Alan Neuromedical Technologies, L.L.C.

2002 Timberloch Place, Suite 200
The Woodlands, Texas 77380
(281) 259-8563***Fax (888) 501-5518

PATIENT REGISTRATION SHEET

Please complete the ENTIRE form and sign where indicated.
Please provide the receptionist with a Photocopy ID.

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security #: ____- ____ - ____ Marital Status: _____

Home #:(____) _____ Cell#: (____)_____ Email: _____

Name of my PRIMARY CARE PHYSICIAN is: _____ Phone: _____

Employer Name: _____ Employer Address: _____

Employer City: _____ State: _____ Zip: _____ Phone#: (____)_____

Referred by: _____ Reason for visit: _____

Is this an on the job injury? Yes._____ No _____ If yes, Date of injury (mo./day/yr.)____/____/____

Is there an attorney involved? Yes_____ No _____ Attorney Name & #: _____

Person responsible for payment: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insurance Company: _____ Phone#: _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policy Holder: _____ Social Security#: _____

Name of Policy Holders Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holders Date of Birth: ____/____/____ Group# (if worker's comp., claim#): _____

Name of Secondary Insurance: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policy Holder: _____ Social Security#: _____

Name of Policy Holders Employer: _____ Policy Holders Date of Birth: ____/____/____

**I authorize payment of medical benefits to the physician for services provided.
** I authorize the release of any medical or other information necessary to process insurance claims.
** I hereby authorize Dr. Donald Rhodes to examine and treat me as necessary.

Signature of Patient: _____ Date ____/____/____

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NAME: _____ DATE: _____

PLEASE TELL US ABOUT YOUR RECENT MEDICAL HISTORY.

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PAST MEDICAL HISTORY

NAME:_____ DATE: _____

Chief complaint or concern, in the patient's own words.

_____

_____

_____

_____

_____

_____

_____

Past medical history: How is your present health with regard to current illnesses, past illnesses, and childhood diseases. Who is your medical physician (s)?

_____

_____

_____

_____

_____

_____

_____

_____

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NAME:_____ DATE: _____

Past Medical History

Past surgical history and hospitalizations: Identify any past surgeries and hospitalizations, their nature, complicating circumstances, reactions to anesthetics, post-operative infections, and current satisfaction with previous procedure.

_____

_____

Current medications: Dose, frequency, durations, and prescriber.

_____

_____

Allergies: Medication, foods, products, or environmental.

_____

_____

Accidents or injuries (auto, work comp., slip & fall, etc.): Recently or in the past.

_____

_____

Social History: Occupation and length of current or past employment. What effect does that complaint have on the job? What makes the situation more tolerable? Recreational activities, hobbies and/or habits? Alcohol, cigarettes, and/or drug use or abuse?

_____

_____

_____

Family History: Includes relevant data on family members (parents, spouse, siblings, and children) with regard to age, current state of health, and cause of death. Identify other family members who have had similar problems.

_____

_____

_____

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NAME:_____ DATE: _____

REVIEW OF SYSTEMS/SYMPTOMS (ROS)

Please circle any condition or symptoms that apply

1. Skin: Recent rashes, lumps, itching, hair loss, growth or change, nail changes or changes in skin color, changes in size or color of moles, tendency toward hypertrophic scars or keloid formation.

2. Head and neck: History of headaches, dizziness, fainting spells, migraines, concussions or conclusions, seizure disorders, enlarged thyroid, and neck range of motion.

3. Ears: Hearing loss or decreased auditory acuity, infections or discharge, recurring discomfort, or ringing in the ears.

4. Eyes: Visual defect or disturbances, double vision, tearing problems, cataracts, glaucoma, infections, or discharge.

5. Nose: Sense of smell, recurrent bloody noses, nasal polyps, sinusitis, or recurrent colds.

6. Mouth and throat: Sores of the tongue or mouth, dental or gum disease, difficulty eating or swallowing food, recurrent sore throats, tonsillitis, or difficulty speaking.

7. Cardiovascular: History of heart attacks, chest pain, cerebral vascular accidents, palpitations or arrhythmias, shortness of breath at rest or exertion, swelling or history of anticoagulant therapy.

8. Respiratory: Shortness of breath, productive cough, obstructive pulmonary disease, recurrent bronchitis of pneumonia, need to sleep with multiple pillows, or asthma.

9. Gastrointestinal: History of nausea, vomiting diarrhea, constipation, abdominal distress, frequency of bowel movements and consistency, bloody or tarry stools, gallbladder disease, pancreatic disease, or laxative use.

10. Genitourinary: Frequent urination, painful urination, difficulty starting or stopping, bladder or kidney infections, kidney stones, blood in the urine, history of sexually transmitted diseases, or lesions of the genitalia.

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REVIEW OF SYSTEMS/SYMPTOMS (ROS) CONT.

11. Musculoskeletal: History of joint pain or muscle pain, weakness or cramping, family history of myopathic disease, including current lower extremity complaints or history of arthritic conditions.

12. Neurologic: History of seizures, tremors, paresthesia, difficulty in coordinating activity, walking, or paralysis.

13. Psychological or psychiatric: Mental illness or instability, depression, anxiety, present or past history of psychiatric treatment.

14. Metabolic or endocrine: Intolerance to heat or cold, excessive urination, increased thirst or appetite, excessive sweating, loss of appetite, recent loss or gain of weight, thyroid disease, or diabetes.

15. Hematologic: History of anemia, blood disorders, sickle cell disease, previous blood transfusion, AIDS, or hepatitis.

Comments:

_____

_____

_____

_____

SIGNATURE: _____ DATE: _____

NAME: _____
(PLEASE PRINT)

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MEDICAL AUTHORIZATION

I, hereby authorize the offices of Alan Neuromedical Technologies, LLC and/or Dr. Donald Rhodes to obtain, examine, inspect and copy, any and all, medical records, medical reports, test results, hospital records, hospital reports, X-ray and/or records concerning _____.

I, hereby authorize the offices of Alan Neuromedical Technologies, LLC and/or Dr. Donald Rhodes to obtain, still or moving photographs to be used for educational and/or scientific proposes.

Facsimile, photo static, carbon or other copies of this authorization shall be treated as an original.

Signed this _____ day of _____ 20 _____

_____ _____
Patient or Parent Signature Date

_____ _____
Witness Date

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WAIVER OF LIABILITY

The undersigned understands that they will be responsible for the charges for their medical treatment. An itemized billing will be supplied by Alan Neuromedical Technologies, LLC and/or Dr. Donald Rhodes so that these charges can be submitted to the insurance company. However, in the event that the insurance company deems the charges made are not reasonable and customary, the undersigned will still be responsible for those charges.

_____ _____

Name of Patient (Please Print Name) Date

_____ _____

Signature (Responsible Party) Date

_____ _____

Witness Date

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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____

Birthdate _____

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This notice takes effect on _____and remains in effect until we replace it.

1 OUR PLEDGE REGARDING MEDICAL INFORMATION,

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2 OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical Information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3 USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will Not use or disclose your medical information, for any purpose not listed below, without your specific written authorization. Until specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative, or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical-Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Heath Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of *Abuse, Neglect,* or *Domestic Violence:* We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety, or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to **Worker's Compensation and/or other similar programs.**

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, **crimes on our premises, and crimes in emergencies.**

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. **Look at or get copies of certain parts of you medical information. You may request that we provide copies in** a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of the notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you a $20.00 administration fee, a fee of $0.50 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different **locations. Your request that we communicate your medical information to you by different means or at** different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not **create the information you want changed or for certain other reasons. If we deny your request, we will** provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

Past Medical History for VECTTORx

Revision 021014

VECTTOR serial number _____

___ Patient #1 ___ Patient #2 ___ Patient #3

Patient name _____ Phone (_____)_____

Date of birth Month _____ Day _____ Year _____

Email address _____

Address _____

City _____ State _____ Zip _____

Primary Diagnosis _____

Secondary Diagnosis _____

_____

Medications ___ No

___ Yes (Name of med, strength of med, and how often taken)

_____

_____

_____

_____

Worst upper body pain _____

Worst lower body pain _____

Other medical problems _____

_____

_____

Trouble sleeping?

___ Yes

___ No

Allergies

___ Airborne

___ Food

Heart problems

___ No

___ Yes _____

_____

Asthma or Lung problems

___ No

___ Yes _____

___ No inhaler

___ Inhaler

Peripheral Neuropathy (numbness)

___ Upper body

___ Lower body

Constipation

___ Yes

___ No

Headaches

___ No

___ Yes

___ Migraine (How often) _____

___ Sinus (How often) _____

Neck ache

___ No

___ Yes

Acid reflux

___ No

___ Yes

Shoulder pain

___ No

___ Yes

Arm pain

___ No

___ Yes

Wrist pain

___ No

___ Yes

Back Pain

___ Upper back

___ Middle back

___ Lower back

___ Extends into leg or legs _____ yes _____ no

Leg pain

___ No

___ Yes

Knee pain

___ No

___ Yes

Cancer

_____ No

_____ Yes _____

_____

Leg swelling?

___ No

___ Yes ___ Right ___ Left ___ Both

___ Slight ___ Moderate ____ Severe

Wheelchair

___ No

___ Yes ___ Part time ___ Full time

Walker

___ No

___ Yes ___ Part time ___ Full time

Cane

___ No

___ Yes ___ Part time ___ Full time