**PATIENT INFORMATION**

**PLEASE PRINT** **MUST COMPLETE IN FULL**

Name: (Last)_____(First)_____(Middle)_____

Parents name if patient is a minor or student: Mother/Father _____

Mailing Address: _____City:_____State:_____Zip:_____

Physical Address: _____City:_____State:_____Zip:_____

Date of Birth: _____ Age:____ Social Security #_____ Sex: MALE ____FEMALE ____

Home # _____ Cell # _____ Work # _____

Preferred method of communication: (please circle all that apply): Phone: HOME CELL WORK EMAIL

Email Address: _____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED Spouse's Name_____

Ethnicity (Please circle one): HISPANIC /LATINO NOT HISPANIC/LATINO DECLINED

Race:_____

Preferred Language: _____

*Who referred you to our office?*_____

Occupation:_____ Employer: _____

Emergency Contact:_____ Phone: _____

Emergency Contact:_____ Phone: _____

**ACCIDENT/ATTORNEY INFORMATION**

*Is your visit here today due to a worker's compensation accident*? **YES or NO** (circle one)

*Is your visit here today due to a slip and fall accident?* **YES or NO** (circle one)

*Is your visit here today due to an automobile accident*? **YES or NO** (circle one)

*If **YES**, please state date of accident or injury:* _____

*Is your visit here related to any injury that is not your fault?* **YES or NO** (circle one)

*Are you currently being represented by an attorney regarding your injury?* **YES or NO** (circle one)

*Do you plan on seeking legal representation for this injury?* **YES or NO** (circle one)

Attorney Name: _____ Phone: _____

**INSURANCE INFORMATION**

Health Insurance Carrier: _____ (receptionist will copy card)

Insured Name: _____ DOB _____ Insured Social Security _____

Secondary Insurance Carrier: _____ (receptionist will copy card)

Insured Name: _____ DOB _____ Insured Social Security _____

Signature of patient: _____ Date: _____

Signature of responsible party if student or minor: _____ Date: _____

**Assignment of Benefits**: I authorize payment of medical benefits to George Ray Williams, MD, LLC for services described. I accept full responsibility for total amount of bill. I understand that if anything above is untrue, I am responsible for the full bill. If payment is not made on time I am responsible for a finance charge.

Signed:_____Date:_____

**Medicare Information**: Charges not covered by Medicare or Managed Care will be the patient's responsibility, please ask if you have any questions. I recognize that current, valid insurance information is necessary for reimbursement. I hereby authorize that attached insurance companies to pay directly to: George Ray Williams, MD, LLC benefits on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge amounts due from me, outstanding greater than 30 days will be assessed a finance charge of 1 ½% per month.

Signature:_____Date: _____

**Release of Medical Information**

I, _____, DOB:_____

Give written permission to George Ray Williams, MD, LLC to provide information from my medical records to the following person(s):

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand that providing the aforementioned person(s) with my personal medical records is at my sole discretion. No other person(s) than those named will be provided access to my medical records, except as required by law. I agree to hold harmless George Ray Williams, MD, LLC in the release of my medical records provided to those person(s) stated above. This authorization is in effect this date and until written authorization from me is submitted to George Ray Williams, MD, LLC.

_____ _____

Printed Name Signature Date

# GEORGE RAYMOND WILLIAMS, MD, LLC

**PATIENT INFORMATION AND HISTORY**

What is your injury or complaint that you are being seen for today?_____

_____

Date your symptoms began:_____ If your symptoms are a result of an injury or accident, please explain.

_____

_____

_____

Have you had an MRI or CT scan? **YES or NO**

If yes, at which facility? _____

Have you had any of these treatments for this injury/complaint? (Please circle those that apply)

**Physical therapy Chiropractic manipulation Acupuncture Epidural Steroid injections**

Height _____ Weight _____

What is your occupation? _____

Have you ever had general anesthesia? **Yes or** No (circle one)

Have you had any problems with anesthesia? **Yes** or **No** (circle one) Describe if yes: _____

_____

**Primary Care Physician:** _____

**General Surgeon Preference:** _____

**Cardiologist Preference:** _____

**Physical Therapy Preference:** _____

**Home Health Preference if needed?**_____

_____ _____

Patient Signature Date

**MEDICATION LOG**

| Medication | Dosage<br>e.g. mg strength | How taken<br>e.g. times per day |
|---|---|---|
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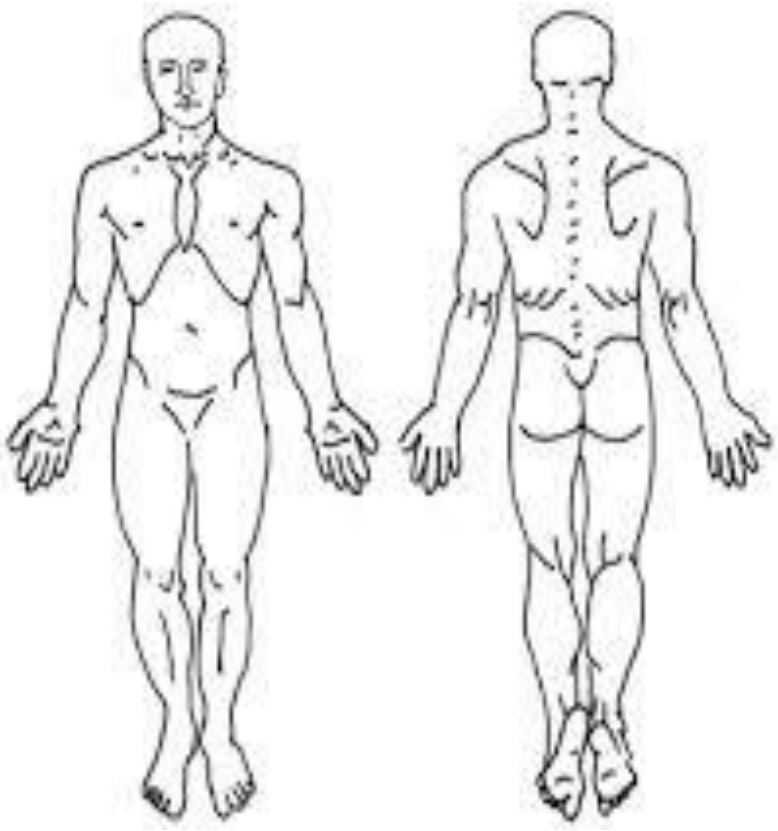
# GEORGE RAYMOND WILLIAMS, MD, LLC

Patient Name: _____ Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. It is not necessary to use all of the symbols, only the ones with affect you.

| Aching | Numbness | Pins and Needles | Burning | Stabbing | Other |
|---|---|---|---|---|---|
| □ | ⬭ | ======= | X | // | ● |



Pain in Arm(s) Compared with Neck:

1. Worse than
2. Same as
3. Less than

Pain in Leg(s) Compared with Back:

1. Worse than
2. Same as
3. Less than

Circle the Quality of your pain with 0 being Normal and 10 being Unbearable 0 1 2 3 4 5 6 7 8 9 10 Neck

Circle the Quality of your pain with 0 being Normal and 10 being Unbearable 0 1 2 3 4 5 6 7 8 9 10 Arm(s)

Circle the Quality of your pain with 0 being Normal and 10 being Unbearable 0 1 2 3 4 5 6 7 8 9 10 Back

Circle the Quality of your pain with 0 being Normal and 10 being Unbearable 0 1 2 3 4 5 6 7 8 9 10 Leg(s)

I certify that the above information is correct:

_____

Patient Signature

# FINANCIAL POLICY

To avoid misunderstanding, our Billing Department invites early discussion of financial problems or questions regarding fees, payment from insurance carriers, etc. **Financials are NOT to be discussed with the Doctor.** General requirements for maintaining your account in good standing are as follows:

**Office Visit Co-Payments, Deductibles, and Coinsurances:**
Office visit co-payments, deductibles, and coinsurances are collected at the time of services are provided. Please refer to your insurance ID card or contact your health plan to verify your payment responsibility. All outstanding charges are due and payable within 30 days of the first billing.

**Surgical Procedure Payments:**
Our Billing Department will contact you with an estimate of your financial responsibility and answer any questions you may have. Surgical procedures are scheduled once benefits have been verified,your financial obligation has been met, and surgery clearance obtained.

**Insurance:**
We cannot accept the responsibility of negotiating claims with insurance companies or other persons. It is your responsibility to provide accurate insurance information. You are also responsible for payment of your health care within a reasonable time - regardless of the status of the claim. In circumstances where a claim is pending or when treatment will be for an extended period of time, it is recommended that a payment plan be initiated.

Private Insurance: please provide our office with all insurance information including your insurance card(s). If you are not the primary cardholder for your insurance, we will need the primary cardholder's name, address, date of birth and social security number.

Workers' Compensation: if your visit is covered by Workers' Compensation, please verify the information we have in your file is correct and your visit has been approved by your adjuster before each appointment.

Automobile/Third Party Liability: Our office does not file private insurance for auto/3rd party liability claims unless subrogation has been filed and proof provided to us.

Legal: our office accepts legal cases on a case by case basis. Please provide our office with the name, address and phone number of your attorney. Your visit must be approved by the physician's staff and your attorney prior to receiving services.

**Reduction or Rejection of your Claim:**
Your insurance policy is a contract between you and your insurance company. It is important to understand its provisions. We cannot guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects our claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

**Billing:**
An itemized statement covering all health care services received will be mailed to you on a monthly basis. **Payment** is due within 30 days. Charges and payments for services received during the last few days before your billing date may appear on the following monthly statement.

By my signature on this form, I attest I have read the above Financial Policy and understand and agree with its terms. I also authorize the release of the medical information necessary to process my claim with my insurance company and authorize my insurance company to pay directly the amount due me in my pending claim for medical/surgical treatment for me or my beneficiary of this policy. I understand I am financially responsible for any balance not covered by my insurance carrier. If your account is turned over for collections, we reserve the right to charge you the 35% collection fees/cost.

Patient Signature:_____ Date:_____

Patient Printed Name:_____

# Prescription Policy

Revised 8/20/14

1. Contact yourpharmacy and have them fax a refill request to our office. Medications are only refilled on the day they are due. No prescriptions will be refilled on Saturdays or Sundays. If your medication falls due over the weekend, it will be filled on the following Monday.

2. We ask that you do **not repeatedly** call the office to check on the status of your prescription refill. This will only slow the process of completing your request. Please check with your pharmacy between 4:30 pm & 5:00 pm on the day your prescription is due to determine to see if your request was filled or denied.

3. You must notify our office if you receive any prescriptions for controlled substances from **other** physicians. Failure to do so will result in the inability of our office to provide with you additional medications.

4. You should not share your medicines with anyone else and you should always keep them in a safe place. Lost or stolen medications will **not** be replaced.

5. Narcotics (pain medications) are frequently provided as one component of managing acute and post operative pain (12 weeks) management program. If you are prescribed narcotics to assist with managing your pain, you could potentially develop drug **dependence**,possibly requiring a drug rehabilitation program or counseling if these medications ever need to be stopped.

6. You have the option of being treated without narcotics (pain medications).

7. I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this State's Board of Pharmacy, in the investigation of possible misuse, sale, or other diversion of my pain medication. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

8. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in being without medication for a period of time.

9. I agree that I will submit to random blood or urine test if requested by my doctor to determine my compliance with program of pain control medication.

10. I understand that if I break this Agreement, my doctor will be unable to prescribe all controlled medications. I agree to follow to follow these guidelines. A copy of this document was provided to me.

_____ _____

Patient Signature Date

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy City: _____ Pharmacy State: _____

# GEORGE RAYMOND WILLIAMS, MD, LLC

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

| Patient Name (Last, First, Middle) | | DOB |
|---|---|---|
| Address | | SSN |
| City | State | ZIP |

| Provider Authorized to Release the PHI: | Entity Receiving the PHI: | | |
|---|---|---|---|
| | Name | | |
| | Address | | |
| | City | State | ZIP |
| | Attention: | | |

This authorization will expire on the following date or event:

Date: Event:

Purpose of this Disclosure:

### PHI and Dates of PHI Authorized for use or Disclosure

| Description | Start Date | End Date |
|---|---|---|
| □ **All PHI in the record** | | |
| □ **Progress Notes** | | |
| □ **Laboratory Tests** | | |
| □ **X-Ray Tests/Reports** | | |
| □ **History and Physical Examination** | | |
| □ **Discharge Summary** | | |
| □ **Consultation Reports** | | |
| □ **Itemized Billing Statement** | | |
| □ **Other:** | | |

**The following information will be released when included in the above information unless you indicate otherwise:**

( ) AIDS or HIV test Results

( ) Psychiatric or mental care/treatment

( ) Alcohol, drug or substance abuse treatment

( ) Other (Specify):

**I understand that:**

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provided authorized to release the protected health information, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

| **Signature of Patient:** | **Date** |
|---|---|
| **Signature of Patient's Representative (if necessary):** | **Date** |

**Personal Representative's Relationship to Patient:**