Wellspine

FRANCISCO J. BATLLE, MD

PATIENT INTAKE FORM

PATIENT INFORMATION Date: _____/_____/_____

Name:(First) _____ (M.I.) ____ (Last)_____

Age: _____ DOB ____/____/_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Social Security #: _____ Driver License #: _____ State_____

Address: _____City_____State_____Zip_____

Employment: ☐ FT ☐ PT ☐ Student ☐ Retired ☐ Other (please specify) _____

Name of employer: _____ Address: _____ Ph# _____

CONTACT PREFERENCES

Primary Phone #: _____ ☐ Cell ☐ Work ☐ Home May we text you? ☐ Y ☐ No

Alt. Phone #: _____ ☐ Cell ☐ Work ☐ Home May we text you? ☐ Y ☐ No

E-mail: _____ May we email you? ☐ Y ☐ No

Emergency Contact: Name: _____ Relationship to patient: _____

Mobile #: _____ Wk./Hm #: _____ E-mail: _____

RESPONSIBLE PARTY (*if other than patient*)

Name: (First)_____ (M.I.)____ (Last)_____

Social Security #: _____ Driver License #: _____ State_____

Address: _____City_____State_____Zip_____

Phone: _____ E-mail: _____ Relationship to patient: _____

MEDICAL INSURANCE INFORMATION ☐ Commercial Insurance ☐ PI ☐ WC

Primary Insurance: _____ ID# _____ Grp# _____

Name of Insured: _____ Insured DOB _____/____/_____

Phone# on back of card -**OR**- Adjuster name and #: _____

Secondary Insurance: _____ ID# _____ Grp# _____

Name of Insured: _____ Insured DOB ____/____/_____

Phone# on back of card **-OR-** Adjuster name and #_____

Work related injury? ☐ Y ☐ N Auto Accident? ☐ Y ☐ N Date of Injury: ____/____/_____

Briefly describe injury: _____

REFERRAL SOURCE: How did you hear about us?

☐ Physician? (Name): _____ ☐ PCP ☐ Specialist

☐ One of our patients? _____ ☐ Internet ☐ Facebook

☐ Instagram ☐ Staff ☐ Other_____

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PATIENT INTAKE FORM

HISTORY AND PHYSICAL INFORMATION Date Completed: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

Age: _____ ☐ Male ☐ Female Height: _____ Weight: _____

Reason for Consultation: _____

_____

_____

Please check box for any conditions that may apply to YOU:

☐ Heart Disease	☐ Diabetes	☐ HIV or AIDS
☐ High Blood Pressure	☐ Kidney Disease	☐ Hepatitis
☐ Low Blood Pressure	☐ Asthma	☐ Liver Disease
☐ Heart Failure	☐ Emphysema	☐ Ulcers
☐ Heart Attack	☐ COPD	☐ Gastric Reflux
☐ Chest Pain	☐ Tuberculosis	☐ Cold Sores/Fever Blisters
☐ Pacemaker	☐ High Cholesterol	☐ Bleeding Disorder
☐ Angina	☐ Anemia/Blood Disorder	☐ Seizures
☐ Stroke	☐ Psychiatric Diagnosis	☐ Implants_____
☐ Drug Allergies	☐ Other Allergies (i.e.: latex) _____	

Do you currently take blood thinners/aspirin on a regular basis?	☐ Yes	☐ No
Do you bruise easily?	☐ Yes	☐ No
Have you ever had a reaction to an injection of a local anesthetic?	☐ Yes	☐ No
Do you become nauseated after general anesthesia?	☐ Yes	☐ No
Do you become lightheaded/nauseated at the site of needles?	☐ Yes	☐ No

Do you have a FAMILY HISTORY of any of the following?

☐ Heart Disease	☐ Seizures	☐ Respiratory Disease
☐ Blood Disorders	☐ Kidney Disease	☐ Liver Disease
☐ Cancer	☐ Malignant Hypothermia	☐ Other _____

Physicians seen on regular basis:

Physician_____ Specialty_____ Last Exam ____/____/_____

Physician_____ Specialty_____ Last Exam ____/____/_____

PHARMACY: _____ Address: _____ Phone#: _____

CURRENT MEDICATIONS (Please include herbal supplements):

Medication _____Dosage/Mg_____ Frequency_____

Medication _____Dosage/Mg_____ Frequency_____

Medication _____Dosage/Mg_____ Frequency_____

Medication _____Dosage/Mg_____ Frequency_____

PREVIOUS SURGERIES/MAJOR ILLNESS:

Surgery/Illness _____ Year _____ Physician _____

Surgery/Illness _____ Year _____ Physician _____

RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ (patient or guardian), authorize the office of Dr. Francisco J. Batlle to disclose and release my medical records to the following individuals:

1. Name_____Relationship_____
   Duration: ☐ authorization does not expire ☐ in effect until (date) _____/_____/_____
2. Name_____Relationship_____
   Duration: ☐ authorization does not expire ☐ in effect until (date) _____/_____/_____

_____**INITIAL** I understand that I have the right to revoke this authorization in writing at any time, however doing so it will have no bearing on any disclosures made prior to my revocation.

FINANCIAL RESPONSIBILITY AGREEMENT

- For all in-network services, we will bill insurance plans and accept the negotiated rate agreed upon between the insurance carrier and our office. Patient is responsible for all balances on the negotiated rate after final insurance adjudication and indicated as patient responsibility. Patient is also responsible for *all charges deemed not billable and not covered by insurance plan* (i.e., cosmetic and elective procedures, goods and services deemed not medically necessary by insurance plan).
- For all out-of-network services, as a courtesy to our patients, we will bill your insurance company, provided that the patient agrees to the Assignment of Benefits acknowledgement in the section below. *Please understand that you are responsible for all charges that are not paid by your insurance carrier.* You are responsible for your account balance, regardless of your agreement with your carrier. You are responsible for all pre-certifications, pre-authorizations or referrals required by your insurance plan. Please contact your insurance plan administrator if you need assistance.
- Our office will adhere to our pre-determined financial policies and fees for service. Fees are not negotiable.
- After final claim adjudications, patient will be sent statement reflecting any adjustments, if applicable. If there is a remaining balance, patient is expected to clear balance with 30 days. After three monthly statements or 90 days, your patient account will go into review and may be sent to an outside collection agency.
- Fee for returned checks added to balance: $50.
- A no show fee equal to the fee for scheduled service will be assessed for missed appointments where 24-hour notice was not provided.
- A late-cancellation fee equal to one half of the fee for scheduled service will be assessed for appointments that are cancelled less than 24 hours prior to appointment.
- Patient authorizes provider to collect and archive financial information for the purpose of recurring transactions as agreed upon by patient/guardian and provider, and to collect for no-show and late-cancellation fees.

AGREEMENTS AND ACKNOWLEDGEMENTS

_____**INITIAL** For the purpose of demographic and other personal information verification, I affirm that the information I have provided is true and correct to the best of my knowledge.

_____**INITIAL** I acknowledge that I have received and have agreed to the financial responsibility agreement provided to me in this document and signed by me. I agree to the terms herein and accept ownership of and responsibility for my account.

_____**INITIAL** I authorize the release of any information relation to all claims for benefits submitted/to be submitted on my behalf or on behalf of my dependent. I expressly agree that my signature on this document authorizes my physician to submit claims for benefits for medical services rendered/to be rendered by this provider. I hereby authorize **assignment of benefits** to Francisco J. Batlle, M.D., and a photocopy of this agreement is considered valid as original.

_____**INITIAL** I acknowledge receipt of NOTICE OF HIPAA AND PRIVACY PRACTICES, as provided to me in this document and by the office of Francisco J. Batlle, M.D., upon request.

_____**INITIAL** In order to facilitate the best possible medical care, I agree to my responsibilities and to participate in my own care and in partnership with my doctor in the following ways:

1. I will keep my appointments as scheduled. I will arrive on time and will keep follow-up appointments. I understand that my doctor will want to know how my conditions progresses and my response to treatment. If I miss an appointment an do not reschedule, I assume the risk of untreated complications.
2. I will inform my doctor if I decide **NOT** to follow the recommended treatment plan.

_____**INITIAL** I hereby give my ***consent to receive treatment services*** from Francisco J. Batlle, M.D. and his staff as directed under his supervision. We want you to be involved in your medical care, and we invite you at any time to ask questions, seek clarification, report symptoms or discuss concerns.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

_____

PRINTED NAME OF PATIENT OR GUARDIAN