Utah Spine Medicine New Patient Intake Form

Name:_____ **Date:**_____ **DOB:**_____ Gender:_____

Referring Provider:_____ Primary Care Provider:_____

What is the main issue that brings you here today?_____

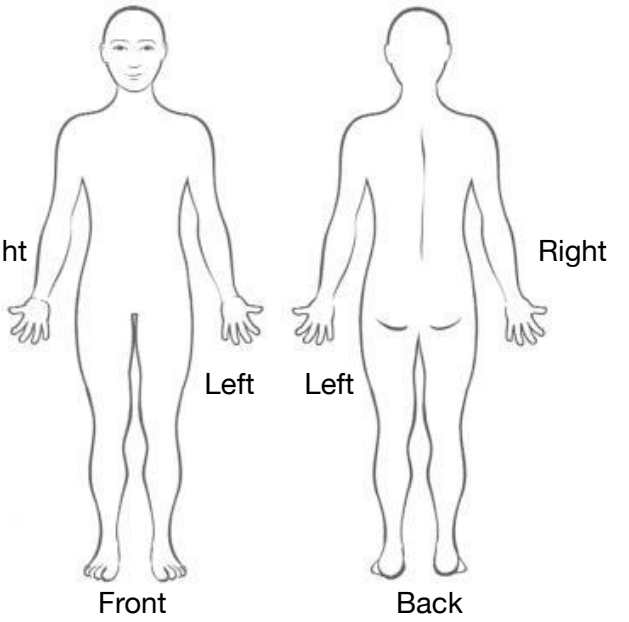
_____

Is this injury: Work related? ☐ Yes ☐ No From a motor vehicle accident? ☐ Yes ☐ No

Do you have legal representation? ☐ Yes ☐ No Date of injury_____

How did your pain begin?_____

Please Indicate the Location(s) of Your Pain:



*For Dr. Cheng (**Please DO NOT write in the box**)*

Duration

Quality

Numbness

Weakness

Bowel/Bladder

Fevers/Chills/Night Sweats/Wt.Loss

Other

What level is your pain (0 = No Pain, 10 = Worst Pain in the World)

Today (0-10) _____ Pain at its LEAST (0-10) _____ Pain at its WORST (0-10) _____

Do you have trouble sleeping? ☐ Yes ☐ No

What makes your pain increase?_____

What makes your pain decrease?_____

Do you take pain medication? ☐ No ☐ Yes

List_____

Do you take any other medication? ☐ No ☐ Yes

List_____

Do you have any allergies? ☐ No ☐ Yes List_____

Who have you seen for your pain? ☐ Primary Care Provider ☐ ER ☐ Urgent Care ☐ PT ☐ Chiropractor

What treatment have you tried for your pain? ☐ PT ☐ Chiropractor ☐ Acupuncture ☐ Massage ☐ Yoga

☐ Pilates ☐ Ice ☐ Heat *Responses (for Dr. Cheng)*_____

Please continue to next page.

Have you had any imaging of your spine performed? ☐ No ☐ X-ray ☐ MRI ☐ CT ☐ Bone Scan

Have you had any spinal injections? ☐ No ☐ Yes Date(s):_____

Were these injections with X-ray guidance? ☐ Yes ☐ No ☐ Don't Know

Do you have any medical issues? ☐ No ☐ Yes

List_____

Have you had any spinal surgeries? ☐ No ☐ Yes

List_____

Have you had any non-spinal surgeries? ☐ No ☐ Yes

List_____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Prefer Not to Answer

Occupation/Employer:_____Last Day Worked:_____

Do you use:

Tobacco ☐ Yes ☐ No If yes, how many packs/day:_____For how many years:_____

Recreational Drugs ☐ Yes ☐ No If yes, please list:_____

Alcohol ☐ Yes ☐ No If yes, how many drinks per week:_____

Do you have any family history of medical problems? ☐ No ☐ Yes

List_____

Review of Systems (please check all that apply)

☐ Fevers	☐ Ringing in Ears	☐ Wheezing	☐ Joint Pain/Swelling	☐ Anxiety
☐ Chills	☐ Hearing Changes	☐ Abdominal Pain	☐ Loss of Joint Mobility	☐ Depression
☐ Night Sweats	☐ Inner Ear Pain	☐ Heartburn	☐ Skin Rash	☐ Abnormal Bleeding
☐ Weight Loss/Gain	☐ Chest Pain/ Pressure	☐ Diarrhea	☐ Skin Growth	☐ Bruising
☐ Fatigue	☐ Heart Arrhythmias	☐ Constipation	☐ Itching	☐ Recurrent Infections
☐ Headaches	☐ Heart Palpitations	☐ Loss of Bowel Control	☐ Hair/Nail Changes	☐ Breast Lumps
☐ Dizziness	☐ Leg Swelling	☐ Blood in Stool	☐ Skin Dryness	☐ Breast Discharge
☐ Difficulty Swallowing	☐ Blood Clots	☐ Urinary Frequency	☐ Balance Difficulty	☐ Breast Feeding
☐ Visual Changes	☐ Shortness of Breath	☐ Urinary Urgency	☐ Walking Difficulty	☐ None
☐ Eye Redness	☐ Cough	☐ Loss of Urinary Control	☐ Other:	

I attest that the above information accurately represents my symptoms and medical history.

_____

Patient Signature

Utah Spine Medicine
Emil Cheng, M.D.

Release of Information Disclosure

The law requires us to create and keep records of each patient's medical treatment. Utah Spine Medicine safeguards those records and their use and discloses such records and the information they contain only in accordance with state and federal privacy laws. Such uses and disclosures are described in the "Notice of Privacy Practices." You should receive a copy of this notice for your review, and you acknowledge such receipt by your signature on the Patient Information Form. You may request a copy of this notice to keep for your records. I authorize this facility to release to my insurance company and all parties involved in my treatment any information concerning the diagnosis, treatment plan, professional opinion, and medical or surgical procedures performed, as well as information contained on this form. I also authorize any physician, practitioner, hospital or any other medically-related facility to release to this facility any and all information regarding my medical history to include medical, hospital, and other facility records, imaging reports, laboratory reports, and any other related reports.

Financial Agreement Disclosure

By signing the Patient Information Form, I agree to pay any amount owed within 60 days of when such charges are incurred. I understand that it is my responsibility to provide updated and correct insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay any amount owing as set forth herein. I agree that interest will accrue on any past-due amount at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount owing is referred to a third-party debt collection agency, I agree that in addition to any other amount allowed for by law, such as interest, court costs, reasonable attorney's fees, etc., I will also be responsible for a collection fee of up to 40% of the principal amount owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to any amount incurred by me or by any individual for whom I have legal responsibility, whether such charges are incurred today or after today. I further agree to pay a service charge of $30.00 for each check tendered by me but returned to this facility unpaid by my bank or credit union.

I hereby consent to being contacted by telephone at any number provided by me or anyone associated with me or acting on my behalf to Utah Spine Medicine or anyone acting on its behalf. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf. I understand and agree that such contact may be initiated by Utah Spine Medicine or any of its affiliates, agents, contractors or assignees, including but not limited to billing companies and/or third party collection agencies and that the methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automated dialing device and/or the use of text messages, which may result in data charges on mobile devices.

Utah law requires Utah Spine Medicine to provide the responsible party or parties with notice, by certified mail, 60 days prior to placing any delinquent balance of my account with a collection agency or reporting any delinquent balance to any credit bureau, which actions may negatively impact my credit score. I understand that I will be charged a fee of $10.00 if any such notice is sent to me.

I agree that I am responsible for any co-pay or deposit as required and I understand that non-payment at the time of service and having my co-pay or deposit billed may result in an additional fee of $10 per instance. I may also be asked to reschedule my appointment.

Utah Spine Medicine
Emil Cheng, MD

Patient Information Form

Last Name_____First Name_____Middle Initial_____Preferred Name_____

Mailing Address_____Apt #_____City_____State_____Zip_____

Gender_____ Date of Birth_____Age_____

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Prefer Not to Say

Mobile Phone_____Home Phone_____Other Phone_____

Preferred Contact Number ☐ Mobile ☐ Home ☐ Other

Email Address (we use a HIPAA-approved Patient Portal)_____

Emergency Contact_____Phone_____Relationship_____

Referring Provider_____Primary Care Provider_____

Primary Insurance Information

Insurance Carrier_____Plan_____

Group ID (if applicable)_____Plan/Member ID_____

Policy Holder's Name (as printed on card)_____

Policy Holder's Date of Birth_____Relationship to Patient_____

Secondary Insurance Information

Insurance Carrier_____Plan_____

Group ID (if applicable)_____Plan/Member ID_____

Policy Holder's Name (as printed on card)_____

Policy Holder's Date of Birth_____Relationship to Patient_____

Auto or Industrial Insurance Information (if applicable)

Insurance Carrier_____ ☐ Industrial ☐ Auto Date of Injury_____

Insurance Address_____City_____State_____Zip_____

Employer (at time of injury)_____Claim Number_____

Adjuster Name_____Phone_____Fax_____

I have reviewed the "Release of Protected Health Information" and "Financial Agreement" disclosures and by signing this document, as either the patient or patient's authorized representative, accept the terms contained in the disclosures. I also understand that liens on settlements are not an acceptable payment with Dr. Cheng.

_____ _____

Patient or Patient's Representative Signature **Date**

Utah Spine Medicine
Emil S. Cheng, M.D.

HIPAA Compliance Patient Consent Form

Patient Name: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent form.

If the terms of the notice change, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone you to confirm appointments? ☐Yes ☐No

May we leave a message at home or on your cell phone? ☐Yes ☐No

May we discuss your medical care with members of your family? ☐Yes ☐No

If YES, please name the members allowed:

_____

_____

Signature: _____ Date:_____

Utah Spine Medicine

Emil S. Cheng, M.D.

No Show and Cancellation Policy

We make every attempt to schedule our patients in a timely manner. It becomes more difficult to do so if patients do not keep their appointments. We certainly understand that circumstances may arise and we encourage anyone experiencing symptoms of COVID-19 or other illness to reschedule their appointment as soon as possible.

If you will not be able to keep your scheduled appointment, we ask that you call and give us at least 24 hours notice, when possible.

If you do not give sufficient notice or do not come to your appointment, you will be assessed a $50 charge. This charge will be paid upon scheduling your next appointment.

If you are more than 10 minutes late for your appointment, you may be asked to reschedule. This will be determined on a case-by-case basis, depending on our schedule that day.

If you have extenuating circumstances that makes it impossible for you to attend your appointment or give notice of your cancellation, please call our office. We will assess the no-show charge on a case-by-case basis.

_____ _____

Patient or Patient Representative Signature Date

_____ _____

Patient Printed Name Date of Birth

Revised 2/2022