HOT SPRINGS PHYSICAL MEDICINE AND REHABILATATION CLINIC

Ross A. Hardy, MD
Drake C. Hardy, MD

APPOINTMENT: _____

REASON FOR APPOINTMENT: _____

Dear Patient:

Welcome to our practice!

At Hot Springs Physical Medicine and Rehabilitation Clinic, we provide our patients with the best care available. Enclosed find new patient information and release forms. We are located at One Mercy Lane, Suite 305 in the Medical Office Building in front of CHI St Vincent.

Before your appointment, please carefully read and complete all forms. Once complete, you may drop these forms at our office prior to your visit. If this is not possible please bring the completed forms with you to your appointment.

At the time of your appointment you will need the following:

- Your insurance card/cards
- Your driver's license or picture ID
- New patient information and release forms
- List of current medications

If you cannot keep your appointment for any reason, please contact our office 24 hours prior to your appointment. If you fail to do so, there will be a $50 charge for all regular appointments and a $100 charge for any EMG testing appointments and you may not be rescheduled.

Personal hygiene is especially important to help prevent infection. Please bathe before your appointment. If you have poor hygiene you may need to be rescheduled.

Thank you for choosing Hot Springs Physical Medicine and Rehabilitation Clinic, Ross A. Hardy, M.D. and Drake Hardy, M.D. Please feel free to contact us at 501-525-4785 with any questions or concerns.

We are not connected to CHI St. Vincent's network. We do not have access to your information and therefore this paperwork must be filled out.

Sincerely,

New Patient Co-Ordinator
Hot Springs Physical Medicine and Rehabilitation Clinic

One Mercy Lane #305
Hot Springs, AR 71913
Phone (501) 525-4785 Fax (501) 525-4794

HOT SPRINGS PHYSICAL MEDICINE AND REHABILITATION CLINIC
REGISTRATION FORM

Date: _____

PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	MARITAL STATUS (Circle One) Never Married Married Divorced Widowed
SOCIAL SECURITY #	DATE OF BIRTH	AGE	SEX (Circle One) Male Female
ADDRESS CITY STATE ZIP		HOME PHONE	CELL PHONE

RACE:	ETHNICITY;
○ AMERICAN INDIAN ○ BLACK OR AFRICAN AMERICAN ○ WHITE ○ DECLINE ○ ASIAN ○ NATIVE HAWAIIAN OR PACIFIC ISLANDER ○ OTHER	○ HISPANIC / LATINO ○ NOT HISPANIC / LATINO ○ OTHER ○ DECLINE

ARE YOU EMPLOYED?	IF YES	OCCUPATION
○ YES ○ NO	○ FULL TIME ○ PART TIME	

EMPLOYER	EMPLOYER'S ADDRESS	EMPLOYER'S PHONE NUMBER

PRIMARY INSURANCE ***(if any information is the same as above, please put "same")***

NAME OF INSURED DOB	RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF SPOUSE PARENT
EMPLOYER (IF NOT PATIENT)	INSURANCE ID#
INSURANCE COMPANY	GROUP #

SECONDARY INSURANCE ***(if any information is the same as above, please put "same")***

NAME OF INSURED DOB	RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF SPOUSE PARENT
EMPLOYER (IF NOT PATIENT)	INSURANCE ID#
INSURANCE COMPANY	GROUP #

PRIMARY CARE DOCTOR: _____

IN CASE OF EMERGENCY: _____ ***Phone number:*** _____

ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF MEDICAL INFORMATION:

I request that payment of my insurance benefits be made on my behalf to the clinic for any services furnished to me by any doctor in the clinic. I authorize any holder of medical information about me, to release this information, if needed to determine these benefits. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Signed: _____ **Date:** _____

HOT SPRINGS PHYSICAL MEDICINE AND REHABILITATION CLINIC

Date: _____

Name: _____ **Age**: _____ □ **Male** □ **Female**

Height _____ **Weight** _____ **Left Handed** _____ **Right Handed** _____

Please give a short explanation of your symptoms and how they affect you:

_____

_____

_____

Medication Allergies _____

_____

Other Allergies _____

Past Medical History

AIDS
- □ HIV Positive

Substance Abuse
- □ Alcohol Abuse
- □ Drug Abuse
- □ Suicide Attempt

Arthritis
- □ Osteoarthritis
- □ Rheumatoid Arthritis

Mental Health Disease
- □ Bipolar
- □ Schizophrenia
- □ Depression
- □ Eating Disorder

Blood Disorders
- □ Anemia
- □ Hemophilia
- □ Blood Clots
- □ Bleeding Disorders

Cancer
- □ Breast CA
- □ Lung CA
- □ Colon CA
- □ Prostate CA
- □ Chemotherapy
- □ Radiation therapy

Diabetes
- □ Type I
- □ Type II

LUNG DISEASE
- □ Asthma
- □ Bronchitis
- □ COPD / Emphysema/
- □ Tuberculosis
- □ Pneumonia
- □ Sleep Apnea
- □ Shortness of Breath

Degenerative Disc Disease
- □ Scoliosis
- □ Osteoporosis

Fracture
- □ _____
- □ _____

Rotator Cuff Tear
- □ Right
- □ Left

Leg Length Discrepancy
- □ Right
- □ Left

Kidney Disease
- □ Renal Hypertension
- □ Dialysis
- □ Transplant
- □ Frequent infections
- □ Kidney Stones
- □ Gout (high uric acid)

Liver Disease
- □ Diabetes
- □ Cirrhosis
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C

Thyroid Disease
- □ Graves Disease
- □ Hashimotos Disease
- □ Overactive Thyroid
- □ Underactive Thyroid

Stroke
- □ CVA (Stroke)
- □ TIA's (Mini-strokes)

Heart Disease
- □ Heart Disease
- □ Atrial Fibrillation
- □ CHF (Heart Failure)
- □ High Blood Pressure
- □ High Cholesterol
- □ Rheumatic Fever
- □ Pacemaker
- □ Valve Replacement
- □ Open Heart Surgery
- □ Transplant
- □ Arrhythmia
- □ Cardiomyopathy

HEADACHE
- □ Tension
- □ Cluster
- □ Migraine
- □ Allergy or Sinus
- □ Hypertension HA
- □ Caffeine
- □ Rebound headache

Gastrointestinal
- □ Reflux (GERD)
- □ Ulcerative Colitis
- □ Ulcers/Reflux
- □ IBS (Irritable Bowel)
- □ Bowel Obstruction

Neuropathy
- □ Peripheral
- □ Diabetic Peripheral
- □ Proximal Neuropathy
- □ Mononeuropathy

Other
- □ Glaucoma
- □ Fibromyalgia
- □ Post Polio Syndrome
- □ Multiple Sclerosis
- □ Parkinson's Disease
- □ Psoriasis
- □ Prostate Problems

Past Surgical History

Unremarkable
- □ No Surgeries

Abdominal Surgeries
- □ Appendectomy
- □ C-Section
- □ Gallbladder
- □ Gastric Bypass
- □ Hernia Repair
  - Area: _____
- □ Hysterectomy
- □ Nephrectomy
- □ Transplant
- □ Amputation:
  - Area:_____
  - □ Left
  - □ Right

Breast Surgery
- □ Augmentation
- □ Reduction
- □ Mastectomy
  - □ Right
  - □ Left

Cataract Extraction
- □ Left
- □ Right

Craniotomy
- □ Yes
- □ No

Dialysis
- □ AV Graft
- □ AV Fistula

Heart Surgery
- □ CABG - bypass
- □ Pacemaker
- □ Defibrillator
- □ Heart Stents
- □ Aortic Valve Replaced
- □ Mitral Valve Replaced
- □ PTCA (Angioplasty)

Hemorrhoidectomy
- □ Yes
- □ No

Lung Surgery
- □ Bronchoscopy
- □ Pneumonectomy

Neck/Throat Surgery
- □ Tonsillectomy
- □ Carotid Endarterectomy
- □ Parathyroidectomy
- □ Thyroidectomy

Orthopedic Surgery
- □ Carpal Tunnel release
  - □ Right
  - □ Left
- □ Cubital Tunnel release
  - □ Right
  - □ Left
- □ Hip replacement
  - □ Right
  - □ Left
- □ Knee Arthroscopy
  - □ Right
  - □ Left
- □ Knee Replacement
  - □ Right
  - □ Left
- □ Rotator Cuff Repair
  - □ Right
  - □ Left
- □ Shoulder Replacement
  - □ Right
  - □ Left

Pain Procedures
- □ Nerve blocks
- □ Radiofrequency
- □ Trigger Point Inj
- □ SI Joint Injection
- □ Knee Injections

Prostrate Surgery
- □ Prostatectomy
- □ TURP

Spine Surgery
- □ Cervical
- □ Thoracic
- □ Lumbar
- □ Spinal Fusion
  - □ Yes
  - □ No
- □ Kyphoplasty
- □ Vertebroplasty
- □ **Other**

_____

_____

Family History

Adopted? Yes _____ No _____ If adopted or do not know family history please skip this section

Please mark : M = MOTHER F=FATHER B = BROTHER S = SISTER

_____ Alcoholism	_____ Blood Transfusions	_____ Angina	_____ Melanoma
_____ Anemia	_____ Breast Cancer	_____ High Blood Pressure	_____ Ovarian Cancer
_____ Arthritis	_____ Cervical Cancer	_____ High Cholesterol	_____ Uterine Cancer
_____ Anxiety	_____ Colon Cancer	_____ Ulcers	_____ Thyroid Disease
_____ Asthma	_____ Depression	_____ Surgery - Cervical	_____ Weight Disorder
_____ Back Problems	_____ Diabetes	_____ Surgery - Lumbar	_____ Headaches
_____ Birth Defects	_____ Growth/Development	_____ Surgery - Thoracic	_____ Other: _____
_____ Blood Clots	_____ Heart Disease	_____ Lung Cancer	_____

	Mother	Father	Sister	Brother	Addt'l Siblings
Circle One	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	
Age: Current or at death					

Social History

□ Married □ Divorced □ Single □ Widowed □ Live Alone □ Does not live alone □ Number of children: _____	□ Current Smoker How much _____ Date started _____ □ Former Smoker Date Quit _____ □ Never Smoked	□ Alcohol Use □ Yes □ No If yes how often? _____ □ Exercise □ Yes □ No If yes how often? _____	□ Substance Abuse □ Yes □ No □ Drug Rehab □ Yes □ No When _____

Employment

□ Works Full Time □ Works Part Time □ Retired □ Disabled	**JOB DESCRIPTION: (explain all activities at workplace)** _____ _____ _____

Review of Systems

General
□ Weight loss
□ Fatigue
□ Fever

Eyes
□ Vision loss
□ Double Vision
□ Change in Vision

ENT
□ Pain
□ Hearing loss
□ Dizzy
□ Tooth/Gum Pain

Cardiovascular
□ High Blood Pressure
□ Chest Pain
□ Palpitations
□ Murmur

Respiratory
□ Cough
□ Bronchitis
□ Coughing up blood
□ Shortness of Breath

GI
□ Trouble swallowing
□ Nausea/vomiting
□ Heartburn
□ Constipation
□ Diarrhea
□ Bloody stool
□ Abdominal pain

GU
□ Bloody urine
□ Urgency/incontinence
□ Pain with urination

Musculoskeletal
□ Joint pain
□ Stiffness
□ Limp
□ Spasms
□ Muscle Pain
□ Limited movement

Skin
□ Rash
□ Lumps
□ Redness
□ Itching

Neurological
□ Headache
□ Paralysis
□ Fainting
□ Numbness
□ Tingling
□ Weakness
□ Vertigo
□ Seizures

Psychological
□ Depression
□ Anxiety
□ Moodiness

Endocrine
□ Sweating
□ Thirsty
□ Always cold
□ Always hot

Hematology
□ Bleeding
□ Blood Clots

Allergy
□ Hives
□ Hay Fever

CURRENT MEDICATIONS *(Please list medications, dosage and how taken)*

A LIST OF MEDICATIONS IS ALSO ACCEPTABLE

MEDICATION	DOSAGE	HOW TAKEN

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of the form.

_____ _____

Signature **Date**

HOT SPRINGS PHYSICAL MEDICINE AND REHABILITATION CLINIC
HIPAA CONSENT FORM

I understand that as a part of my healthcare, Hot Springs Physical Medicine and Rehabilitation Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I understand and have been offered a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that Hot Springs Physical Medicine and Rehabilitation Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Hot Springs Physical Medicine and Rehabilitation Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hot Springs Physical Medicine and Rehabilitation Clinic change their notice, they will send a copy of any revised notice to the address provided.

COMPLETE:

Name of Individual Request Pertains to	Date of Birth
Mailing Address	Telephone Number

I wish to have the following **restrictions** to the use of disclosure of my health information:

_____

I grant the clinic's staff and physician's permission to discuss my protected health information and other personal information with the following persons:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

I [ ] do / [ ] do not authorize Hot Springs Physical Medicine and Rehabilitation Clinic to forward/fax "Return to Work" excuses to my employer or school.

I [ ] do / [ ] do not authorize Hot Springs Physical Medicine and Rehabilitation Clinic to leave appointment information on my answering machine.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE/RELATIONSHIP OF PATIENT'S REPRESENTATIVE DATE

HOT SPRINGS PHYSICAL MEDICINE AND REHABILITATION CLINIC
ROSS A HARDY, MD

Financial Policy

BASIC POLICY:
Payment is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not have insurance, payment in full is expected at the time of your visit.

FOR PATIENTS WITH INSURANCE:
If we are members of your insurance group, we will bill the insurance carrier for payment to come directly to us. You will be responsible for co-payments, deductibles, and co-insurance only. **All co-payments and deductibles are due and payable at the time service is provided.**

If we are not members of your insurance group we will bill most insurance carriers for you if the proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Payment for these claims will come directly to us. If our office can be of any assistance with your insurance carrier please let us know.

MEDICARE PATIENTS:
Our office accepts Medicare assignment. We will also bill secondary insurances for you. All co-payments and deductibles are due and payable at the time the service is provided.

NON-COVERED SERVICES:
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

RETURNED CHECKS:
A $25.00 fee will be assessed to your account for each returned check. This fee and the original check amount must be paid in full with cash, credit card, or money order prior to your next appointment. After receiving two (2) returned checks, we will no longer accept checks as a method of payment.

MISSED APPOINTMENTS / NO SHOWS:
If it is necessary to cancel a scheduled appointment, we require at least 24 hours' notice. A **late cancellation** is considered when a patient fails to cancel their scheduled appointment with a **24 hour advance notice.** A **no-show** is when a patient misses an appointment with no notice or shows up too late to the appointment to be seen. A **$50.00 fee** will be billed to your account for late cancellations and no-shows for regular office appointments. A **$100.00 fee** will be billed to your account for late cancellations and no-shows for EMG testing appointments. By signing below, I agree that I am financially responsible for any charges incurred for late cancellations or no-show appointments.

ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage and assign directly to Hot Springs Physical Medicine and Rehabilitation Clinic all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office of Hot Springs Physical Medicine and Rehabilitation Clinic to release all information necessary to secure the payment of benefits or to pre-certify their services as required by my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to Hot Springs Physical Medicine and Rehabilitation Clinic for any services furnished me by any member of this clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCVA-1500 form, or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare, assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the determination of the Medicare carrier.

I have read, understood, and agreed to the above financial policy for payment of professional fees. I understand that I, the patient, am ultimately responsible for all professional fees.

Signature: Date:

HOT SPRINGS PHYSICAL MEDICINE AND REHABILITATION CLINIC
ROSS A HARDY, MD
DRAKE C HARDY, MD

APPOINTMENT CANCELLATION POLICY

Your appointment time is important to you, your physician, and to others who need our services.

If it is necessary to cancel a scheduled appointment, we require at least 24 hours' notice. A **late cancellation** is considered when a patient fails to cancel their scheduled appointment with a **24-hour notice.** A **no-show** is when a patient misses an appointment with no notice or shows up too late to the appointment to be seen. **A fee of $50.00 will be billed to your account for late cancellations and no-shows for regular office visit appointments. A fee of $100.00 will be billed to your account for late cancellations and no-shows for any EMG testing appointment.** You will be personally responsible for this charge. This charge will not be billed to nor paid for by your insurance company. Futures appointments will not be scheduled until this fee is paid.

You will receive an appointment reminder card at your visit with the date and time for your next visit. You will also receive a call to verify your appointment several days prior to the appointment date.

Please help us keep the scheduling of appointments fair for everyone.

Thank you.

_____ _____

Patient Signature Date