BEST SURGERY & THERAPIES

REGISTRATION FORMS

PERSONAL INFORMATION

First name: | MI: | Last name: | Date:

Date of birth: | Age: | Social Security#:

Driver's license#: | Email: | Home phone#: | Cellphone#:

Current mailing address: | City: | State: | ZIP code:

Sex: ☐ Male ☐ Female ☐ Intersex Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

If you are married or otherwise partnered, what is the person's name?

Race:

☐ Black/African-American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ American Indian ☐ Hispanic or Latino

☐ Decline to answer ☐ Asian ☐ Alaska Native ☐ Other:

Ethnicity:

☐ Not Hispanic or Latino ☐ Decline to answer ☐ Hispanic or Latino ☐ Unknown

Preferred language:

☐ English ☐ Spanish ☐ Decline to answer ☐ Other

INSURANCE INFORMATION

We MUST obtain this information to coordinate with your insurance company and provide the best care.

Primary insurance: | Insurance company's phone#: | Policyholder's name (as on card): | Policyholder's relationship:

Insurance claims address:

Policyholder's DOB: | Policyholder's SSN: | Member ID/policy#: | Group#:

Secondary insurance: | Insurance company's phone#: | Policyholder's name (as on card): | Policyholder's relationship:

Insurance claims address:

Policyholder's DOB: | Policyholder's SSN: | Member ID/policy#: | Group#:

SIGNATURE NEEDED

Patient/guardian signature: | Printed name: | Date:

ACTIVITY/LIFESTYLE MODIFICATIONS

What is your primary concern?

How long have you had this problem?

What additional treatment options have you received for this problem?

Please list any restrictions you have:

Are you able to perform household chores? ☐ Yes ☐ No

Are you able to sit for long periods of time? ☐ Yes ☐ No

Are you able to stand for long periods of time? ☐ Yes ☐ No

Does your pain interfere with your daily job functions? ☐ Yes ☐ No

If yes, please explain:

Primary physician name:

Phone#:

Specialist name:

Type of physician:

Phone #:

Please list all medications including vitamins, supplements, etc

Please clearly list below any medications you take including vitamins, supplements, etc.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Med name 20mg	Twice a day	4-1-2017	Cholesterol

MEDICAL HISTORY

Please indicate if you have any of the following and explain below:

- ☐ Angina
- ☐ Headaches/migraines
- ☐ Pacemaker/defibrillator
- ☐ Arthritis
- ☐ Heart attack
- ☐ Prior infections
- ☐ Asthma
- ☐ Heart murmur
- ☐ Pulmonary (lung) disease
- ☐ Bleeding disorders
- ☐ Heart rhythm abnormalities
- ☐ Rheumatic fever
- ☐ Cancer
- ☐ Hepatitis
- ☐ Seizures
- ☐ Cholesterol disease
- ☐ High blood pressure
- ☐ Skin disorders
- ☐ Congestive heart failure
- ☐ HIV/AIDS
- ☐ Sleep apnea
- ☐ Coronary heart disease
- ☐ Kidney/bladder disease
- ☐ Strokes/TIA
- ☐ Depression/anxiety
- ☐ Liver disease
- ☐ Tremors
- ☐ Diabetes
- ☐ MRSA
- ☐ Thyroid disease
- ☐ Fibromyalgia
- ☐ Multiple sclerosis
- ☐ Tuberculosis
- ☐ Gastrointestinal disease
- ☐ Nervous system disease
- ☐ Vascular disease
- ☐ GERO
- ☐ Osteoporosis
- ☐ Other

If any of the above was checked, please explain:

ALLERGIES

Please clearly list any allergies, medical or nonmedical.

Type of allergy	Reaction	Severity (please check one)			
		Mild	Moderate	Severe	Life Threatening
Example: Penicillin	Hives, itching and rash	☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
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		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Patient Pharmacy

Name: Phone:

Address: City: State: ZIP code:

FAMILY HISTORY

Place a check by any family conditions and fill in the rest of the row.

Mother= M, father = F, sibling= S, child = C, maternal grandparent= MG, paternal grandparent= PG

Condition (Please check)	Which family member?						Onset	Current family member condition
	M	F	S	C	MG	PG		
☐ Arthritis								
☐ Bleeding disorders								
☐ Cancer								
☐ Cholesterol disease								
☐ Coronary heart disease								
☐ Diabetes								
☐ Heart attack								
☐ High blood pressure								
☐ Kidney/bladder disease								
☐ Liver disease								
☐ Neuromuscular disease								
☐ Osteoporosis								
☐ Pulmonary disease								
☐ Stroke								
☐ Thyroid disease								

PATIENT HISTORY

Have you ever used any form of nicotine or tobacco? ☐ Yes ☐ No If you answered yes: How many packs per day? _____ How many year used: _____

Do you drink coffee, tea or soda? ☐ Yes ☐ No If you answered yes: How many cups per day? _____ Per week? _____

Do you drink alcohol? ☐ Yes ☐ No If you answered yes: How many drinks per day? _____ Per week? _____

SURGICAL HISTORY

Please indicate if you have had any of the following procedures, conditions or surgery on any of these areas:

☐ Abdominal (stomach)	☐ Gallbladder	☐ Nerve stimulator or pump	☐ Anesthesia complications	☐ Hand
☐ Pacemaker/defibrillator	☐ Angioplasty/stents	☐ Hemorrhoids	☐ Prostate	☐ Appendix
☐ Hernia	☐ Shoulder	☐ Arm	☐ Hip	☐ Spine (neck/back)
☐ Breast	☐ History of dura leak	☐ Thyroid	☐ Chest/lung	☐ Knee
☐ Tonsil/wisdom teeth/adenoids	☐ Coronary artery bypass	☐ Leg	☐ Uterus/ovary	☐ Elbow
☐ Low back/lumbar spine	☐ Varicose veins	☐ FooUankle	☐ Neck/cervical spine	☐ Wrist

If any of the above was checked, please explain:

_____

_____

_____

_____

_____

_____

SIGNATURE NEEDED

Patient/guardian signature: _____ Printed name: _____ Date: _____

BEST SURGERY & THERAPIES

PATIENT AUTHORIZATION TO REQUEST/RELEASE MEDICAL INFORMATION

THIS FORM ALLOWS BEST HEALTH CLINIC TO RELEASE RECORDS ON YOUR BEHALF.

Patient name:

Date of birth: | Last four digits of SSN: | Phone #:

Address: | City: | State: | ZIP code:

I hereby authorize BEST Health Clinic its affiliates, medical staff, employees and their representatives to release my protected health information in the manner listed below, and to the following:

Choose only one method to send by:

☐ Mail ☐ Fax ☐ Secure email (records will expire after 60 days if left unopened)

RECORDS REQUESTED:

☐ All records (notes, labs, reports, images) ☐ Disc of ALL images (only)

☐ Specific item only (please list):

If images are requested, a mailing address must be provided or records will not be sent.

Send to:

☐ Send to the address listed above ☐ Send to a different address listed below

Name:

Address: | City: | State: | ZIP code:

Email: | Phone #: | Fax #:

There may be a charge for copies of records, in accordance with federal and state laws.

This authorization is effective one (1) year from the date signed below, except when revocation or modification is requested in writing by the patient, legal guardian, power of attorney or health care surrogate accompanied by the applicable documentation. I understand that I have the right to revoke or modify this authorization at any time. I understand that if I revoke or modify this authorization, I must do so in writing and present my written request to the Medical Records Team. Additionally, I acknowledge my responsibility to confirm receipt by BEST of such revocation or modification; such confirmation is required via certified mail. I understand that the revocation or modification will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected under federal privacy laws or regulations.

I understand BEST will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

Signature of patient/guardian/power of attorney/health care surrogate | Date

Printed name | Relationship to patient

Use one form for each person from whom you wish BEST to send your health information. You may copy this form as often as needed.

AUTHORIZATION TO VERBALLY DISCUSS HEALTH INFORMATION

You may choose to give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information when you are not present. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Complete this form to let us know to whom we may speak about your information.

HERE ARE SOME EXAMPLES OF WHEN IT MIGHT BE USEFUL FOR YOU TO RELEASE INFORMATION:

- If you want a relative or friend to help you understand medical treatment instructions
- If a relative or friend is helping with billing instructions
- If a relative or friend calls to verify your appointment time
- If a relative or friend comes in and asks if you are here and in or out of the procedure room

Authorization to Verbally Discuss Health Information

Patient name: _____ Date of birth: _____

I hereby authorize Brainard ASC to discuss and disclose specific health information as selected below to the following entity/individual. Name:

Relationship: _____ Phone number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name: _____ Relationship: _____ Phone number: _____

Address: _____ City: _____ State: _____ ZIP: _____

DESCRIPTION OF SPECIFIC INFORMATION TO BE DISCUSSED AND DISCLOSED (PLEASE CHECK ALL THAT APPLY):

- ☐ All health and treatment information
- ☐ Appointment date/times
- ☐ Lab/test results
- ☐ Billing/payment information
- ☐ Other: _____
- ☐ Medical information (including symptoms, diagnosis, pregnancy, medication, and treatment plan)
- ☐ Procedure status/location (whether I'm waiting to go into procedure or have been released)

I understand the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

EFFECTIVE DATES FOR THIS AUTHORIZATION

Authorization automatically expires one (1) year from the date signed below. You have the right to revoke this authorization before the year has passed.

BY SIGNING, I UNDERSTAND THAT:

- I may inspect or copy the protected health information to be used or disclosed.
- I may notify the medical practice in writing if I would like to revoke this authorization.
- This authorization is giving the Brainard ASC permission to discuss my health information as selected above with entity/individual listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).
- I may refuse to sign this authorization, and that this authorization is not a condition of treatment or payment.

PATIENT/LEGAL REPRESENTATIVE

Signature _____ Date _____

Printed name _____

BEST

AUTHORIZATION OF PRIVACY INFORMATION

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Brainard ASC in order to carry out treatment, payment, or health care operations.

I acknowledge that I have been provided with a copy of Brainard ASC Privacy & Security Practices Notice to review a complete description of privacy practices and the potential release and use of your protected health information, and that it is right to review such Notice prior to signing this Consent Form.

I acknowledge that Brainard ASC reserves the right to change the terms of its privacy practices at any time and that in the event the terms of Brainard ASC Privacy & Security Practices Notice change, you I will be notified as required by prevailing laws and may also request a current copy of our the Notice by requesting a copy from our the BEST clinic's front desk staff at any time.

I understand that I retain the right to request to change my consent to the below disclosures, and that I must do so in writing. I understand I may request that Brainard ASC further restrict how your my protected health information is released or used to carry out care, payment, or heath care operations.

Please Note: Brainard ASC encourages you to read the privacy practices and standards of your email and phone provider(s) as their privacy policy may differ from those of Brainard ASC.

IN CONSIDERATION OF ABOVE, I AGREE AND CONSENT TO RELEASING INFORMATION TO ME IN THE FOLLOWING MANNERS:

VIA EMAIL	CONTACT INFO	DATE
☐ Ok to send PHI to email address	_____	_____
☐ Ok to send PHI to alternate email	_____	_____
VIA HOME TELEPHONE		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA CELL PHONE		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA ALTERNATE COMMUNICATION METHOD		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
☐ Ok to FAX PHI to:_____	_____	_____

BY SIGNING BELOW, I ATTEST THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE.

SIGNATURE: _____ DATE: _____

EMERGENCY CONTACT INFORMATION

I authorize BEST Surgery & Therapies to VERBALLY discuss my selected information with the following people, including translation from/to another language:

Contact name 1: _____ Relationship: _____ Home phone#: _____ Cellphone#: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Contact name 1: _____ Relationship: _____ Home phone#: _____ Cellphone#: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

By selecting the following options and signing, I authorize BEST Surgery & Therapies to discuss the following information with my emergency contact(s)

☐ My appointment information ☐ My billing and payment information ☐ My lab/test results ☐ My location within the facility

☐ My medical information (including symptoms, diagnosis, medication and treatment)

Cancellation of this authorization must be submitted in writing.