

**MANCHESTER OSTEOPATHIC HEALTHCARE
PATIENT REGISTRATION FORM**

PATIENT NAME: _____ DATE: _____

STREET ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NO: _____ SEX: _____ DATE OF BIRTH _____

SSN : _____ WORK PHONE NO: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

EMERGENCY CONTACT NAME AND PHONE NO.: _____

INSURANCE INFORMATION

Is this a worker's compensation injury? yes no I don't know

If yes, please ask the receptionist for worker's compensation claim form which must be completed.

Is this a personal injury or automobile accident claim? yes no I don't know

If yes, do you have an attorney? yes no Please complete the auto/liability claim form, which is available from the receptionist.

1) PRIMARY HEALTH INSURANCE PLAN NAME: _____

INSURANCE ID#: _____ GROUP ID#: _____

SUBSCRIBER'S NAME (if different than patient) _____

SUBSCRIBER'S SS# _____ DOB: _____

2) SECONDARY INSURANCE PLAN NAME: _____

INSURANCE ID#: _____ GROUP ID#: _____

SUBSCRIBER'S NAME (if different than patient) _____

SUBSCRIBER'S SS# _____ DOB: _____

This section only needs to be filled out if patient is under the age of 18

MOTHER'S NAME: _____ FATHER'S NAME: _____

STREET ADDRESS: _____ STREET ADDRESS: _____

City, State, ZIP: _____ City, State, ZIP: _____

SS#: _____ DOB: _____ SS#: _____ DOB: _____

MANCHESTER OSTEOPATHIC HEALTHCARE FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked and initial it.

_____ Patient with Insurance: You are responsible for deductibles, copays, noncovered services, coinsurance, and items considered “not medically necessary” by your insurance company. Co-payment amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

_____ Patient without Insurance (Private Pay): Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to visit to meet with our billing specialist.

_____ Worker’s Compensation Patient: As a Worker’s Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Please be sure to inform the office personnel that injury resulted during employment. Your health insurance information will also be obtained as we may bill your health insurance company in the event that your worker’s compensation claim is controverted (disputed). You will then be responsible for the patient portion of your health insurance plan (i.e. deductible, copay, coinsurance amounts). The patient is ultimately responsible for the balance due.

_____ Personal injury (accident): If you are a personal injury/automobile accident patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for services rendered will be your responsibility. Please give all information needed for billing. If statements are to be sent to your attorney instead of to an insurance company, a lien must be signed by your attorney guaranteeing payment for services rendered.

_____ Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays and any noncovered services.

_____ Patient without proof of Insurance: If you do not have evidence of health insurance, or complete information regarding your worker’s compensation claim or personal injury claim at the time of visit, cash payment will be required at the time of visit. If we then receive the appropriate insurance/claim information and obtain payment, your cash payment will be refunded promptly.

_____ Non-participating provider: We do not participate with _____
If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

GUARANTEE OF PAYMENT

Please initial each section on the line provided.

_____ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.

_____ I have been advised that if my health insurance carrier/HMO/Medicaid/Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

_____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

_____ I authorize payment of benefits from my insurance carriers directly to Manchester Osteopathic Healthcare. [If I choose not to initial this item, the benefit payments will be paid to me and I will be responsible for paying Manchester Osteopathic Healthcare].

_____ I understand that there is a \$75 reinstatement fee charged if I miss or cancel my appointment (with less than 24 hours notice) three or more times in a 12 month period. This fee must be paid prior to scheduling another appointment.

_____ Minor Patients only:

The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

**PAYMENT IS REQUIRED AT TIME OF SERVICE
THERE WILL BE A \$25.00 FEE FOR RETURNED CHECKS
For your convenience, we also accept VISA and MasterCard.**

I have read and understand my financial responsibilities as outlined in both pages of this Manchester Osteopathic Healthcare Financial Policy document.

X _____
Patient's signature

Date

Patient's Printed Name

Printed name of person signing on behalf of patient

Relationship to patient

MANCHESTER OSTEOPATHIC HEALTHCARE CONSENT FORM / PRIVACY NOTICE

Please initial each section on the line provided.

_____ Consent for Treatment:

I consent to diagnostic procedures and medical care as necessary in the judgement of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

_____ Medical Release Authorization:

With my consent, Manchester Osteopathic Healthcare may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION
PLEASE REVIEW IT CAREFULLY***

To review the more comprehensive version of this notice or if you have any questions please contact Wendy Jorgensen at (207) 622-4500.

The effective date of this notice is APRIL 14, 2003

Manchester Osteopathic Healthcare is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.

Practice Privacy Policy

At Manchester Osteopathic Healthcare your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

Patient Health Care Information Use & Disclosure

Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

_____ Consent for Contact:

With my consent, Manchester Osteopathic Healthcare may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

Practice Duties - Regarding your health care information

Manchester Osteopathic Healthcare is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

Manchester Osteopathic Healthcare is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

Patient Rights - Regarding their health care information

The patient has the right to request the practice to restrict use and disclosure of protected health information. Manchester Osteopathic Healthcare is not required to agree to the requested restrictions.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to Manchester Osteopathic Healthcare’s use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Manchester Osteopathic Healthcare may decline to provide treatment to me.

X _____
Patient’s signature

Date

Patient’s Printed Name

Printed name of person signing on behalf of patient

Relationship to patient

Initial Visit Patient Questionnaire

Name: _____ Date: _____
 DOB: _____ Primary Care Provider: _____
 Referring Provider: _____

What brings you here for your visit today? _____

Please tell us more about your pain.

Location of pain	Describe (sharp, dull, shooting, throbbing, aching...)
i.e. Right side of low back	intermittent; sharp and shooting

When did the pain begin? _____
 Was the onset of pain: (check one) sudden or gradual?

Trauma history: Have you ever had a significant traumatic injury? no yes If yes, when? _____
 Please give details of injury: _____

Is the pain the result of a work-related injury? yes no unknown
 Is the pain the result of an automobile or personal injury claim? yes no unknown

If you have **headaches**, how many days per month have you had them during the past 3 months?
 0-5 6-10 11-15 16-20 21-25 26-30 more than one a day
 Do you have any other symptoms before or during a headache? _____
 What brings on, or triggers your headaches? _____

Please circle the number on the line below that describes the overall amount of pain you are experiencing today:
 no pain -----worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes the worst your pain has been in the last month:
 no pain -----worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes the least your pain has been in the last month:
 no pain -----worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

Is your pain worse (check the box that best applies):

<input type="checkbox"/>	at night	<input type="checkbox"/>	in the morning	<input type="checkbox"/>	end of shift/day	<input type="checkbox"/>	hot, humid days
<input type="checkbox"/>	no difference day or night	<input type="checkbox"/>	wet/cloudy days	<input type="checkbox"/>	cold days	<input type="checkbox"/>	certain time of year

Please circle the number on the line below that describes your ability to sleep at night:

didn't sleep-----fell asleep immediately
a wink 0 1 2 3 4 5 6 7 8 9 10 and slept all night

Check the box that best describes your emotional health (check ONE):

<input type="checkbox"/>	Happy/cheerful	<input type="checkbox"/>	Optimistic	<input type="checkbox"/>	Anxious	<input type="checkbox"/>	Worried
<input type="checkbox"/>	Angry	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Suicidal	<input type="checkbox"/>	Compulsive
<input type="checkbox"/>	Indifferent	<input type="checkbox"/>	Hopeless	<input type="checkbox"/>	Frustrated	<input type="checkbox"/>	Panicked
<input type="checkbox"/>	Other (please explain):						

Which of the following activities increase or decrease your pain? (Place an **↑ or **↓** in the small boxes)**

<input type="checkbox"/>	getting out of bed	<input type="checkbox"/>	standing up	<input type="checkbox"/>	prolonged standing	<input type="checkbox"/>	sitting
<input type="checkbox"/>	bending backward	<input type="checkbox"/>	lying on back or side	<input type="checkbox"/>	looking up or sideways	<input type="checkbox"/>	washing/combing hair
<input type="checkbox"/>	lifting	<input type="checkbox"/>	twisting	<input type="checkbox"/>	straining	<input type="checkbox"/>	reaching over
<input type="checkbox"/>	coughing/sneezing	<input type="checkbox"/>	leaning forward	<input type="checkbox"/>	going downstairs	<input type="checkbox"/>	long car rides
<input type="checkbox"/>	exercising	<input type="checkbox"/>	computer work	<input type="checkbox"/>	reading	<input type="checkbox"/>	walking
<input type="checkbox"/>	running	<input type="checkbox"/>	other:				

What tests/treatments have you had for your current problem?

Where?

Please look at the following Quality of Life Scale and circle one number between 0 and 10 that best describes your current level of function.

0	Stay in bed all day; feel hopeless and helpless about life
1	Stay in bed at least half the day; have no contact with outside world
2	Get out of bed but don't get dressed; stay at home all day
3	Get dressed in the morning; minimal activities at home; contact with friends via phone or email
4	Do simple chores around the house; minimal activities outside of home two days a week
5	Struggle but fulfill daily home responsibilities; no outside activity; not able to work/volunteer
6	Work/volunteer limited hours; take part in limited social activities on weekends
7	Work/volunteer for a few hours daily; can be active at least 5 hours a day; can make plans to do simple activities on weekends
8	Work/volunteer for at least 6 hours daily; have energy to make plans for one evening social activity during the week; active on weekends
9	Work/volunteer/be active 8 hours daily; take part in family life; outside social activities limited
10	Go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life

Past Medical History: Please check any conditions you have or have had in the past:

AIDS/HIV positive	Alcoholism	Anemia	Anorexia
Appendicitis	Arthritis	Asthma	Bleeding disorders
Blood clots	Cancer	Diabetes	Drug dependency
Emphysema	Epilepsy/seizures	Glaucoma	Goiter
Osteoporosis	Gout	Heart disease	High cholesterol
High blood pressure	Kidney disease	Liver disease/Hepatitis	Migraines
Prostate problems	Psychiatric care	Acid reflux (GERD)	Stomach ulcers
Stroke	Thyroid problems	Irritable Bowel	Depression

Comments: _____

Past Surgical History: Please list all surgeries you have had and the approximate year:

Medications: Please list all of the medications (with dosages if possible) you are taking. Include over-the-counter medications as well.

Allergies: Are you allergic to any medications/substances? no yes: _____

Social History: Do you smoke or chew tobacco? no yes _____ packs per day for _____ years

Did you ever smoke or chew tobacco? no yes When did you quit? _____

Alcohol intake: never rare occasional; Average number of drinks per day: _____

Do you currently, or have you ever used recreational drugs? no yes

Occupation (current or previous): _____

Are you working: Full-time Part-time Retired Disabled

Family History: Have your relatives had any of the following medical problems?

Blood Relative	Arthritis	Migraines	Cancer	Joint Problems	Osteoporosis
Mother					
Father					
Brother/Sister					
Children					
Grandparents					

Review of Systems: Please check any problems you are **now having** or have had **repeatedly** in the last month

Fatigue	Fever	Weight Change	Weakness
Headaches	Dizziness	Head injury	Confusion
Vision changes	Hearing Loss	Ear aches	Sinus trouble
Trouble swallowing	Jaw pain	Chest pain/pressure	Shortness of breath
Rapid heart beat	Irregular heart beat	Calf pain with walking	Swelling of ankles
Blood clots	Chronic cough	Coughing up blood	Wheezing
Poor appetite	Heartburn/Indigestion	Belly pain	Diarrhea
Constipation	Rectal bleeding	Nausea/vomiting	Poor bowel control
Painful urination	Poor bladder control	Difficulty urinating	Rash/Hives
Painful/swollen joints	Back pain	Arm or leg pain	Difficulty walking
Convulsions/seizures	Numbness/tingling	Weakness arms/legs	Difficulty sleeping
Depression	Anxiety	Excess thirst/urination	Easy bruising/bleeding
Other (please describe)			

Comments: _____

For women: Date of last menstrual period: _____
 History of irregular or painful periods? no yes

What is your goal for today's visit? _____

You authorize the release of office notes to your primary care physician and referring physician by signing here: _____

Patient Signature

Reviewed by: _____

Date: _____