Jim Weiss, M.D., Board Certified, A.A.P.M.R.
Interventional Spine, Stem Cell Injections, Electrodiagnosis
and Rejuvenation Medicine

5858 Westheimer Rd. Suite 706
Houston, TX 77057
drjimmd@stemcellcenterhouston.com

Phone: (832) 808-7714
Fax: (713) 583-1848

PATIENT INFORMATION

Office Use: Received By:

Name:_____ Sex: [ ] M [ ] F Weight:_____ Height:_____

Address:_____ Date of Birth:_____

City:_____ State: _____ Zip:_____ Social Security #:_____

Work Phone #:_____ Marital Status: [ ] Married [ ] Single

Cell/Home Phone #:_____ Primary Care Physician:_____

Email:_____ Referring Physician:_____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Not Employed

Employer:_____

Phone#:_____

EMERGENCY CONTACT (NAME AND PHONE#)

(1)_____

(2)_____

(3)_____

RESPONSIBLE PARTY (Must complete if responsible party is other than the insured or patient.)

[ ] Same as Patient [ ] Same as Insured

Relation to Patient:_____

Name:_____ Employer:_____

Address:_____ Phone #:_____

City:_____ State: _____ Zip:_____ Date of Birth:_____

Drivers License #:_____ State_____ Social Security #:_____

PRIMARY INSURANCE (Must complete in its entirety in order for us to file with your Insurance.)

Name of Insured:_____ Relation to Patient:_____

Name of Insurance Company:_____ Insure SS #:_____

Insurance Phone #:_____ Member ID #:_____

Insured Employer:_____ Insured Date of Birth:_____

IS THE PATIENT COVERD UNDER ANY OTHER INSURANCE?YES / NO (IF YES, PLEASE COMPLETE BELOW.)

SECONDARY INSURANCE

Name of Insured:_____ Relation to Patient:_____

Name of Insurance Company:_____ Insure SS #:_____

Insurance Phone #:_____ ID and Policy Group #:_____/_____

Insured Employer:_____ Insured Date of Birth:_____

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company: therefore, making me fully responsible for any charges incurred.

PATIENT/RESPOSIBILITY PARTY SIGNATURE: _____ **DATE:** _____

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MEDICAL OVERVIEW

Name:_____ DOB:_____ Age:_____

What are you seeing the doctor for today?_____

Please indicate how you would rate your pain today? (LOW) 1 2 3 4 5 6 7 8 9 10 (HIGH)

1) Past Medical History:_____Migraines,_____Seasonal Allergies,_____COPD,_____Asthma, _____Hypertension,_____Diabetes,_____High Cholesterol,_____Heart Disease, _____GERD (Acid Reflux), ___Irritable Bowel Disease, _____Inflammatory Bowel Disease, _____Arthritis, _____Gout, _____ HIV, _____Hepatitis, _____ Cancer, Others_____
2) Past Surgical History:_____
3) **Medications: Name, Dosage, Frequency**

_____

_____

4) Drug Allergies:_____
5) Family History:_____
6) Social History: _____Married,_____Single,_____Widowed,_____Divorced How many Children?__

Alcohol:_____None,__Social,_____Moderate Tobacco:__None, __pack per day,
Other: Chewing tobacco, illicit drugs_____

REVIEW OF SYSTEMS (Please circle current symptoms)

GENERAL: Fever, chills, weight changes, malaise/fatigue, night sweats
HEENT: Blurred vision, photophobia, visual changes, hearing loss, ear pain, tinnitus, nasal congestion, nasal discharge, sneezing, post nasal drip, sore throat, swollen glands
CARDIOLOGY: Chest pain, palpitations, shortness of breath when lying down, swelling in lower extremities
RESPIRATORY: Shortness of breath, cough, wheezing
GI: Abdominal pain, nausea, vomiting, diarrhea, constipation, blood in the stools
GU: Blood in urine, painful urination, nighttime urination, urinary frequency, urinary urgency, discharge from penis, vaginal discharge, genital rashes or itching
MUSCULOSKELETAL: Joint pain, back pain, muscle pain
SKIN: Change in skin color, change in hair/nails, rashes, itching
NEUROLOGICAL: Numbness, weakness, loss of balance, headaches, seizures
PSYCHIATRIC: Poor concentration, insomnia, irritability/mood changes, anxiety, depression, suicidal/homicidal thoughts
ENDOCRINE: Heat/cold intolerance, hot flashes
HEMATOLOGIC: Easy bruising or bleeding, tender/swollen lymph nodes
FEMALE: Pain with periods, irregular periods, breast changes or tenderness, first day of last period_____ last pap_____ abnormal pap, hot flashes

OFFICE USE ONLY

BP_____ Pulse_____RR_____ 02Sat_____Temp_____ Ht____Wt____BMI___

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CONDITIONS OF SERVICE

PATIENT NAME:_____ **DOB:**_____

X Initials

Assignment of Benefits

I, or authorized representative/legal guardian acting on behalf of the patient hereby authorize payment of insurance benefits under the terms of my policy directly to James D Weiss MD the ("facility") for services rendered, I am financially responsible and will pay for charges not covered by my insurance plan.

X Initials

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered the facility, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. I understand payment in full is due at the time services are rendered or payment arrangements are to be made before my appointment. I understand that the amount quoted by the facility as being my responsibility is an estimate only and any patient balance remaining after my insurance has processed my claim will be billed to me and due within 30 days. I understand that it is my responsibility to inform the office with a minimum of a 24 hour advance notification if l am unable to make my appointment. I understand that I will be charged a fee for not giving proper notification.

X Initials

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures, in office surgical procedures and such medical treatment as the physician, his/her physician assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at the facility.

X Initials

Acknowledgement of Review of Privacy Practices

I, the undersigned, have reviewed the Privacy Practices, which explains how my medical information will be used and disclosed. I understand that the facility may use several resources to communicate with me including email, phone, text, mail and fax and I do authorize the facility to communicate PHI with me using these methods. 1 understand that I am entitled to receive a copy of the Privacy Practices.

X Initials

Release of Patient Healthcare Information

I hereby authorize the facility and any medical subcontracted providers, to release or obtain patient healthcare information, including but not limited to reports, prior films/images, test results, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the purpose of providing current continuum of care including to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier. Medicare, Medicaid, and any other payer or agency. The healthcare providers of James D Weiss MD may consult with a specialist for the coordination of your care. These specialists may contact you directly on behalf of your James D Weiss MD physician.

X Initials

Physician Ownership Disclosure

This is to inform you that your physician may or may not have an investment interest in the facility, lab, or pharmacy you are referred to. This information is being provided to you to help you make an informed decision about your healthcare. Should you be referred to a facility, lab, or pharmacy at any time and you prefer to use a different provider, you will be advised of alternatives. You should not be treated differently by your physician, physician's staff or the facility if you chose to choose a different facility.

X Initials

Disclosure to Friends and/or Family Members: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

Name_____ Relationship_____

Name_____ Relationship_____

Do you have an advance directive (living will)? ____ Yes _____No If yes, please bring a copy into our office for our files. If no, and you. would, like information on and advanced directive, please speck with your physician.

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Our office thru practice fusion has the capabilities of automatic email, SMS text or voice reminders with your written permission. When these services are in use to us, please tell us your communication preferences Please note that this will improve communication so as to reduce missed appointments. By checking this box you have agreed to prior express consent to receive automatic text and voice messages at the phone number(s).

Patient/Guarantor Signature_____ Date_____

The above authorizations are valid unless you revoke them in writing.