



## Confidentiality Release

If I am not available to accept laboratory or test results myself, I will permit the staff of Neal Alpiner, M.D., to give the results to:

- | Name  | Phone |
|---|-------|
| <input type="radio"/> My Spouse _____                         | _____ |
| <input type="radio"/> My Son/Daughter _____                   | _____ |
| <input type="radio"/> My Parents _____                        | _____ |
| <input type="radio"/> Other _____                             | _____ |
| <input type="radio"/> Specific Physicians _____               | _____ |
| _____   | _____ |
| <input type="radio"/> Case Managers _____                     | _____ |
| <input type="radio"/> May leave results on answering machine. |       |
| <input type="radio"/> DO NOT GIVE RESULTS TO ANYONE BUT ME!   |       |

By signing below I acknowledge that it is my responsibility to notify Dr. Alpiner's staff of dates that tests have been taken so that results may be properly followed up.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

If Patient is a Minor:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

THIS RELEASE FORM WILL LAST THROUGHOUT YOUR TREATMENT WITH THIS OFFICE. A NEW FORM WILL NEED TO BE FILLED OUT IF ANY CHANGES ARE MADE. THANK YOU.  
REV 12/10



**Consent for Treatment/Authorization to Release Information**

Patient Name: \_\_\_\_\_

I hereby voluntarily request to authorize my physician, Neal Alpiners, M.D., to provide medical treatment and care, including but not limited to, diagnostic procedures, x-rays, and administration of medication as is deemed necessary and advisable.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results or the care of treatment which I have hereby authorized.

I authorize Neal Alpiners, M.D., to release information regarding myself or my dependent to my insurance company and agree to have my insurance company pay Neal Alpiners, M.D. directly for services rendered relating to my treatment. I understand that I will be held accountable for any balance left owing under the provision of my policy.

I further understand that my treatment may require more than one occasion of service, therefore, this consent shall carry full force and effect from the date of signature until I am discharged from further outpatient treatment.

I understand that the verification of benefits does not guarantee payment. I acknowledge that it is my responsibility to obtain a referral or authorization for treatment and I will be responsible for any and all bills that are not covered by my insurance company pertaining to my treatment.

\_\_\_\_\_

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PHYSICAL MEDICINE GROUP

Signature of Patient/Legal Guardian

Date

|  |  |
|--|--|
| Patient Name   | Guarantor's Date of Birth  |
| Date of Birth (Patient and Guarantor)  | Address  |
| Home Phone   | Work Phone   |
| Mobile Phone or Pager  | Email Address  |
| Employer   | Occupation (IF APPLICABLE)   |
| <b>PRIMARY</b> Insurance company name and policy number<br>(see your insurance card)               | <b>SECONDARY</b> Insurance company name and policy number<br>(see your insurance card) |
| Claims Address/Phone   | Claims Address/Phone   |
| Effective Date _____   | Effective date _____   |
| Referral necessary to see a specialist? _____  |  |
| Primary care physician name, address and phone   |  |
| Is this a Worker's Compensation or case? If yes, please include date of injury.                    |  |
| Is this an Auto Insurance case? If yes, please include case manager contact info/date of accident. |  |

**Acknowledgement of Receipt of Notice of Privacy Practices**



By signing below, I acknowledge that I have received a copy of the office's Notice of Privacy Practices Form.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

**Documentation of Failure to Obtain Signed Acknowledgement**

On \_\_\_\_\_ (date), \_\_\_\_\_ presented this Acknowledgement of Receipt of Notice of Privacy Practices Form to \_\_\_\_\_. The Patient refused to provide a signature when requested.

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We neither direct nor require you to use any facility which is owned or managed by members of this office. Your signature below acknowledges that this office has not directed nor required to obtain physical therapy services from a facility in which any of our physicians have a financial interest.

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Signature of Patient/Legal Guardian

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Date

**New Patient Information:**

- All co-pays are to be paid upon arrival of your visit and before you are seen.

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- We need a copy of your current insurance card (front and back).
- You are responsible for notifying the administrative office of any insurance changes, address changes or updates to your information.
- A picture ID of the patient's guarantor must be provided.
- Missed appointments without giving the administrative office 24 hours advanced notice, may be subject to a \$25.00 fee.
- You must notify the administrative office if there are any significant changes to your medical health, including reporting a new pregnancy, so that any medications/treatments can be adjusted as needed.

## **Insurance Information:**

- We participate in most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.
- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; We are NOT a party to that contract.

## **Referrals/Authorization/Pre-Certifications:**

- If your Insurance carrier requires a referral for you to see a Specialist, it is your responsibility to request a referral from your Primary Care Physician (PCP). The written referral must state the specific procedure(s) that Dr. Alpinier is authorized to perform.
- We must receive the written referral from your PCP at least **24 hours in advance** of your appointment or the appointment will need to be cancelled and rescheduled. Patients requiring a referral will not be seen without a referral. Referrals may be faxed to our administrative office.
- Your Insurance carrier and/or Auto carrier may require you to obtain prior authorization in order for you to have certain tests or procedures as prescribed by Dr. Alpinier (e.g. MRI, CT Scan, Sleep Study, BOTOX injection, etc.).
- If Dr. Alpinier prescribes tests or procedures for you, we recommend that you immediately contact your Insurance or Auto carrier to inquire if an authorization/pre-certification is required. Your PCP or Auto carrier may be able to assist you with obtaining any necessary authorization/pre-certification prior to having a test or procedure.

## **Office Notes/Medical Records:**

- Notify Dr. Alpinier at the start of each visit if you need his dictated notes or related items forwarded to a case manager, Physician or other individual.
- Provide Dr. Alpinier with the necessary contact information so that he may dictate the information into the note. Our office will then send that note to the appropriate individual.
- If you need any forms completed regarding your medical care, please give them to Dr. Alpinier at the start of your visit so that he may complete such forms as time allows.

## **Prescription Medications:**

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- If you need any prescription medication refills, please request the prescription at the time of your visit.
- If you need any prescription medication refills, and do not have an appointment scheduled, please contact our office and allow at least **48 hours** for your prescription to be called in to your pharmacy. Please note that some medications, including controlled substances, cannot be called in to a pharmacy and may need to be mailed to your home. Dr. Alpinier will not prescribe medication for patients who have not been seen in the office in the last 2 months prior to the request.

## **Prescriptions for Equipment, Therapy or Testing Procedures:**

- If you need a prescription for any equipment or therapy renewal, please request the prescription at the time of your visit. Please make sure you understand the nature of the prescription before you leave the office. You may acquire equipment or obtain therapy at any facility as dictated by your insurance.
- If Dr. Alpinier gives you a prescription for any testing or procedures (e.g. MRI, CT Scan, X-ray, EEG, etc.), please make sure you understand exactly what needs to be done before you leave the office. You may receive your tests at any facility as dictated by your insurance. (See information above regarding authorization/pre-certification.)
- When lab work and/or diagnostic studies are ordered through this office, it is the patient's exclusive responsibility to have the testing done and it is the patient's exclusive responsibility to contact our office for results within a reasonable period of time. This office does not perform laboratory or radiologic diagnostic studies.
- Dr. Alpinier will not write or sign a prescription/request for equipment or therapy if he has not seen the patient in the office in the last 2 months prior to the request.

## **Payment for Services Rendered:**

- The balance of your bill is due and payable when the statement is issued, and is past due if not paid by the end of the billing cycle. If your account is past due, you will receive a letter from us stating you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will not be able to be seen in the office until your balance is paid in full and all charges for future visits will be collected up front.
- Returned Checks: There is a fee of \$25 for any checks returned by the bank.
- Divorce: In case of divorce or separation, the party responsible for the account is the parent authorizing treatment for the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- Personal Injury: If you are being treated as part of a personal injury lawsuit or claim or auto claim, we require verification from your attorney prior to your initial visit. **PAYMENT OF THE BILL REMAINS THE PATIENT'S RESPONSIBILITY.**

**By signing I agree that I have read and accepted  
Dr. Alpinier's Patient Policies.**

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Name

Date

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## NEW PATIENT HISTORY AND PHYSICAL

*Please complete all information on this form to the best of your knowledge.  
If none in a particular section, write n/a or none.*

Patient Name: \_\_\_\_\_ M F

Date of Birth: \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

Date: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Whom may we thank for this referral?

\_\_\_\_\_

The reason for today's office visit is: \_\_\_\_\_

\_\_\_\_\_

### **Past Medical History: (Please check all items that you have had in the past)**

- Acne  Autism  Depression  Hepatitis  Rash  \_\_\_\_\_  
 Anemia  Cancer  Diabetes  Jaundice  Seizures  \_\_\_\_\_  
 Asthma  Chickenpox  Emotional prob.  Joint problems  Skin problems

\_\_\_\_\_

- ADD  Colic  Headache  Murmurs  Tumors  \_\_\_\_\_  
 ADHD  Constipation  Hearing loss  Chronic ear infections  Weakness

Other \_\_\_\_\_

### **Allergies: (List allergen name and the type of reaction)**

Medication (s): \_\_\_\_\_ Reaction:

\_\_\_\_\_

Medication (s): \_\_\_\_\_ Reaction:

\_\_\_\_\_

Food/Insects/Other: \_\_\_\_\_ Reaction:

\_\_\_\_\_

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**Family History:** (List any major medical conditions that your Mother, Father, Maternal Grandparents, Paternal Grandparents, Aunts, Uncles and Siblings may have. Example Mother/Diabetes)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Social History:**

Family:

Primary language spoken: \_\_\_\_\_ Who lives in the home with the patient?

\_\_\_\_\_

Environment/Home:

Home location: City Rural

Type of home: Apartment House Other:

\_\_\_\_\_

Tobacco/smoke exposure? \_\_\_\_ Yes \_\_\_\_ No; If yes, who? \_\_\_\_\_ How much?

\_\_\_\_\_

Exercise: \_\_\_\_ Yes \_\_\_\_ No; If yes: \_\_\_\_\_x/week Type:

\_\_\_\_\_

Substance Abuse:

Alcohol use? \_\_\_\_ Yes \_\_\_\_ No How much? \_\_\_\_\_ Drug use? \_\_\_\_ Yes  
\_\_\_\_ No

Tobacco Use? \_\_\_\_ Yes \_\_\_\_ No How much? \_\_\_\_\_ How long?

\_\_\_\_\_

**Pediatric Patients:**

School Activities:

School Name: \_\_\_\_\_ Attendance: Good Fair Poor

Performance/Grades: \_\_\_\_\_

Other activities outside of school?

\_\_\_\_\_

Safety:

Seat belt use? \_\_\_\_ Yes \_\_\_\_ No Helmet use? \_\_\_\_ Yes \_\_\_\_ No

Developmental History:

Not Delayed

Delayed

Other (explain)

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**Present Medications:** (List the name and dose of each medication you are currently taking.)

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**Surgeries:** (Check all surgeries that the patient has had or handwrite if necessary)

- Adenoidectomy (adenoids)  Myringotomy (ear tubes)  \_\_\_\_\_  
 Appendectomy (appendix)  Pyloric stenosis repair  \_\_\_\_\_  
 Cholecystectomy (Gall bladder)  Tonsillectomy (tonsils)  \_\_\_\_\_  
 Congenital heart disease surgery  Umbilical hernia repair

\_\_\_\_\_   
 Fracture repair: \_\_\_\_\_

\_\_\_\_\_   
 Inguinal hernia repair  \_\_\_\_\_

**Symptoms:** (Check all symptoms that you currently have)

**General: Neck: Female Genitourinary: Endocrine:**

- \_\_\_ Chills \_\_\_ Neck Mass \_\_\_ Pelvic pain \_\_\_ Appetite changes  
\_\_\_ Fair Health \_\_\_ Neck Pain \_\_\_ Urinary Complaints \_\_\_ Excessive thirst  
\_\_\_ Fatigue \_\_\_ Swollen Glands \_\_\_ Vaginal bleeding problem  
\_\_\_ Fever \_\_\_ Vaginal discharge

\_\_\_ Good Health **Respiratory: Hematology:**

- \_\_\_ Night sweats \_\_\_ Cough **Male Genitourinary:** \_\_\_ Anemia  
\_\_\_ Poor Health \_\_\_ Coughing up blood \_\_\_ Blood in urine \_\_\_ Gums bleeding  
\_\_\_ Sleep difficulties \_\_\_ Shortness of breath \_\_\_ Penile discharge  
\_\_\_ Weight Gain \_\_\_ Sputum production \_\_\_ Urination difficulty  
\_\_\_ Weight Loss \_\_\_ Wheezing

**Skin: Breast: Musculoskeletal:**

- \_\_\_ Bruising \_\_\_ Breast pain \_\_\_ Joint pain  
\_\_\_ Changes in Moles \_\_\_ Breast lump \_\_\_ Muscle pain  
\_\_\_ Dryness \_\_\_ Nipple discharge \_\_\_ Muscle weakness  
\_\_\_ Hair Loss \_\_\_ Swelling of area: \_\_\_\_\_

\_\_\_ Itching/Rash **Cardiovascular:**

\_\_\_ New lesions \_\_\_ Chest pain **Neurological:**

- \_\_\_ Scalp problems \_\_\_ Chest pressure \_\_\_ Dizziness  
\_\_\_ Yellowing of skin \_\_\_ Palpitations \_\_\_ Fainting spells  
\_\_\_ Headaches

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**Eye/Ear/Nose/Throat: Gastrointestinal: \_\_\_ Memory problems**

- Earache  Abdominal pain  Numbness
- Gums bleeding  Black, tarry stool  Seizures
- Hearing decreased  Constipation  Tremors
- Nose bleeds  Diarrhea  Weakness
- Ringing in ears  Difficulty swallowing
- Runny Nose  Nausea **Psychiatric:**
- Sinus Pain  Rectal bleeding  Anxiety
- Sore Throat  Vomiting  Depression
- Throat hoarseness  Vomiting blood  Mood swings
- Visual disturbances

Do you have any specific questions that you want your doctor to address?

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**Preferred Pharmacy:** \_\_\_\_\_

**Address/Phone/Fax :** \_\_\_\_\_

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## INJURY - PLEASE FILL OUT IF APPLICABLE

### DETAILS OF INJURY: WHERE, WHEN AND HOW INJURY OCCURRED

|  |  |     |
|--|--|-----|
| Did patient sustain an injury or trauma? | Y                                      | N   |
| Date of Injury _____                     |  |     |
| Was injury or onset related to:          | Work                                   | Y N |
|  | Auto Accident                          | Y N |
|  | Other (school, sports, activity, etc.) | Y N |

How did injury/onset occur?

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Where did the injury/problem occur?

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What body parts were injured?

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Any previous treatment of this problem? Please include medications.

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Is this injury potentially going to be in litigation?

Y

N

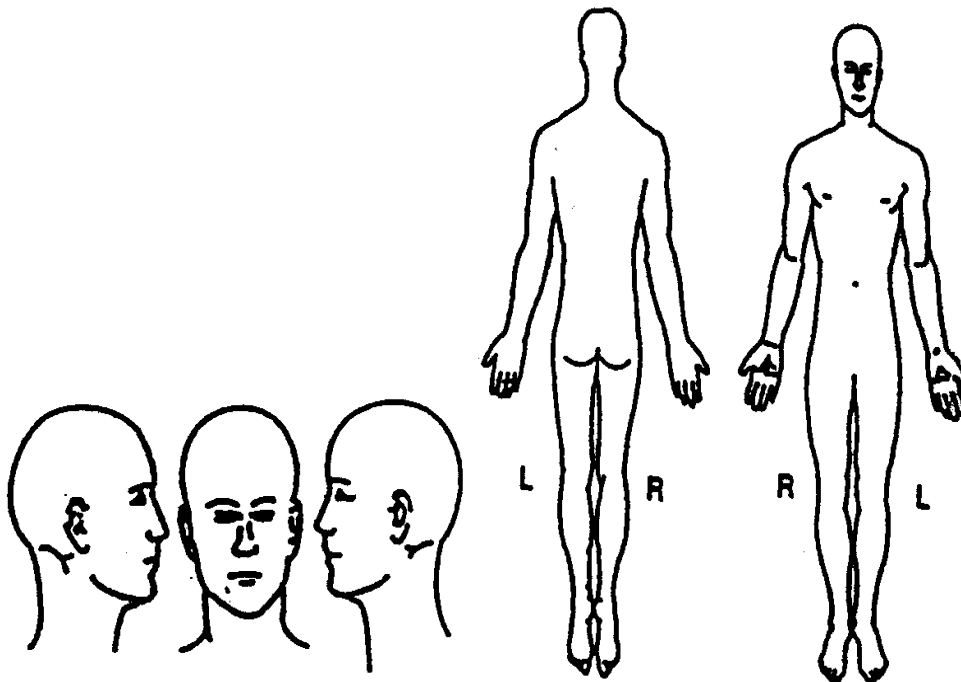
Name of Physician(s) who have treated patient for this issue prior:

When?

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## PAIN (If applicable)

Draw the location of your pain or area affected by shading in the diagram



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## HISTORY OF PRESENT ILLNESS:

Location of Pain? (e.g. Low back, neck, groin, buttock, left knee, etc).

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How long have you noticed the pain?

\_\_\_\_\_Days \_\_\_\_\_Weeks \_\_\_\_\_Months \_\_\_\_\_Years

Rate your USUAL pain: (circle)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Describe your pain: (circle)

Burning    Tingling    Numbness    Pinprick    Stabbing  
Deep-pressure    Tightness    Spasms

Any prior injury or pain before the event above: Please describe.

Have you had any previous related surgery?

## CONCUSSIVE/HEAD INJURY:

Are you currently experiencing any of the following;

Dizziness    Headaches    Nausea    Vertigo    Loss of Balance  
Concentration Issues    Visual Disturbance    Other (please explain)

## PRIOR IMAGING/TESTING

Y    N

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X-RAY    MRI    CT    EMG    Bone Scan    Laboratory    Other

If yes, when and where test performed?