IMS INTEGRATED MEDICAL SERVICES

Patient Registration Sheet

Personal Information Today's Date: _____

Patient First Name: _____ Initial: _____ Last Name: _____

DOB: _____ Age: _____ Social Security #: _____ Email: _____

Address: _____
Street Apt # City/State/Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: ☐ M ☐ F Language: ☐ ENG ☐ SPAN ☐ OTHER: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D ☐O

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined ☐Unknown

Race: ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Declined ☐ Unknown
☐ Native Hawaiian/Other Pacific Islander

Occupation: _____ Retired: ☐ YES ☐ NO From: _____

Employer Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Financial Responsible Party Information (If not self)

Responsible Party Name: _____ Relationship to patient: _____

DOB: _____ Age: _____ Social Security #: _____

Emergency Contact Name: _____ DOB: _____

Phone Number: _____ Relationship to patient: _____

Insurance Information (Please provider copy of insurance card)

Primary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

Secondary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

Acknowledgement and Consent for Treatment

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that the consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) you consent to treatment at this office or any other location under common ownership; and (3) the information you have provided is true and accurate.

Signature of Patient/Representative: _____ Date: _____

Printed Name of Patient/Representative: _____ Relation: _____

IMS INTEGRATED MEDICAL SERVICES

Patient Acknowledgment and Financial Responsibility Agreement

Patient Name: _____ Date of Birth: _____ Account #: _____

We at Integrated Medical Services, Inc. (IMS) are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient.

Insurance Information: You are responsible for making sure we have current insurance information on file for you, including a copy of your insurance care. Failure to provide this information in a timely manner may result in charges being billed directly to you. We ask that you please update and verify your record at each visit.

Assignment of Benefits: I hereby assign to IMS any insurance or other third-party benefits for health care services provided to me. I understand the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward all health insurance or third-party payment that I receive for services rendered immediately upon receipt.

_____ Initial Here

Medicare Patient Certification and Assignment of Benefits: I certify that any information I provide IMS, if any, in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is true and accurate. I request payment of authorized benefits to be made on my behalf to the practice by the Medicare and Medicaid program.

_____ Initial Here

Release of Medical Information: I authorize IMS to release my medical information required to process my insurance claim.

_____ Initial Here

Health Plan Deductibles, Co-Payments and Co-Insurance: If you have not met your health plan's deductible on the date of service, we will collect an estimated amount before services are rendered and apply that to your deductible. Please note that you may receive a bill for additional charges. You are responsible for any co-payments and co-insurance required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: We will make all efforts to verify your insurance coverage prior to rendering services, however ultimately it is your responsibility to ensure payment of any charges incurred. Any service performed by an IMS provider that is not covered by your insurance is your responsibility. Please review and understand your insurance benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment. Additionally, we do our best to ensure a valid referral is on file for services you receive. However, if your insurance policy requires a referral, you are responsible for making sure that those requirements have been met prior to being seen.

Self-Pay: If you don't have health insurance, are on a plan that IMS is not contracted with, or we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. There may be additional charges depending on the services actually provided for which you may receive a bill.

Third-Party Collections: I acknowledge that IMS may use the services of a third-party business associate or affiliated entity as an extended business office (EBO Servicer) for medical account billing and collections.

Returned Checks: I understand that IMS charges a $25.00 fee for any returned checks.

No Show Policy: If you are unable to make your appointment, we ask that you cancel at least 24 hours before the scheduled date. Failure to cancel an appointment in a timely manner may result in a no-show fee of $25.00. Multiple no shows may result in being discharged from IMS.

Consent to Telephone Calls for Financial Communications: I agree that, in order for IMS, or its agents to service my account or to collect any amounts owed, I expressly agree and consent that the practice and its agents may contact me by telephone at any number provided, without limitations of wireless, or any number forwarded or transferred from that number, regardless of services rendered, for my related financial obligations. Methods of contact may include using a pre-recorded voice messaging services or use of automatic dialing services as applicable.

_____ Initial Here

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who accompanies the patient to the appointment is responsible for all payments due at the time of service.

If you have any questions regarding your bill, please contact the IMS billing office at (602) 633-3838.

I have read the above IMS financial policies. I understand and agree to be bound by their terms. I also understand that IMS has the right to amend these policies at any time.

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient: _____

Printed Name of Responsible Party: _____ Relation to Patient: _____

Contact Phone Number of the Responsible Party: _____

IMS INTEGRATED MEDICAL SERVICES

Patient HIPAA Acknowledgement and Consent Form

Patient Last Name | Patient First Name | MI | Date of Birth

Notice of Privacy Practices

I acknowledge that I have received the IMS Notice of Privacy Practices, which describes the ways in which IMS may use and disclose my healthcare information of its treatment, payment, healthcare operations and other described and permitted uses. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I also understand that this information may be disclosed electronically by IMS or its agent. To the extent permitted by law, I consent to the use and disclosure of my information of the purposes described in the IMS Notice of Privacy Practices.

_____ Initial Here

Disclosure to Others

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM IMS OR THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION WITH? IF YES, PLEASE LIST BELOW:

I give permission for my Protected Health Information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to the following below:

First Name	Last Name	Relationship	Contact Number

Communication about My Healthcare

I agree that IMS and the provider or agent of the provider may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

I hereby permit IMS and the provider or other healthcare professionals involved in my care to release healthcare information for the purposes of treatment, payment or healthcare operations.

I hereby consent to the use of my email, cellular telephone or other electronic communication methods for appointment reminders and other important healthcare communications. I understand that I may opt out of these communications at any time.

I understand that IMS uses an electronic health record that will update to the information and consents I provide here and that for my convenience this information will be updated at all of our affiliated clinics that share an electronic health record in which I have a relationship.

I authorize IMS to contact on the telephone numbers I have provided ant that IMS may leave an electronic message if indicated to do so.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

IMS INTEGRATED MEDICAL SERVICES

Review of Systems

Patient Name: _____ DOB: _____

General:	☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Trouble sleeping ☐ Sweats ☐ Stamina ☐ Appetite ☐ Energy
Skin:	☐ Rash ☐ Dryness
Ears:	☐ Decreased hearing ☐ Ringing in ears (Tinnitus) ☐ Earache
Eyes:	☐ Vision ☐ Blurred/Double vision ☐ Pain
Respiratory:	☐ Cough ☐ Shortness of breath
Cardiovascular:	☐ Chest pain or discomfort ☐ Palpitations ☐ Swelling (Edema)
Gastrointestinal:	☐ Swallowing difficulties ☐ Change in appetite ☐ Nausea ☐ Diarrhea ☐ Constipation
Urinary:	☐ Frequency ☐ Urgency ☐ Incontinence
Musculoskeletal:	☐ Muscle or joint pain ☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints
Endocrine:	☐ Heat or cold intolerance ☐ Sweating
Psychiatric:	☐ Anxiety ☐ Depression ☐ Memory loss ☐ Stress ☐ Hallucinations ☐ Delusions

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Patient Name: _____ DOB: _____

Patient height: _____ Patient weight: _____

CHIEF COMPLAINT: Please explain why you have come here, include problems, date of onset, sudden or gradual onset, frequency, duration, nature and factors which bring on, worsen or improve this complaint. Please describe intermittent problems/spells as best you can.

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY (Please mark all problems referring to the following functions)

NEUROLOGICAL PROBLEMS:

☐ Headaches ☐ Numbness ☐ Tingling ☐ Neck Pain ☐ Low Back Pain ☐ Weakness in upper/lower limbs

☐ Seizures ☐ Confusion ☐ Memory Loss ☐ Jerks ☐ Involuntary Movements ☐ Falls

☐ Dizziness ☐ Gait or Imbalance Disturbances ☐ Tremor Vision Problems ☐ Swallowing Problems

☐ Speech Problems ☐ Head Trauma ☐ Hearing Loss ☐ Concussion ☐ Incontinence

MEMORY QUESTIONS (circle one):

1. Short-term memory loss. **Yes** **No** If yes, for how long _____ years, _____ months
2. Do you forget recent conversations and events? **Yes** **No**
3. Do you forget recent where things are placed? **Yes** **No**
4. Do you have difficulties with concentration and attention? **Yes** **No**
5. Do you have difficulties with finding the right words **Yes** **No**
6. Do you forget appointments? **Yes** **No**
7. Do you walk into a room forget what you were supposed to do? **Yes** **No**
8. Do you get confused sometimes in middle of conversation or doing something not knowing what you were doing or saying? **Yes** **No**
9. Do you have difficulty taking medications? **Yes** **No**
10. Do you have difficulties with doing finances? **Yes** **No**
11. Do you have difficulties driving with directions? **Yes** **No**

IMS INTEGRATED MEDICAL SERVICES

Patient Name: _____ DOB: _____

MEDICAL PROBLEMS:

☐ Hypertension ☐ Diabetes ☐ Hyperlipidemia ☐ Stroke/TIA ☐ Heart Attack

☐ Ischemic Heart Disease ☐ Kidney Disease ☐ Liver Disease ☐ Asthma ☐ COPD

☐ Thyroid Disorder ☐ Lupus ☐ Rheumatoid Arthritis ☐ Meningitis ☐ HIV

☐ Cancer, If yes, what type of cancer: _____

☐ Blood Clots ☐ Deep Vein Thrombosis/Pulmonary Embolism ☐ Atrial Fibrillation ☐ Fibromyalgia

☐ Anxiety ☐ Schizophrenia ☐ Bipolar Disorder ☐ Depression

PAST SURGICAL HISTORY: (Please list all surgeries you have had)

☐ Spine Surgery ☐ Heart Surgery ☐ Carpal Tunnel Surgery

☐ Other Surgeries: _____

CURRENT MEDICATIONS AND DOSAGES:

Medication	Dosage	Medication	Dosage

DRUG ALLERGIES: (Please list allergies to any medications and the reaction to the medications)

_____

_____

PHARMACY INFORMATION: (Please list the name, address and phone number. If you do not have this information, please list the major cross streets)

_____

FAMILY HISTORY:

☐ Alzheimer's ☐ Stroke/Heart Attack ☐ Epilepsy ☐ Migraine/Headache ☐ Neuropathy ☐ Tremors

☐ Parkinson's ☐ None ☐ Other: _____

SOCIAL HISTORY:

Smoking: ☐ Yes ☐ No If yes, how many a day _____

Alcohol: ☐ Yes ☐ No If yes, amount _____

Caffeine: ☐ Yes ☐ No If yes, amount _____

Illicit Drugs: ☐ Yes ☐ No If yes, type _____

Previous Alcohol or Drug Abuse: ☐ Yes ☐ No If yes, type _____

Occupation: _____

IMS INTEGRATED MEDICAL SERVICES

IMS Neurology

The purpose of this short questionnaire is to screen your risk for cardiovascular and/or neurological disease. This will also be done on an annual basis so that your medical provider can track your disease improvements or progression. VSAT stands for Vital Systems Assessment Test, and it is a combination of individual tests for heart rate variability, pulse wave velocity and sudomotor function. We ask that you fill this out in its entirety so we can determine your eligibility to have this test.

Today's Date: _____

Patient Name: _____ Phone Number: _____

☐ Male ☐ Female Primary Insurance: _____ ID: _____

Date of Birth: ____/____/____ Have you had a VSTAT Test in the past (circle answer): YES NO

SECTION 1

Are you pregnant? Yes / No

Do you have a pacemaker or defibrillator? Yes / No

Do you have a pain or insulin pump? Yes / No

Do you have any electrical or metal implants or sensors of any kind? Yes / No

SECTION 2 – *Have you ever been diagnosed with any of the following cardiovascular diseases or symptoms?*

Peripheral Vascular Disease (Circulation disorders in blood vessels)? Yes / No

Do you have or have you had a chronic ulcer(s)? (Stage II, III, IV) Yes / No

Raynaud's Syndrome (Discoloration of fingers and/or toes when exposed to changes in temperature, cold or hot or emotional event)? Yes / No

Do you have hypertension (High blood pressure)? Yes / No

Do you often experience abdominal pain? Yes / No

Do you have or have you had gangrene? Yes / No

Embolism of the upper limb/limbs (Artery obstruction in the arms)? Yes / No

Beurger's disease (Inflammation or clotting in blood vessels in hands or feet)? Yes / No

SECTION 3 – *Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?*

Multiple Sclerosis? Yes / No

Pain in your arms or legs? Yes / No

Pain in your neck often (Cervicalgia)? Yes / No

Hypotension (Very low blood pressure)? Yes / No

Hands and feet get cold easily? Yes / No

Dizzy and/or light headed when you stand up? Yes / No

Bell's Palsy? Yes / No

Carpal Tunnel (chronic pain, numbness, or tingling in the hand)? Yes / No

Pain in your lower back (Lumbago)? Yes / No

Pain in your upper back (Thoracic Pain)? Yes / No

Rapid Heart Rate (Tachycardia)? Yes / No

Tingling or numbness in hands, arms, legs, or feet? Yes / No

Often experience a lack of coordination when active (Ataxia)? Yes / No

SECTION 4 – *Personal and Family History*

Do you have a history of CVA or TIA (Stroke or mini-stroke)? Yes / No

Has anyone in your immediate family (blood relatives) been diagnosed with cardiovascular disease (CVD), or have you had a heart attack? Yes / No

Do you have diabetes? Yes / No

Has anyone in your immediate family (blood relatives) passed away from Sudden Cardiac Death Syndrome (SCD)? Yes / No

Do you smoke or have you ever smoked? Yes / No

Do you have high cholesterol? Yes / No

NOTICE OF HIPAA AND PRAVACY PRACTICES: This office protects your privacy as well as optimizes your quality of care through access to your healthcare data, as part of your privacy, we will never share your information with a third party for marketing purposes. However, HIPAA guidelines allow sharing of general information for statistical reasons, such as a government health department or official third party. Your information may be used within this office or practice or with other healthcare professionals for training and education purposed pursuant to HIPAA guidelines.

Patient Signature:	**Provider Signature:**