Confidential Health Information Questionnaire

This information is needed so we can better serve you. Please fill in ALL portions of the form if you need assistance please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

Your Name:_____Date:_____

Address:_____

City:_____State:_____Zip_____

Home #:_____Cell #:_____

Email:_____Age:_____Date of Birth_____

SSN:_____Maritial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation:_____Employed By:_____

Work #:_____Work Address_____

Is your visit due to an accident? ☐ Yes ☐ No

Are you a Medicare patient? ☐ Yes ☐ No If Yes, Medicare #_____

Your Spouse's Name_____

Spouse's Employer:_____Spouse's Work #:_____

In Case of Emergency

Name of person to contact:_____

Their Home and Work #:_____

Name of Nearest Relative(Not Living With You)_____

Their #_____

Who referred you to our office so we may thank them?_____

Referring Physician:_____

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient Signature:_____Date:_____

Parent or Guardian(Print):_____Date:_____

Parent or Guardian Signature:_____

Please complete the information on the opposite back. Thank you!

Insurance Coverage Information Page 2

Medical Insurance

Insurance Carrier:_____Phone:_____

Policy Holder Name:_____Policy #:_____

Group Number:_____

Workers Compensation Injury

Employer:_____Phone:_____

Address:_____ Supervisor:_____

Was injury/accident reported to supervisor: ☐ Yes ☐ No Date:_____Time:_____

Workers Comp Carrier:_____Policy#:_____

Carriers Phone:_____Adjuster:_____

Claim Number:_____

Auto/Personal Injury

Do you have a "Med Pay" on your Auto Policy: Yes/No Amount:$_____

Insurance Carrier Name:_____Phone:_____

Adjuster:_____ Claim #:_____

Third Party Payer (Other Involved Vehicle Insurance)

Third Party (Person at Fault) Name:_____

Their #:_____ Their Insurance Carrier:_____

Their Insurance Carrier #:_____

Adjuster:_____ Claim #_____

Patient Signature:_____Date:_____

Present Complaints (Please Circle Any That Apply) Page 3

Headache	Feet/Hand Cold	Head Seems Heavy	Upper Back Stiffness
Mental Dullness	Depression	Confusion	Mid Back Stiffness
Loss of Memory	Loss of Smell	Pins/Needles in Arms Right /Left	Lower Back Stiffness
Dizziness	Loss of Taste	Pins/Needles in Hands Right/Left	Neck Stiffness
Nervousness	Constipation	Pins/Needles in Legs Right/Left	Neck Pain
Fainting	Diarrhea	Unbalanced Chest Pain	Upper Back Pain
Shortness of Breath	Tension	Rib Pain	Mid Back Pain
Eye Strain/Pain	Blurred Vision	Neck Restriction	Low Back Pain
Fear	Irritability	Double Vision	Ear(s) Ringing

Difficulty in: ☐ Standing ☐ Sitting ☐ Bending ☐ Walking

Pain Radiation to the: ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

☐ Neck ☐ Base of Skull ☐ Ribs ☐ Shoulders

Pain in the: ☐ Foot ☐ Ankle ☐ Knee ☐ Hip ☐ Heel Spurs

Other:_____

Since the time this/these complaint(s) began, what, if anything have you tried that **did not** work?____

_____

Has the problem interrupted your sleep? Yes / No How?_____

Does anyone in your family have the same or similar condition Yes / No Who?_____

List any doctors or therapists that you have seen for this complaint:

1._____ Specialty_____

2._____ Specialty_____

Relevant Medical History: (please circle the conditions **you have or had previously**)

Arthritis	Concussion	Epilepsy	Hepatitis	Muscular Dystrophy	Rheumatic Fever
Asthma	Convulsion	Fibromyalgia	High Blood Pressure	Neck Pain/Spasms	Sinus Trouble
Anemia	Diabetes	Hand/Wrist Pain	HIV	Neuritis	Sciatica
Back Pain/Spasm	Digestion Problems	Headaches	Measles	Numbness	TB
Cancer	Dizziness	Heart Problems	Multiple Sclerosis	Polio	Venereal Disease

Please complete the information on the opposite side. Thank You!

Patient Signature:_____Date:_____

Present Complaints

List any operations that you've had and approximate dates:

1._____Date:_____Dr:_____

2._____Date:_____Dr:_____

3._____Date:_____Dr:_____

4._____Date:_____Dr:_____

Are you allergic to any medications? Please List: _____

_____

Are you taking any medication? Please List: _____

_____

Do you wear Orthotics (Shoe Inserts)? Yes / No Type:_____

Are you Pregnant? Yes / No Due Date:_____

Do you: Smoke: Yes / No Amount per day:_____

Drink: Yes / No Light Medium Heavy

Exercise: Never Sometimes Frequently Regularly

Please Check The Type of Care Desired

Temporary Relief

Nutrition

Total Health Care

Herbs / Acupuncture

Control of immediate Problem

I prefer the doctor to select the type of care desired

Does anyone in your family have a similar health related problem? Yes / No

Who:_____ What Condition:_____

Care they are recieving :_____

Patient Signature:_____ Date:_____

Dr. Andrew Kong & Associates

Family History

Patient Name: _____ Date:_____

Please indicate if anyone in your immediate family has had any of the following. (DO NOT INCLUDE YOURSELF)

□ Diabetes	□ Cancer	□ Neurological Disease
□ Thyroid Dysfunction	□ Hepatitis	□ Musculoskeletal Disease
□ Kidney Disease	□ Aids/Venereal Disease	□ Mental Disorder
□ High/Low BP	□ Arthritis	□ Other:_____
□ Atherosclerosis	□ Asthma	□ Other:_____
□ Heart Disease/Stroke	□ Tuberculosis	□ Other:_____

Please check if you have or have ever had any of the following.

□ Nervousness	□ Diabetes	□ Sinus Trouble
□ Irritability	□ Hypoglycemia	□ Wheezing/Asthma
□ Depression	□ Allergies _____	□ Emphysema
□ Fatigue	□ Heart Disease/Stroke	□ Generally feeling run-down
□ Thyroid Dysfunction	□ Cancer	□ Inadequate Exercise
□ Weight Gain _____lbs.	□ Skin Problems	□ Vomiting/Nausea
□ Weight Loss _____lbs.	□ AIDS/Venereal Disease	□ Difficulty Swallowing
□ Loss of Sleep _____ hrs/day	□ Hepatitis	□ Ulcers
□ Coffee _____ cups/day	□ Liver Disease	□ Indigestion/Heartburn
□ Cigarettes _____ packs/day _____ years	□ Alcohol/Drug Abuse	□ Hernia
□ High / Low Blood Pressure	□ Anemia	□ Constipation
□ Vertigo	□ Gallbladder Problem	□ Hemorrhoids
□ Kidney Problems	□ Other _____	□ Other _____

Women Only		**Men Only**
□ Menstrual Pain Where? _____	□ Genital Cancer	□ Urinating Frequently
□ Cramping	□ Discharge	□ Difficulty Starting Urination
□ Irregularity	□ Tumor	□ Night Urination
□ Cycle _____days	□Abortion	□ Burning Urination
□ Birth Control	□ Menopause	□ Dribbling Urination
Type? _____	When?_____	□ Prostate Pain / Swelling
□ Hysterectomy	□ Are you Pregnant?	□ Inability to Achieve Erection
When? _____	Yes / No / Not Sure	□ Inability to Maintain Erection

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Thank you for trusting us with your health. We consider it an honor and a privilege to treat you and your family and friends. We look forward to helping you achieve lifelong health and well being. Remember, your health is a contract between you and your doctor.

In order to achieve your health goals, please answer the following statements.

How willing are you to:

(1 Least Willing—5 Most Willing)

Significantly modify your diet	5	4	3	2	1
Take nutritional supplements every day	5	4	3	2	1
Keep a record of everything you eat each day	5	4	3	2	1
Modify your lifestyle (work demands, sleep habits)	5	4	3	2	1
Practice relaxation techniques	5	4	3	2	1
Engage in regular exercise	5	4	3	2	1
Have periodic lab tests to assess progress	5	4	3	2	1
Follow the doctor's recommended treatment plan	5	4	3	2	1
Keep scheduled appointments as much as possible	5	4	3	2	1

Comments: _____

_____

_____

Patient Signature _____ **Date** _____

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Children's Metabolic Screening Questionnaire

(AGES 13 AND YOUNGER)

Name_____Age_____Date_____

Rate each of the following symptoms based upon your health in the past 30 days:

0 – Never or almost never have the symptoms

1 – Occasionally have it, effect is not severe (I do not like the symptom.)

2 – Occasionally have it, effect is severe (I <u>really</u> do not like the symptom.)

3 – Frequently have it, effect is not severe (I do not like the symptom.)

4 – Frequently have it, effect is severe (I <u>really</u> do not like the symptom.)

Add the numbers for each section, and then add the totals for each section to arrive at the grand total.

DIGESTIVE	ENERGY/ACTIVITY	JOINT/MUSCLES
__Nausea or Vomiting	__Fatigue, sluggishness	__Pain or aches in joints
__Diarrhea	__Apathy, sluggishness	__Arthritis
__Constipation	__Hyperactivity	__Stiff, limited movement
__Bloated feeling	__Restlessness	__Pain, aches in muscles
__Belching, passing gas	__TOTAL	__Weakness or tiredness
__Heartburn		__TOTAL
__TOTAL		

EMOTIONS	HEAD	NOSE
__Mood swings	__Headaches	__Stuffy nose
__Anxiety, fear, nervous	__Faintness	__Sinus problems
__Anger, irritability	__Dizziness	__Hay fever
__Depression	__Insomnia	__Sneezing attacks
__TOTAL	__TOTAL	__Excessive mucus
		__TOTAL

EYES	MIND	HEART
__Watery, itchy eyes	__Poor memory	__Skipped heartbeats
__Swollen, reddened or sticky eyelids	__Confusion	__Rapid Heartbeats
	__Poor concentration	__Chest pain
__Dark circles under eyes	__Poor coordination	__TOTAL
__Blurred/tunnel vision	__Difficulty making decisions	
__TOTAL	__Stuttering, stammering	
	__Slurred speech	
	__Learning disability	
	__TOTAL	

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LUNGS	MOUTH/THROAT	WEIGHT
__Chest congestion	__Chronic coughing	__Binge eating/drinking
__Asthma, bronchitis	__Gagging, need to clear throat	__Craving certain foods
__Shortness of breath	__Sore throat, hoarse	__Excessive weight gain
__Difficulty breathing	__Swollen or discolored tongue,	__Compulsive eating
__TOTAL	gums, lips	__Water retention
	__Canker sores	__Underweight
	__TOTAL	__TOTAL

EARS	SKIN	SLEEP
__Itchy ears	__Acne	__Difficulty sleeping through night
__Earaches, ear infection	__Hives, rashes, dry skin	__Difficulty falling asleep
__Drainage from ears	__Flushing or hot flashes	__Difficulty waking up/getting
__Ringing in ears, hearing loss	__Excessive sweating	started
__TOTAL	__Hair loss	__Difficulty getting 8 hours sleep
	__TOTAL	__TOTAL

OTHER

__Frequent illness
__Frequent/urgent urination
__Genital itch, discharge
__Bedwetting

GRAND TOTAL_____

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Interventional Pain Management

Patient Consent—Assignment of Benefits—Release of Information

Patient Name_____ SSN_____

Insurance Company_____ Phone Number_____

Member Name_____ Id#_____ Grp# _____

Patient Consent:

I hereby authorize the providers and staff to perform such services as deemed medically necessary by the physician to diagnose and treat my child _____. I understand the physician may find it necessary to perform diagnostic testing that may cause some mild discomfort. Because the doctor orders the necessary tests to increase the accuracy of their diagnosis and guide their continued care and treatment, I hereby authorize the performance of the necessary tests.

Parent Initials:_____

I hereby give **Interventional Pain Management** permission to leave messages on my answering machine or voicemail, regarding my appointments or account information, if I am not home.

Parent Initials:_____

Assignment of Benefits:

I hereby assign to **Interventional Pain Management 4235 Maray Drive, Rockford, IL, 61107**, ("Provider") all my rights and benefits under the above referenced policy ("the policy") and direct the above stated Insurance Company to pay Provider directly, at the above address by check made to **Interventional Pain Management** any benefits due under the policy for any and all medical services or the like performed on my behalf by provider.

If the above Insurance Company prohibits direct payment to **Interventional Pain Management,** THEN I HEREBY INSTRUCT AND DIRECT the above named Insurance Company to ISSUE ALL CHECKS FOR PAYMENT OF SERVICES TO MYSELF AND PROVIDER AS A CO-PAYEES, and further grant to **Interventional Pain Management** the full power to endorse said check. If I received payments due to **Interventional Pain Management** , it is my obligation to remit the same amount to **Interventional Pain Management.**

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

The payment to **Interventional Pain Management** shall not exceed my indebtedness to provider, and I further agree to pay in full in a very timely manner, ANY AND ALL OF ANY BALANCE DUE TO PROVIDER and not paid by insurer. **Parent Initials:**_____

Release of Information:

I hereby authorize the release of medical records necessary to process this claim. I also hereby authorize my insurance carrier(s) to release all information requested by **Interventional Pain Management.** I agree to provide ANY and ALL relevant information requested. I also authorize the RELEASE of any and all information pertinent to my case to ANY INSURANCE COMPANY, ADJUSTOR OR ATTORNEY involved in this case.

Parent Initials:_____

A PHOTOCOPY, FACSIMILE AND/OR NCR COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

MY SIGNATURE BELOW ATTESTS THAT I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

SIGNATURE of Parent/Guardian : _____ Date:_____

SIGNATURE of Witness: _____ Date:_____

Dr. Andrew Kong & Associates

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that the health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain the patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relations with you (such as laboratories that only interact with physician and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of our personal health information, but this must be in writing. Under this Law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some suture time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS'

To our valued patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing our patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, law and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a compliance program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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Interventional Pain Management

Financial Agreement

Initials	#	Policy
	1	**Information**– You agree to provide your correct name, current and correct address, phone number, email, insurance information, social security number and driver's license or picture identification at the time of registration.
	2	**Financial Responsibility—**You accept financial responsibility for all charges for services rendered to you. If a minor or other persons are under a guardianship, the parent or guardians accompanying the patient assumes this liability.
	3	**Self Pay—**All payments are expected at the time of service or by an authorized payment plan. Our payment plans make care an affordable part of your family budget. Failure to keep current with your payment plan may cause termination of care.
	4	**Insurance—**All deductibles, co-payments and co-insurance are expected at the time of service. You are considered a cash patient until you bring all of your insurance information.
	5	**Slow Insurance Response—**You agree that if your insurance company takes more than 60 days to respond to your insurance claim, that we shall consider your services your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.
	6	**Payment Methods**– We accept cash, check and several major credit cards.
	7	**Collections**— Any unpaid balances will be placed for collections, with an agency or with an attorney. All collection costs, attorney fees, and court costs will be added to the total amount due. Anything over 120 days we reserve the right to apply a 2% interest charge. **No New Appointment, medication refills or medical record information will be allowed or released until the account is up to date.**
	8	**Forms Fees and Medical Records**— There is a charge for copies of medical records including FMLA, immigration, disability or any other government forms, charges may vary.
	9	**Appointment and No Show Fees**— Our office will schedule appointments as a common courtesy for patients and in consideration of your time. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. **A no show fee of $50 will be charged.** If you are scheduled for a procedure or minor surgery you will be charged the total amount of that day of service. New patients will be charged the total office charge for the day.
	10	**Patient Discharge**— This practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality consideration, this practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.

Patient Signature _____ **Date:** _____

Witness/PAR _____ **Date:** _____

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Authorization to Share Information

_____ **I give my permission** to disclose medical information pertaining to my treatment and progress to my primary care physician listed below. This allows us to keep your primary doctor informed on the progress you make while at IPM. It also helps spread the word of how holistic health continues to benefit our patients.

Initials

_____

*Physician Name (First & Last Name)

_____

*Address

_____

City State Zip

_____

*Phone Number

_____ I **do not** wish to disclose any of my medical information with my primary care physician.

Initials

Please sign below to give permission to disclose your health information.

Patient Print _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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