

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 **Daniel L Munton, MD PA**. 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 _____

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, closely 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 Dr. Munton, Vince Viola, PA or Ted Chaka, PA-C. I will fill and refill these prescriptions at one pharmacy that I provide to Dr. Munton, Vince Viola, PA or Ted Chaka. 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. Munton's, Vince Viola's or Ted Chaka'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. Munton, Vince Viola, PA-C or Ted Chaka PA-C 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 you run out of my medication before my refill date, I understand that **it will not be replaced** until time for your next refill.
3. By signing this agreement, I am promising to comply with random urine, blood, DNA 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 be 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. Munton 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 my physician.
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 the same has been explained to me by my physician and/or their staff. In addition, I fully understand the consequences of my not adhering to this contract.

Patient Signature: _____ **Date:** _____

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

Daniel L Munton, MD PA

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 your intended absence at least 24 hours in advance at 325.698.4545 press 0 Or the medical assistant's extension.

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. If you are scheduled for a procedure such as Spinal Injection or Nerve Conduction Studies (EMG) you must call in advance to cancel/reschedule this appointment. These procedures are booked in advance and have waiting lists. If you do not cancel ahead of time or notify our office that you are unable to attend your procedure before your scheduled date, we will not be able to reschedule you with our office for any further treatment. ***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 Daniel L Munton, MD PA 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 Daniel L Munton, MD PA, 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

DISCLOSURE AND CONSENT
Medical Treatment from Physician Assistants

TO THE PATIENT: *You have the right as a patient, to be informed about your care. This disclosure is simply an effort to make you better informed*

I(we) understand that Vincent Viola, PA-C and Ted Chaka, PA-C are Physician's Assistants who are under the direction of Dr. Daniel L Munton, MD. I authorize Vince Viola, PA-C or Ted Chaka, PA-C to provide care based on his license requirements.

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

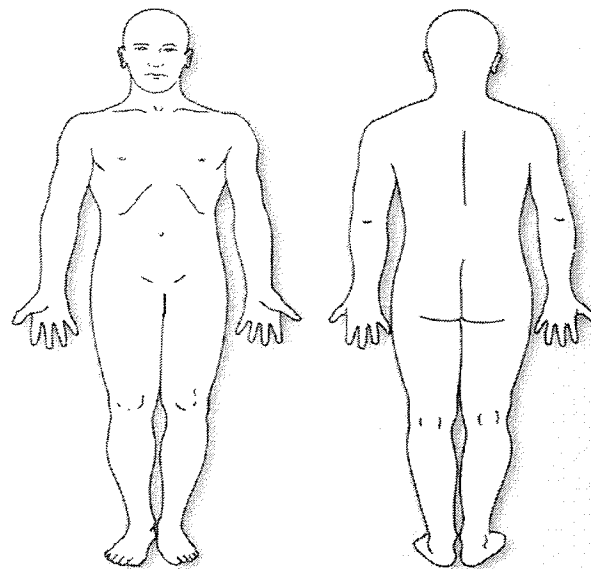
Pain: XXX

Numbness: OOO

Aching: ////

What treatments have you done?

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Heat | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Home Exercises | <input type="checkbox"/> Tens Unit | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Trigger Point injections | <input type="checkbox"/> Braces | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Joint Injections | <input type="checkbox"/> Facet injections | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Epidural Injections | <input type="checkbox"/> Pain Medications | <input type="checkbox"/> Nerve Test |
| <input type="checkbox"/> Anti-Inflammatory Medications | | |



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