Patient Information

Last _____ First_____ Date of Birth_____ Age_____

Address _____
Street or PO Box City State Zip Code

Home Phone _____ Cell Phone_____ Email_____

Social Security #_____ Ethnicity_____ Sex: **M / F** Marital Status: **S M D W**

Employer_____ Occupation_____ Work Phone_____

Spouse Name_____ Employer_____ Work Phone_____

IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:

Parent name_____ Cell Phone_____ Alternate Phone_____

Parent name_____ Cell Phone_____ Alternate Phone_____

Responsible Party _____ Birth Date_____ SSN_____

Address if Different_____
Street or PO Box City State Zip Code

INSURANCE INFORMATION******PLEASE PROVIDE CARD SO THAT WE MAY MAKE A COPY*****

Insurance #1_____ Name of Insured_____

Relationship to Patient_____ Birth Date_____ SSN_____

Insurance #2_____ Name of Insured_____

Relationship to Patient_____ Birth Date_____ SSN_____

If over 18 can we contact your parent listed above to discuss financial information? _____ **YES** _____ **NO**

Is this an accident that occurred during school sports? **YES / NO** if yes, Date_____

Have you been injured on the job? **YES / NO** If yes, Date_____ If yes, who is your employer? _____

If accident, is there an attorney involved? **YES / NO** If yes, attorney name_____

Is this condition a pre-existing condition or a medical condition existing at a time when new insurance is applied for, for which treatment is not covered by the insurance? **YES or NO**

In case of emergency, please notify_____ Relationship_____ Phone #_____

Who referred you to this practice? _____ Primary Care Provider _____

Assignment of Insurance Benefits

I hereby authorize assignment of my medical and/or surgical benefits to include major medical benefits that I am entitled, private insurance, Medicare, and any other health plans to my physician at **Jennifer L. Johnson, MD, PLLC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

_____ _____
Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

Staff Initial_____

Jennifer L Johnson, MD, PLLC

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Medications used in the management of pain are very useful but have a high potential for misuse and are, therefore, are controlled by local, state and federal governments. They are intended to diminish or relieve pain thus improving a patient's function and/or their ability to work. Because my physician is prescribing this medication to help in the management of my pain, I agree to these following conditions:

1. I will only receive controlled substance prescriptions and non-controlled prescriptions for my pain management from Jennifer Johnson, MD. I will fill and refill these prescriptions at one pharmacy that I provide to Dr. Johnson. If it is discovered that I am receiving controlled substance prescriptions for my condition from any other physician or if I am using multiple pharmacies to obtain these prescriptions for my pain management, I understand that I will be discharged from Dr. Johnson's care immediately.
2. I understand that I am to take the medications that I have been given in the dose and frequency that Dr. Johnson has prescribed. I am responsible for the controlled substance medications or non-controlled prescriptions for my pain management. If my medication is lost, misplaced, stolen or if I run out of my medication before my refill date, I understand that my medication **will not be replaced** until time for the next refill.
3. By signing this agreement, I am promising to comply with random urine, blood, or breath testing as deemed necessary by my doctor in order to document the proper use of my medication and confirm compliance. I also understand that driving a motor vehicle or operating heavy machinery may not by allowed while taking a controlled substance or non-controlled substance prescriptions for my pain management, and it is my responsibility to comply with the laws of the state while taking these medications.

I UNDERSTAND THE FOLLOWING POLICY OF THIS PRACTICE:

4. Refills of controlled substance medications:
   a. Refills will be made only during regular office hours Monday through Friday 8:30 to 4:30p.m **REFILLS WILL NOT BE MADE IN THE EVENING OR ON WEEKEND/HOLIDAYS**
   b. Refills will not be made if you run out early or lose your prescriptions or if your prescriptions Are stolen. You will be responsible to take your medications as prescribed by Dr. Johnson and should not stray from the written directions.
   c. Refills will not be made as an "emergency" such as on Friday afternoon. If you know that you will run out of your medication on the weekend, please call 24 hours in advance to let the physician know what day you will run out of the medicine.
5. I understand that if I violate any of the above conditions regarding my prescription for controlled substance medications or non-controlled prescriptions for my pain management, I will be terminated from the prescribing doctor's practice. If the violation involves obtaining a controlled substance medication or non-controlled prescriptions from another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities, pharmacies and appropriate authorities.
6. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined. My treatment may change at any time at the discretion of Dr. Johnson.
7. I authorize the doctor and my pharmacy to cooperate fully with the city, state, or federal law enforcement agency, including Texas Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to authorizations.

I have read this contract completely and my physician and/or her staff has explained the same to me. In addition, I fully understand the consequences of my not adhering to this contract.

Patient Signature: _____ **Date:** _____

Staff Initial: _____ **Physician Signature:** _____

Jennifer L. Johnson, MD, PLLC

Office Procedures

Referrals: If your insurance requires a referral from your primary care physician, it is your responsibility to obtain one before you can be seen. If you do not get one, your appointment will be rescheduled. There are no exceptions.

Financial Policy: All co-pays, deductible amounts, and non-covered services for office visits are due at the time of service. If you have any questions, please call our office at 325-698-4545 ext 212.

Insurance: Please bring your current insurance card and picture ID. We will make a photocopy of both your insurance card and picture ID. We will file your insurance for you. All charges will be the patient's responsibility. Any unpaid insurance claims after 60 days will be billed to the patient. Regardless of insurance, payment remains your personal responsibility.

Minors: a parent or guardian who is legally allowed to give medical consent must accompany all minors under the age of 18.

Agreement to Pay for Medical Services: there could be a patient portion incurred with each visit. As a courtesy, we do file private health insurance; however, ***there may be a patient portion to be paid for left over costs after the services are rendered***. These could include but are not limited to calendar year deductibles, coinsurance, and non-covered services.

Past Due Balances: If your account balance is more than 120 days past due and you do not have a financial agreement in place, you will be turned over to a collection agency. I understand that I am responsible for any collection fees and/or attorney fees.

Cell Phone Usage Do you give our office consent to contact you on your cell phone regarding appointments, healthcare information and/or billing questions? **YES or NO**

X_____ _____

Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

No Show Policy

No Show Policy:

- To ensure that we are able to provide appropriate and consistent service for you; we ask that you make every effort to attend all scheduled appointments.

-If you are unable to attend a scheduled appointment, please call to notify our staff of you intended absence at least 24 hours in advance at 325.698.4545 press 0 or ext. 233.

No Shows: If you fail to call ahead and do not keep your clinic appointment, we will call you to remind you of our clinic's No Show Policy. If a second missed appointment occurs without an advanced notice, you will lose your standing appointment and will need to call us to reschedule. If there is a third No Call/No Show, you will be discharged as a patient. **A fee of $25.00 will be charged to you if you no show/no call**.

***Note:** If you are a Workers' Compensation Patient, your employer and insurance carrier will be notified of any no-show appointments.

FAILURE TO KEEP APPOINTMENTS WILL RESULT IN DISCHARGE FROM OUR MEDICAL PRACTICE.

I have read, understand and agree to follow these conditions.

X_____ _____

Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

Staff Initial _____

Release of Protected Health Information HIPPA

My Protected Health Information may be released to the following person(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

***If you would like anyone other than yourself to be able to call our office and to discuss your account or medical information you must print his/her name in the space provided. This does include spouses.**

***If patient is a student athlete, can private health care information be discussed with the school's certified athletic trainer?** YES or NO

In order to ensure that you receive comprehensive and quality healthcare, do you consent to have your medical records sent to any of your **primary care doctors or specialists on record?** YES or NO

I hereby authorize my physician Jennifer L. Johnson, MD, PLLC, to release any information obtained in the course of my examination that my insurance company may request. I authorize any holder of medical information about me to release to the **insurance, Medicare, or any other health plan or its agents**, any information needed to determine these benefits or the benefits payable to related services. YES or NO

X_____ _____

Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

Acknowledgement of Review of Notice of Privacy Practices (HIPAA)

I have reviewed this office's Notice of Privacy Practices from Jennifer L. Johnson, MD, PLLC, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

X_____ _____

Signature of Patient (If less than 18 years of age Parent/Legal Guardian) Date

Staff Initial _____

Initial Intake Form

Name_____ Age _____ Date_____

Date of Birth _____ Referring Physician _____Family Physician_____

What is your main problem? _____

When did it start? _____

How long has this problem been present? Number of: _____ Days _____ Weeks _____ Months _____ Years

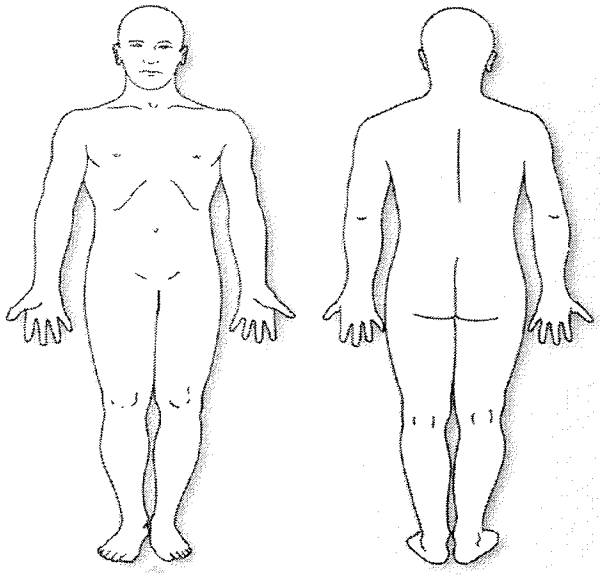
How did this problem begin? (***Circle all that apply***) Suddenly Gradually Accident Sports injury Work injury Fall

What makes it worse? _____

What makes it better? _____

Mark on the diagram where you are having the following symptoms:

Pain: XXX Numbness: OOO Aching: /////



What treatments have you done?

- ☐ Physical Therapy
- ☐ Home Exercises
- ☐ Trigger Point injections
- ☐ Joint Injections
- ☐ Epidural Injections
- ☐ Anti-Inflammatory Medications
- ☐ Heat
- ☐ Tens Unit
- ☐ Braces
- ☐ Facet injections
- ☐ Pain Medications
- ☐ Ice
- ☐ Chiropractic
- ☐ Surgery
- ☐ MRI
- ☐ Nerve Test

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
(No pain) (Worst pain)

Review of Systems: Please check if you have recently experienced the following

CONSTITUTIONAL

- ☐ Weight loss-last 6 months
- ☐ Fever
- ☐ Chills
- ☐ Night sweats

RESPIRATORY

- ☐ Shortness of Breath
- ☐ Cough ☐ Wheezing

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath w/walking

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Popping/clicking
- ☐ Joint Instability
- ☐ Joint Catching/locking

GASTROINTESTINAL

- ☐ Vomiting/Nausea
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Constipation
- ☐ Abdominal pain

SKIN

- ☐ Skin wounds or ulcers

NERVOUS

- ☐ Sleep disturbance
- ☐ Numbness ☐ Headache

GENITO-URINARY

- ☐ Bladder Problems

FEMALE

- ☐ Possibly pregnant

HEMATOLOGY

- ☐ Taking blood thinning meds

Signature: _____Date:_____

Medical History Form

Name: _____ Age: _____ Date of Birth: _____

What pharmacy do you use to fill medications? _____

Medications and dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies/Reactions:

_____ _____ _____

_____ _____ _____

Past Medical History

Do you have or have you had any of the following medical conditions? (*Please circle*)

Cancer	Kidney Disease	Blood Disorders	Diabetes
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Gout
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Depression	Anxiety	Thyroid Problems
HIV/AIDS	High Cholesterol	Osteoporosis	Psychiatric disorder
Arthritis	Rheumatoid Arthritis	Headaches	

Other: _____

Surgical History

Have you had any of the following surgical procedures? *(Please circle and include dates)*

Back Surgery _____

Neck Surgery _____

Knee Surgery _____

Shoulder Surgery _____

Heart Surgery _____

Other: _____

Family History

Does anyone in your family suffer from any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Diabetes
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Gout
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Arthritis	Depression	Anxiety
HIV/AIDS	High Cholesterol	Osteoporosis	Thyroid Problems
Arthritis	Rheumatoid Arthritis	Headaches	Psychiatric disorder

Other: _____

Social History

Are you: Married Single Divorced Widowed

Do you smoke? YES or NO Packs per day _____

Do you drink alcohol? YES or NO Drinks per week _____

Are you working? YES or NO Job Description: _____ **Are you on restrictions?** Yes or NO