



Thank you for choosing ALT-MED Medical and Physical Therapy Programs for your health care needs.

All aspects of your medical care and billings will be kept confidential according to the Health Insurance Portability and Accountability Act (HIPPA). ALT-MED has implemented procedures to insure the confidentiality of your records. Please notify the ALT-MED staff if you have any questions about these policies designed to protect your rights as a patient or any questions in regards to your therapy here at ALT-MED.

*Sincerely,
Patrick B. Massey M.D. Ph.D.
President, ALT-MED Therapy Programs*

ALT-MED Medical and Physical Therapy Programs will be submitting your charges for service directly to your insurance company. In order to ensure uninterrupted medical care, the following policies have become a necessity.

- To bill your insurance directly, ALT-MED requires a credit card imprint and signature.
- ALT-MED will receive payments, directly from your insurance, for services rendered.
- When the claim is adjudicated (paid or denied), a statement (Explanation of Benefits) will be sent, by the insurance company, to you and ALT-MED.
- Upon receipt of this Explanation of Benefits, ALT-MED will charge the balance due, to your credit card on file, and mail the receipt to you.
- Upon completion of the program and when the balance due = \$0.00, the credit card imprint will be returned to you.
- A \$25 service fee will be issued for any denied credit card charges.
- Medical services may be terminated if 2 or more denied charges occur.

Please complete the following authorization:

I, _____ on date _____, hereby authorize ALT-MED Research Group to charge my credit card for the balance due as stated on my insurance explanation of benefits. The below signature will serve as the authorizing signature for said charges for services rendered. I understand that my credit card will continue to be charged until my balance for services rendered = \$0.00 regardless of the last date I was seen at the facility.

Signature

Date

Check one Visa
 Master Card Card Number: _____
 AMEX
 Discover Exp Date (MM/YY) _____

INSURANCE

- *ALT-MED submits to the posted **PRIMARY** insurance carriers **ONLY**.*
- *Please supply the office with your insurance information, to facilitate any inquiries your insurance may make at a later date.*
- *A copy of your insurance cards will be needed for verification, as well as the information completed below.*

Primary Ins. Co: _____	Address to send claims: _____
ID# _____	_____
Group# _____	Phone number: _____
Name of Insured: _____	Insured SSN#: _____
Insured Birthdate: _____	Relationship to Patient: _____

Secondary insurance information is only to facilitate any inquiries your insurance may make at a later date. ALT-MED does NOT submit claims to the Secondary insurance.

Secondary Ins. Co: _____	Address to send claims: _____
ID# _____	_____
Group# _____	Phone number: _____
Name of Insured: _____	Insured SSN#: _____
Insured Birthdate: _____	Relationship to Patient: _____

Is this injury the responsibility of your employer?	Yes	No
Is this injury due to a motor vehicle accident?	Yes	No
Are you in litigation for your current injury?	Yes	No

If yes, provide the following information:

Name of Company/Insurance: _____

Address: _____ Phone: _____

Agent/Contact Name: _____ Date of accident: _____

Name of Company/Insurance: _____

Address: _____ Phone: _____

Agent/Contact Name: _____ Date of accident: _____

PATIENT INFORMATION

Name: _____ Birthdate: ____ / ____ / ____ Sex: M F
 Single Married Widowed Separated Divorced SS#: _____
Address: _____ Apartment#: _____
City: _____ State: _____ Zip Code: _____
Occupation: _____ Employer Name/Address: _____
How did you hear about ALT-MED? Newspaper Lecture (where?) _____
 Doctor referral (whom?) _____ Friend (whom?) _____ Other _____

CONTACT INFORMATION

Home Phone: _____ Work Phone: _____ ext: _____
Cell Phone: _____ email: _____
Best time and place to reach you: Home Work Cell AM PM

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell phone: _____

INSURANCE

ALT-MED submits to the posted primary insurance carriers only. Please supply the office with your insurance information, to facilitate any inquiries your insurance may make at a later date. A copy of your insurance cards will be needed as well as the information completed below.

Primary Ins. Co: _____	Secondary Ins. Co: _____
Name of Insured: _____	Name of Insured: _____
Insured Birthdate: _____	Insured Birthdate: _____
Insured SSN#: _____	Insured SSN#: _____
Relationship to Patient: _____	Relationship to Patient: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **ALT-MED Research Group** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signed _____ Date _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **ALT-MED Research Group** for any services furnished me by that physician and his staff. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed _____ Date _____

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

- Good general health lately No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes
 Headaches No Yes

EYES

- Eye disease or injury No Yes
 Wear glasses/contact lenses No Yes
 Blurred or double vision No Yes

EARS/NOSE/MOUTH/THROAT

- Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic sinus problems or rhinitis No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change No Yes
 Swollen glands in neck No Yes

CARDIOVASCULAR

- Heart trouble No Yes
 Chest pain or angina pectoris No Yes
 Palpitation No Yes
 Shortness of breath walking or lying flat No Yes
 Swelling of feet, ankles or hands No Yes

RESPIRATORY

- Chronic or frequent coughs No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

GASTROINTESTINAL

- Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements or constipation No Yes
 Rectal bleeding or blood in stool No Yes
 Abdominal pain No Yes

GENITOURINARY

- Frequent urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Change in force of strain when urinating No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes
 Male – testicle pain No Yes
 Female – pain with periods No Yes
 Female – irregular periods No Yes
 Female – vaginal discharge No Yes
 Female – # of pregnancies: _____
 Female – # of miscarriages: _____
 Female – date of last pap smear: _____

MUSCULOSKELETAL

- Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

INTEGUMENTARY (skin, breast)

- Rash or itching No Yes
 Change in skin color No Yes
 Change in hair or nails No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast lump No Yes
 Breast discharge No Yes

NEUROLOGICAL

- Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes
 Convulsions or seizures No Yes
 Numbness or tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Head injury No Yes

PSYCHIATRIC

- Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes

ENDOCRINE

- Glandular or hormone problem No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes
 Skin becoming dryer No Yes
 Change in hat or glove size No Yes

HEMATOLOGIC/LYMPHATIC

- Slow to heal after cuts No Yes
 Bleeding or bruising tendency No Yes
 Anemia No Yes
 Phlebitis No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

ALLERGIC/IMMUNOLOGIC

- History of skin reaction or other adverse reaction to:
 Penicillin or other antibiotics No Yes
 Morphine, Demerol, or other narcotics No Yes
 Novocain or other anesthetics No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin or other serums No Yes
 Iodine, merthiolate or other antiseptics No Yes
 Other drugs/medications: _____

- Known food allergies: _____

 Environmental allergies: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X

Signature of patient (or parent/guardian if minor)

Date

Doctor's Review: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Date
Signature of Doctor	Date

Welcome to Our Practice

As a new patient, please fill out the information found below to the best of your ability.

Patient # _____ Physician _____ Date _____

Patient name _____ Chief complaint _____

History of Present Illness:

Location _____ **Quality** _____
(Where is the pain/problem?) (Example: normal versus abnormal color, activity, etc.)

Severity _____ **Duration** _____
(How severe is the pain/problem on a scale of 1-5 (5 being the most severe)) (How long have you had this pain/problem, or when did it start?)

Timing _____ **Context** _____
(Does this pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ **Modifying Factors** _____

(What other associated problems have you been having?) (What makes the pain/problem worse or better? Have you had previous episodes?)

Patient Medical History:

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Measles	<input type="checkbox"/> No <input type="checkbox"/> Yes	Veneral Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Blood or Plasma Transfusions	<input type="checkbox"/> No <input type="checkbox"/> Yes	Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mumps	<input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Back Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Mitral Valve Prolapse	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chickenpox	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bladder Infections	<input type="checkbox"/> No <input type="checkbox"/> Yes	High or Low Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
Whooping Cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hemorrhoids	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Scarlet Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Migraine Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Ulcer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diphtheria	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hives or Eczema	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Smallpox	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	AIDS or HIV+	<input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Pneumonia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Infectious Mono	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding Tendency	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatic Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Polio	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bronchitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Any Other Disease (please list)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date of last chest x-ray:	_____		
Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hernia	<input type="checkbox"/> No <input type="checkbox"/> Yes				

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, City, State/Prov.
_____	_____	_____
_____	_____	_____

Medications (include nonprescription):

Have you ever taken Fen-Phen/Redux? No Yes

Patient Social History:

Marital status: Single Married Separated Divorced Widowed
Use of alcohol: Never Rarely Moderate Daily
Use of tobacco: Never Previously, but quit: _____ Current packs/day _____
Use of drugs: Never Type/frequency: _____
Excessive exposure at home or work to: Fumes Dust Solvents Airborne particles Noise

Family Medical History:

Age	Diseases	If deceased, cause of death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
Spouse _____	_____	_____
Children _____	_____	_____