE BENEFITS AND POWER OF ATTORNEY

Name of Patient:_____Date of Accident: _____

I hereby authorize and direct any insurance company and/or my attorney to pay directly DT Medical Consulting, PLLC sums as may be due and owing the office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office.

I hereby further give a lien to said Office against any and all insurance benefits that I may be entitled to and any and all proceeds for any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

I hereby assign all of my interest and rights to PIP benefits, which shall include, but not be limited to the right to file a PIP suit or seek arbitration for PIP benefits relative to treatment by said Office. I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against any insurance carrier that may be liable for payment of PIP benefits, and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit. Further, in the event that the within assignment is not consented to by an insurer or in any other manner is held invalid by any party, arbitrator or any other person, I hereby give this Office the power of attorney to bring any arbitration proceeding or suit in my name on my behalf as if I had filed such action myself. I further agree to fully cooperate with regard to prosecuting such action or proceeding.

I understand that I remain personally responsible for the total amounts due the Office for services, subject to Arizona law. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. I further understand and agree should I receive any payments made on my behalf from any insurance company I will endorse the check over to DT Medical Consulting, PLLC within 30 days of my receipt of same and fully understand that failure to do so will result in collections procedures against me.

I authorize this Office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization, so long as the request is submitted in writing. I agree that the above mentioned Office is hereby given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bill. I further authorize any insurance company and any other physicians who have treated me for this accident to provide this Office with any documentation needed, with regard to the payment of my bills.

Patient Signature:_____Date: _____

DT MEDICAL CONSULTING, PLLC

2990 N. Litchfield Road, Suite #4
Goodyear, AZ 85395
Phone: 623-323-2750

6305 W. McDowell Road, Suite #4
Phoenix, AZ 85035
Fax: 623-321-9069

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

RELEASE OF MEDICAL RECORD

Patient Name:_____ Birthdate:_____

Address: _____

Phone Number: _____

To/From: _____

Phone: _____ Fax: _____

□ Medical Record

I understand:

1. I may revoke this authorization except to the extent that it has already been acted upon.
2. Treatment may not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
3. Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
4. Unless other revoked, this authorization will expire three (3) years from the date of my signature.
5. I may have signed copy of this authorization.

_____ _____
Patient or Personal Representative's Signature Date