



Midlothian Medical and Sports Center - New Patient Form

Patient Information:

Name: _____

Date: _____

Email: _____

DOB: _____

Gender: Male Female

Phone: _____ Secondary Phone: _____

Address: _____

Marital Status: Single Married Divorced Widowed Separated

Employer: _____

Emergency Contact: _____ Phone: _____

Who can we thank for referring you to our practice: _____

Responsible Party (If Different):

Name: _____ Relationship: _____

Phone: _____

Insurance:

Yes No

Primary Insured Name: _____ Insurance Provider: _____

ID #: _____ Group #: _____

Health History:

Chief Complaint: _____

Pain Location: _____ Severity (1-10): _____

Duration: _____ Onset: _____

Associated Symptoms: _____

Factors Improving/Worsening: _____

Past Medical History: (Circle that apply): Asthma, Arthritis, Diabetes, Hypertension, Stroke, Cancer, Thyroid Disease, Kidney Disease

Other: _____

Allergies: _____

Medications: _____

Surgeries/Hospitalizations: _____

Family Medical History:

Father: _____ Conditions: _____

Mother: _____ Conditions: _____

Siblings/Children: _____

Social History: Alcohol: Never Rarely Moderate Daily

Tobacco: Never Rarely Moderate Daily

Drugs: Never Yes (Type/Frequency): _____

Symptom Checklist (Rate 1-5):

Muscle Aches: ____

Joint Pain: ____

Back Pain: ____

Neck Pain: ____

Headaches: ____

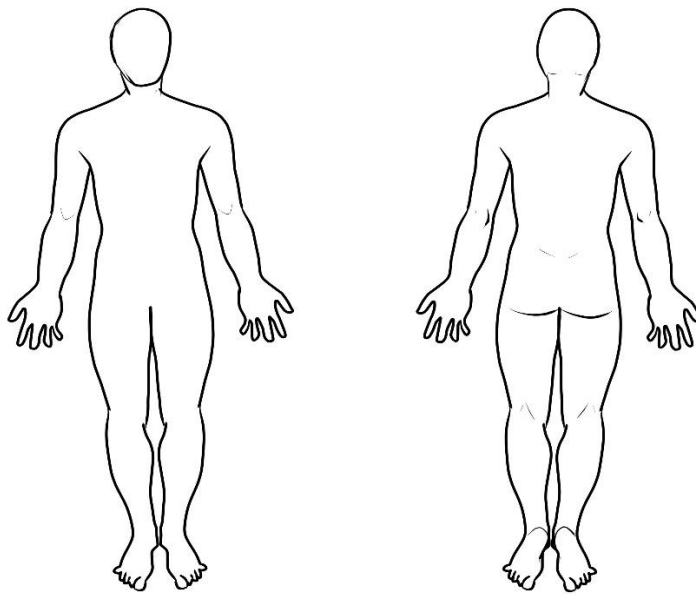
Numbness/Tingling: ____

Fatigue: ____

Diagram of the human body for marking areas of pain:

Pain Diagram

Please use the chart below to mark the area of discomfort:



Use the space below to describe your pain:

Consent for Treatment: I consent to receiving treatment as deemed necessary by Midlothian Medical and Sports Center.

Signature: _____ Date: _____

Consent for Communication: I consent to receive appointment reminders and health-related communications via: Phone Text Email

Preferred Contact: _____

Signature: _____ Date: _____

Patient Rights and Responsibilities:

I acknowledge receipt of Patient Rights and Responsibilities.

Signature: _____ Date: _____

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Midlothian Medical and Sports Center** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signature: _____ Date: _____

For Office Use Only: Reviewed by: _____ Date: _____

Provider Statement of Patient/Client Rights and Responsibilities

- Patients/Clients have the **right** to be treated with dignity and respect.
- Patients/Clients have the **right** to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients/Clients have the **right** to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients/Clients have the **right** to access care easily and in a timely fashion.
- Patients/Clients have the **right** to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients/Clients have the **right** to share in developing their plan of care.
- Patients/Clients have the **right** to the delivery of services in a culturally competent manner.
- Patients/Clients have the **right** to information about the organization, its providers, services, and role in the treatment process.
- Patients/Clients have the **right** to information about provider work history and training.
- Patients/Clients have the **right** to information about clinical guidelines used in providing and managing their care.
- Patients/Clients have a **right** to know about advocacy and community groups and prevention services.
- Patients/Clients have a **right** to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients/Clients have the **right** to know about laws that relate to their rights and responsibilities.
- Patients/Clients have the **right** to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.
- Patients/Clients have the **responsibility** to treat those giving them care with dignity and respect.
- Patients/Clients have the **responsibility** to give providers the information they need, in order to provide the best possible care.
- Patients/Clients have the **responsibility** to ask their providers questions about their care.
- Patients/Clients have the **responsibility** to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients/Clients have the **responsibility** to let their provider know when the treatment plan no longer works for them.
- Patients/Clients have the **responsibility** to tell their provider about medication changes, including medications given to them by others.
- Patients/Clients have the **responsibility** to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients/Clients have the **responsibility** to let their provider know about their insurance coverage, and any changes to it.
- Patients/Clients have the **responsibility** to let their provider know about problems with paying fees.
- Patients/Clients have the **responsibility** not to take actions that could harm others.
- Patients/Clients have the **responsibility** to report fraud and abuse.
- Patients/Clients have the **responsibility** to openly report concerns about quality of care.
- Patients/Clients have the **responsibility** to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients/Clients have the **right** and the **responsibility** to understand and help develop plans and goals to improve their health.

Patient Copy