OPTIMUM HEALTHCARE

1819 Broadway St. STE 101 | Pearland, TX 77581
Phone: 281.993.4109 Fax: 877.781.6179
optimumpmr.com

Optimum Healthcare
REGISTRATION FORM
(Please Print)

Today's date:			Primary Care Provider:			
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single Mar Div Sep Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino		Preferred Language:	Email address:			
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian ❑ African American ❑ White ❑ Hispanic ❑ Other						
Street address:		Social Security #:	Home phone #: Cell Phone#:			
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:		Work phone #:			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Pharmacy	**Address/Ph#**					

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )			
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer of Subscriber:	Employer address: City State Zip	Employer phone #: ( )			
Is this patient covered by insurance? ❑ Yes ❑ No						
Please indicate primary insurance	❑ [Insurance]					
Case Manager Name		Phone#	❑ Medicaid #	❑ Other		
Subscriber's name:	Subscriber's #:	Birth date: / /	Group #:	Policy #:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	Child	❑ Other		

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone #:	Alternate phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Optimum PMR or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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MEDICAL HISTORY

Medical Illnesses

- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Blood clot/pulmonary emboli
- ☐ Diabetes
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Fibromyalgia
- ☐ Heart bypass
- ☐ Heart Disease
- ☐ Hepatitis or HIV (any form)
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Lupus or other auto immune disease
- ☐ Psychiatric Disorder
- ☐ Stroke and/or heart attack
- ☐ Thyroid disease
- ☐ Trouble passing urine or take Flomax or Avodart
- ☐ Cancer (type): _____Year: _____

Social:

- ☐ I am sexually active
- ☐ I want to be sexually active
- ☐ I have completed my family
- ☐ My sex has suffered
- ☐ I haven't been able to have an orgasm
- ☐ I have used steroids for athletic purposes

Habits:

- ☐ I Smoke cigarettes/cigars _____ /day.
- ☐ I drink alcoholic beverages ____ / week.
- ☐ I drink 10+ alcoholic beverages/ week.
- ☐ I use caffeine _____ /day.

Female Patients

Preventative Medical Care:

- ☐ Last menstrual period (est. year if unknown): _____
- ☐ Last Pap: _____
  - ☐ Normal
  - ☐ Abnormal
- ☐ Last Mammogram:

  _____
  - ☐ Normal
  - ☐ Abnormal
- ☐ Medical/GYN Exam in the last 12 months
- ☐ Mammogram in the last 12 months
- ☐ Bone Density in the last 12 months
- ☐ Pelvic ultrasound in the last 12 months

Medical/Surgical History:

- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Hysterectomy with removal of ovaries
- ☐ Hysterectomy only
- ☐ Oophorectomy Removal of Ovaries

Birth Control Method

- ☐ Menopause
- ☐ Hysterectomy
- ☐ TubalLigation
- ☐ Birth Control Pills
- ☐ Vasectomy
- ☐ Other: _____

  _____

  _____
- ☐ Mental /Emotional Difficulty
- ☐ Sexually Transmitted Disease
- ☐ HIV
- ☐ AIDS/ARC
- ☐ Abnormal Weight Gain
- ☐ Abnormal Weight Loss
- ☐ Numbness Groin/Buttocks

Male Patients

- ☐ Testicular/ProstateCancer
- ☐ Elevated PSA
- ☐ Prostate enlargement
- ☐ Prostate exam in the last 12 months

Other

- ☐ Sinus Problems
- ☐ Hay Fever
- ☐ Allergies
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ History of Infection
- ☐ Fever (Continuous)
- ☐ Visual Disturbance
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Stroke: Date _____
- ☐ Aortic Aneurysm
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Multiple Sclerosis
- ☐ Ulcer
- ☐ Liver Trouble
- ☐ Kidney Trouble
- ☐ Urinary Retention
- ☐ Frequent Urination
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Dislocated Joints
- ☐ Spinal Disc Disease
- ☐ Bone Fracture(s)
- ☐ Other _____

  _____

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SYMPTOM CHECKLIST

	Never	Mild	Moderate	Severe
Acne				
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Rapid Hair Loss				
New Migraine Headaches				
Female				
Facial Hair				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Male				
Breast Development				
Shrinking Testicles				
Decrease in beard growth				
Decreased morning erections				
Decreased desire/libido				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		
Prostate Cancer		

Patient Name: _____

Date: _____

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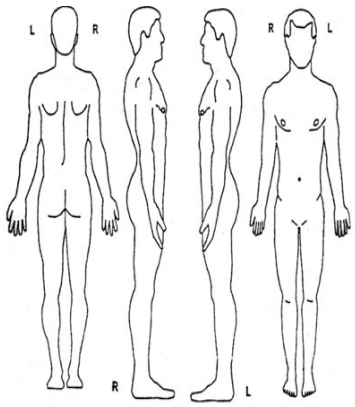
PATIENT INFORMATION / HISTORY FORM

Referring Physician: _____
Primary Care Physician: _____
Briefly describe your main problem: _____
_____
Indicate on the pictures below the area(s) of your pain. Use "X" for pain and "0" for numbness.



When did your complaints start? (approximate date)
_____
How did your pain start?
_____
Is your pain: ☐ occasional ☐ Intermittent ☐ frequent ☐ constant
Present level of intensity (cirle one) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
No Pain Mild Moderate Severe Excruciating
What words best describe your symptom(s): (Circle as many as apply)
☐ Sharp ☐ Burning ☐ Throbbing ☐ Aching ☐ Cramping ☐ Dull ☐ Hot
☐ Crushing ☐ Stabbing ☐ Shooting ☐ Electricity ☐ Tingling ☐ Cold

Other _____
What eliminates or eases the symptom(s)? (Circle as many as apply)
☐ Lying down ☐ Standing ☐ Exercise ☐ Medication ☐ Muscle Relaxants ☐ Nothing
Other:_____
Do you have loss of control of your bowels or bladder? ☐ Yes ☐ NO

Do you have pain that shoots down your arms or legs? ☐ Yes ☐ NO

Do you have any increasing weakness in your arms? ☐ Yes ☐ NO

Whom do you live with? _____

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PATIENT INFORMATION / HISTORY FORM

Please list all past hospitalizations / surgeries you have had:

_____

_____

Please list all current prescription medications and any vitamins:

_____

_____

_____

Do you have any MEDICATION ALLERGIES? Yes: No:
If yes, list drug and reaction: _____

_____

List any pain medications you have tried in the past: _____

_____

Do you take any of the following medicines: (Circle any that apply)
☐ Coumadin ☐ Aspirin ☐ Plavix ☐ Lovenox ☐ Heparin

Please indicate which tests you have had to evaluate your present pain (with date):
MRI:_____ CT Scan: _____Myelogram: _____ Bone Scan: _____Discogram: _____EMG: _____
Other: _____

Please list any procedures you have received for your pain (with date): _____

_____

Please list any other treatments you have received for your pain (TENS, Chiropractic, Physical Therapy, Biofeedback): _____

WORK HISTORY:
What is/was your occupation? _____

☐ **Full Time** ☐ **Part Time** ☐ **Unemployed** ☐ **Temporary** ☐ **Self-Employed** ☐ **Full Time Student**

Employers Name: _____
Employers Address: _____

Do you drink Caffinated Drinks? ☐ **Never** ☐ **<1 per day** ☐ **1-2 /day** ☐ **3-4 /day** ☐ **5+/day Days Per Week**
Do you exercise: ☐ **Never** ☐ **<1** ☐ **1-2** ☐ **2-3** ☐ **3-4** ☐ **5+**
☐ **Walking** ☐ **Jogging** ☐ **Cycling** ☐ **Swimming** ☐ **Golf** ☐ **Tennis** ☐ **Strength Training** **Other:** _____

Drug/Substance Abuse? ☐ **No** ☐ **Yes** **If Yes, Discuss With Doctor**

Have You Ever Had A Serious Accident/Injury? ☐ **Yes** ☐ **No**
Auto: _____
Work Related: _____
Personal: _____
Sports Injury: _____
Other: _____

This office charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require treatments for illnesses or problems may be charged separately for each service when both are provided on the same day.

This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record.

- **Collections**

All balances billed are due upon receipt of a statement. Unpaid balances greater than 90 days are subject to our collection process.

- **Returned Checks**

There is a $20.00 fee charged for all returned checks.

- **Small Balance Policy**

If a credit or due balance exists on your account equal to $9.99 or less, and is more than 90 days old, the account will be automatically adjusted according to our small balance policy. If you are seen within the 90 day period, the small balance will either be credited to your account or requested at the time of service. Following the 90 day period, we will not issue any refunds or send statements for balances equal to $9.99 or less.

- **Appointment Cancelations/No-shows**

If you cancel, miss or no-show for three (3) appointments you may be dismissed from the practice for not complying with the plan of care you and your physician have discussed.

- **High Deductible Health Plans (HSA, HRA, FSA participants)**

Please inform us prior to your visit if you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). You must be prepared with the plan information and pay the patient responsible portion from the HSA, HRA or FSA at the time of service.

- **Minor Aged Patients**

Adults accompanying minor patients (parent or guardian) will be required to complete a Release of Liability and Permission Form. The parent or guardian is responsible for payment of any financial balances for that minor not covered by insurance. For unaccompanied minors, treatment will be denied unless the proper paperwork is received, and the insurance card lists the minor's name.

I have read, understand and agree with this Financial Policy.

Printed Name (Patient or Guarantor)

Signature (Patient or Guarantor) Date:

Office Staff Signature Date:

Financial Policy and Agreement

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is provided to avoid any misunderstanding or disagreement concerning payment for services, tests, and supplies provided by our office.

- **Insurance**

Our office participates with a variety of insurance plans. It is your responsibility to:

1. Bring your current insurance card to every visit and notify us of any changes in your insurance coverage.
2. **Be prepared to pay your co-pay, coinsurance and/or deductible at the time of service.** Payment may be made by cash, check, MasterCard, or Visa. All co-pays and deductible amounts owed are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service. If you have elected to use our practice and our physicians out of your network of coverage please check with your insurance regarding benefit levels. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the payer web address listed on your card. It is your responsibility to understand your benefit coverage.
3. We will submit a claim to your insurance company for you through our Billing Company, Advanced Reimbursement Solutions and Goldstar Medical Billing. Balances not paid per contract with your primary insurance company may be billed to your secondary insurance.
4. You understand that your insurance carrier can choose to assign benefits to Optimum, ChiroHealth, Texas Regen or your insurance may make payment directly to you.
5. You understand and agree that you are financially responsible for all health care service charges that are paid to you directly by your insurance carrier.

- **Payment Details**

We accept Cash, check, and most major credit cards. We have the capability to accept payments over the phone with your debit or credit card account information. We reserve the right to process your payment electronically based on the information you provide us.

- **Surgical and Laboratory Services**

If you are having procedures at Optimum Healthcare, the facility and surgical services are separate providers and will be billed separately from the office services provided to you. Laboratory services provided at our office are also provided by Optimum Healthcare and will also be billed separately from the office services provided to you.

- **Non-covered services**

If you are seeking a non-covered service, do not have insurance, or if you are covered by an insurance for which we are not a provider, we require that you be prepared to pay our fees at the time services are rendered. You may inquire with our staff about self-pay cash discounts for payment at the time of service.

If temporary financial problems affect timely payment on your account you may set up a payment plan.

Specific coverage issues should be directed to your insurance company's member services department (the number should be located on the back of your insurance card).

Assignment of Benefits

Assignment of Medical Benefits and Payment Responsibility to Optimum Physicians Healthcare, PLLC (hereinafter referred to as "Providers"). I, the undersigned patient ("Patient"), acknowledge that Providers reserve the right to use the services of Apollo Billing and Gold Star Medical (hereinafter referred to as AB/GSM) upon Providers' discretion for any part of the claims procedure.

1. **Legal Assignment of Insurance Benefits**: In exchange for and in connection with any and all of the service(s) provided to me ("Services") by Providers, I hereby irrevocably assign to Providers all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, including, without limitation, direct payment to Providers for the Services, appeal rights, rights to fiduciary duties, rights to sue, rights to payment, rights to penalties or interest, rights to plan documents, and rights to information, notices and disclosures from any source, (collectively "Rights") that I had, have or may have in the future pursuant to or in connection with any insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively "Health Coverage"), such that I am hereby transferring all and retaining none of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, I instruct my applicable insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind to please advise and disclose to Providers in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived on any pending claims for benefits under the respective policies. I agree that, should the amount received be insufficient to cover the entire claim I will be responsible for payment of any coinsurance and/or deductible that remains unpaid by my health insurance company, workman's compensation plan and/or auto accident insurance; I will be responsible to Providers for payment of the entire invoice. 2. **Denial of Claim**: I understand that Providers will make every effort to obtain payment for all health care services or products provided by Providers from my insurance company. I agree that I will be jointly and severally financially responsible for any portion of the Providers invoice that is not paid; I understand that I am responsible for any health insurance deductibles and co-payments; I hereby irrevocably assign the benefits payable for any services rendered by Providers to me and authorize Providers to submit a claim to any medical insurance company that I may have for payment to Providers. 3. **One Time Claim Submission**: I understand that Providers will make every effort to obtain payment for all services and or products provided by Providers. I understand that Providers will submit a clean claim one time only and if the claim is not paid, in whole or in part, by my workman's compensation plan and/or auto accident insurance, Providers will look to me for payment of any Providers services and/or products supplied to me. I agree that I will be jointly and severally financially responsible for any portion of the claim, in whole and in part, that is not paid. 4. I certify that the information given by Patient to Providers in applying for payment to my workman's compensation plan and/or auto accident insurance or any other medical insurance that I may have, is correct. I agree that if assigned insurance benefits owed to Providers by me are paid to me, I shall immediately notify Providers of such, and immediately endorse benefits check to Providers. 5. **Appointment as Authorized Representative And Right to Sue**: I hereby designate Provider's designated billing company ("Apollo Billing and Goldstar Medical, LLC" or "AB","GSM") as my duly authorized representative in connection with all matters arising from or relating to Services, Rights and Health Coverage, such that AB/GSM completely and without reservation stands in my shoes and takes my place for all purposes, and is granted absolute power and legal authority to do, seek, claim, appeal or obtain anything that I would have been entitled to do, seek, claim, appeal or obtain in my own capacity pursuant to or in connection with the Services, Rights or Health Coverage, in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedure or entitlement under any Health Coverage. 6. **Agreement to Cooperate**: In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by, any Health Coverage, to effectuate, perfect, confirm or validate my assignment and/or authorization of AB/GSM as my authorized representative, and I promise to assist and cooperate with Providers and AB/GSM as needed or reasonably requested by Providers or AB/GSM in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by Providers or AB/GSM in connection with the Services or relating to any Rights provided under the Health Coverage. I understand that, in the event I do not fulfill any of the above obligations, I will remain personally liable for payment for the Services to the furthest extent of the law. By signing below, I acknowledge my authorization of treatment and receipt of all documentation in accordance with my treatment.

Signature of Beneficiary/Participant/Parent/Legal Guardian

Date

SUBMIT

Printed Name of Beneficiary/ Participant/Parent/Legal Guardian