Point Performance Medicine **301-493-8884**
Point Performance Therapy **301-244-9099**

6400 Goldsboro Road, Suite 340
Bethesda, MD 20817

Patient Registration Form

PATIENT INFORMATION

Patient Name: _____

First *Middle Initial* *Last*

Address: _____

City: _____ State: _____Zip _____

Date of Birth: _____ Referred by: _____

CONTACT INFORMATION

Phone: _____(c) _____ (h) _____ (o)

Email: _____

Emergency Contact: Name _____

Phone: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Subscriber: _____

Policy/ID # _____ Group # _____

Secondary Insurance Company: _____

Subscriber: _____

Policy/ID # _____ Group # _____

Patient Authorization and Consent

INSURANCE AUTHORIZATION

I, _____

Hereby authorize **Point Performance Medicine** to apply for benefits on my behalf for covered services rendered and request that the payment from Medicare or other insurance companies, be made directly to **Point Performance Medicine** (or in the case of Medicare Part B Benefits, to myself or the party who accepts assignment).

_____

Signature

_____

Date

PATIENTS ON MANAGED CARE PLANS (HMO, PPO or IPA)

*Some managed care plans require written authorization forms from your primary care physician for each visit to **Point Performance Medicine**. It is the patient's responsibility to make sure that **Point Performance Medicine** has a valid authorization form before each visit. These forms cannot be issued retroactively. I understand that it is my responsibility to obtain a valid authorization form for each visit from my primary care physician and that I may not be seen if one is not available at the time of my appointment.*

_____

Signature

_____

Date

Medical History Form

(All information is strictly confidential)

Patient Name: _____

Age _____ Birthdate _____

Referring Physician _____ Today's Date _____

What is your reason for visit? _____

Symptoms

(Check (√) symptoms you currently have or have had in the past year.)

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Sweats

NEUROLOGICAL
- ☐ Confusion
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting

EYE,EAR,NOSE,THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistant cough
- ☐ Ringing in ears
- ☐ Sinus problems

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars

MUSCLE/JOINT/BONE

Pain, weakness, swelling in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Hopelessness
- ☐ Suicidal

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

WOMEN *(only)*
- ☐ Are you pregnant? _____
- ☐ Number of children _____

Conditions

(Check (√) conditions you have or have had in the past.)
- ☐ AIDS/HIV Positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer (site: _____)
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea/Herpes/STDs
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesteral
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Osteoarthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spinal Stenosis
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Infections

Medications

(List medications you are currently taking)

Name	Frequency	Dose

Pharmacy Name _____ *Phone* _____

Allergies

(To medications or substances)

_____

_____

_____

_____

_____

Health Habits

Check (√) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other	

Biometric Measures

Weight	
Height	
Hand Dominance	

Your occupation:

Safety Concerns

Falls in the past year? YES ☐ / NO ☐

If yes, how many?

If yes, were you hospitalized? YES ☐ / NO ☐

Do you require walking assistance? YES ☐ / NO ☐

CANE ☐ WALKER ☐ BRACE ☐

Surgeries

Date	Procedure

Radiographic Studies
(Xray/CT/MRI)

Date	Study	Body Region

Family Health History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Prior Treatments

- ☐ Physical Therapy
- ☐ Hand/Occupational Therapy
- ☐ Chiropractic Care
- ☐ Acupuncture
- ☐ Dry Needling
- ☐ Massage
- ☐ Spine Injections
- ☐ Joint/Tendon Injections
- ☐ Orthobiologics (PRP/Stem Cell)
- ☐ Prolotherapy
- ☐ Botox Injections
- ☐ Trigger Point Injections

Current Limitations

LIST 3 ACTIVITIES THAT YOU ARE UNABLE TO DO OR ARE HAVING DIFFICULTY WITH AS A RESULT OF YOUR PROBLEM:

1) _____

2) _____

3) _____

Pain Assesment

DO YOU HAVE/WEAR ANY OF THE FOLLOWING?
- ☐ Glasses
- ☐ Contacts
- ☐ Pacemaker
- ☐ Metal Implant
- ☐ Hearing Aides

IF ACCIDENT, CHECK WHERE OCCURRED
- ☐ Home
- ☐ Auto
- ☐ Work
- ☐ Sports
- ☐ Other

HOW DID YOUR SYMPTOMS BEGIN?
- ☐ Gradually
- ☐ Suddenly
- ☐ Injury

SINCE SYMPTOMS STARTED PAIN IS:
- ☐ Getting Worse
- ☐ Getting Better
- ☐ Same

SIMILAR SYMPTOMS IN THE PAST?
- ☐ Yes
- ☐ No

If yes, how was the problem treated? _____

DESCRIBE YOUR PAIN
- ☐ Sharp
- ☐ Dull
- ☐ Achy
- ☐ Burning
- ☐ Sore
- ☐ Throbbing
- ☐ Cramping
- ☐ Shooting
- ☐ Stabbing
- ☐ Squeezing
- ☐ Constant
- ☐ Intermittent
- ☐ Other

_____

HOW ARE YOU ABLE TO SLEEP AT NIGHT?
- ☐ Fine
- ☐ Moderate difficultly
- ☐ Only with medication

_____

DOES PAIN WAKE YOU FROM SLEEP?
- ☐ Yes
- ☐ No

How often? _____

WHAT MAKES THE PAIN BETTER?
- ☐ Lying down
- ☐ Standing
- ☐ Walking
- ☐ Sitting
- ☐ Other

_____

WHAT MAKES THE PAIN WORSE?
- ☐ Lying down
- ☐ Standing
- ☐ Walking
- ☐ Sitting
- ☐ Stress
- ☐ Other

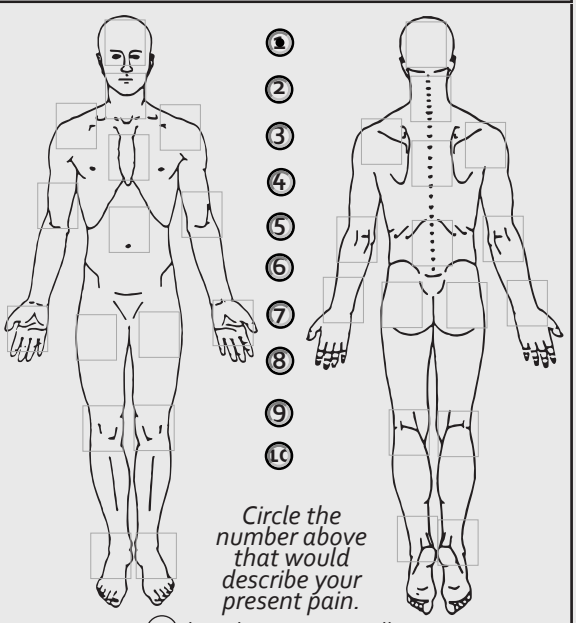
_____

DOES TIME OF DAY AFFECT PAIN?
- ☐ Yes
- ☐ No

When? _____

Pain Diagram

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.



Circle the number above that would describe your present pain.

(1) describes no pain at all.
(10) describes experiencing the worst pain you have ever felt.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

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Notice of Privacy Practices

Effective 1/1/2020

This notice describes how medical information about you may be used and disclosed, and how you may get access to this information. Please review it carefully. If you have any questions about this notice, please contact our Privacy Officer at our practice.

Each time you visit Point Performance your medical record is updated to document your symptoms, exam and test results, diagnosis, treatment and recommendations for future treatment. We are required by law to ensure that your medical information is kept private, to give you this Notice of Privacy Practices, and to follow the terms of the notice that are currently in effect. We may change the terms of our notice at any time. You may request a revised copy of this notice by asking for it at your next appointment or contacting our Privacy Officer.

HOW POINT PERFORMANCE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following describes different ways Point Performance may use and disclose your medical information. We have included examples of each. Your protected health information may be used and disclosed by your physician, Point Performance staff, and others outside of Point Performance involved in providing health care services to you.

Treatment. We may use your medical information to provide, coordinate or manage your medical treatment or services. For example, information obtained by our nurse or physician will be recorded and used to determine the best course of treatment for you. This information may be shared with other healthcare providers involved in your healthcare diagnosis or treatment.

Payment. We may use and disclose your medical information to receive payment for your healthcare services. For example, we may send a bill to you, an insurance company, or a third party that includes information about you and your health care services. We may also communicate with your health insurance carrier for prior approval for a treatment or to determine if a treatment is covered under your plan. We may contact you by phone to discuss your account.

Health Care Operations. We may use and disclose your medical information to support the business activities of the practice. These activities may include equality assessment activities, employee review activities, training of medical students, and conducting or arranging for other business activities. We

may also use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate which physician you are seeing. We may call you by name in the waiting room when your physician is ready to see you.

Business Associates: We may use a third party or business associate to perform various functions necessary to the practice (e.g., billing and IT support/software). We require all business associates to sign contracts stating they will protect your information.

Appointment Reminders. We may use and disclose medical information when we contact you by phone or mail to remind you of an appointment.

As Required By Law. We will disclose medical information when required to do so by federal, state or local law, in response to a court order, valid subpoena, warrant, summons or similar process.

Military and Veterans. We may release medical information of patients in the armed forces as required by military command authorities.

Workers' Compensation. We may release your medical information to comply with workers' compensation laws.

Public Health. We may disclose your medical information for public health reasons. Some common reasons for disclosure are to:

- Prevent or control disease, injury or disability;
- Report births and deaths;
- Report child neglect or abuse;
- Report reactions to medications and/or problems with products (i.e. FDA reporting);
- Notify people of recalls of products they may be using;
- Notify a person who is at risk for exposure to a disease or may be at risk for contracting or spreading a disease or condition;
- Notify the appropriate government authority if we think a patient has been the victim of neglect, abuse, or domestic violence. We will only make this disclosure if you agree or when we are required or authorized by law.

Law Enforcement. When legal requirements are met, we may release your medical information if asked to do so by a law enforcement official:

- For legal processes that are required by law;
- Concerning victim(s) of a crime;
- Regarding a death we believe may have occurred as a result of a crime;
- If a crime occur on the premises of Point Performance
- During a medical emergency when it is likely that a crime has occurred.

Coroners, Medical Examiners and Funeral Directors. Medical information may be released to a coroner or medical examiner for identification purposes or to determine the cause of death. As

authorized by law, we may release medical information to funeral directors to permit the funeral director to carry out his or her duties.

Inmates: If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may release your medical information to the correctional institution or law enforcement official.

SPECIAL SITUATIONS

Emergencies/Communication Barriers: we may disclose your health information in the event of an emergency health situation or if significant communication barriers exist and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances. Your physician will attempt to obtain your consent as soon as possible after the delivery of treatment. If your physician is required by law to treat you, he or she may disclose your health information with or without your consent.

Family and Others Involved in your Care or Payment for your Care: Using our best judgment, we may disclose health information about you to a family member, relative or friend involved in your medical care or the payment of your care.

Organ and Tissue Donation: If you are an organ donor, we may release your medical information to organizations engaged in the procurement, banking or transplantation of organs in order to aid in the organ or tissue donation and transplantation.

Research: We may disclose medical information to researchers if an institutional review board has approved the research proposal and protocols are in place to ensure the privacy of your medical information.

YOUR MEDICAL INFORMATION AND YOUR RIGHTS

Your health record is the physical property of your healthcare provider. The information, however, belongs to you. You have the following rights:

Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical record. This typically includes medical and billing records. If you would like to inspect your medical information, please submit your written request to our Privacy Officer or request access to the patient portal. If you would like to request a copy of your medical information, please submit your written request to the practice.

Right to Request a Restriction: You have the right to request restrictions on the use and disclosure of your medical information. You may request that any or part of your health information be restricted for the purpose of treatment, payment, healthcare operations, or disclosure to family or friends. We are not required to agree to your request. If your physician

determines that it is in your best interest to use and disclose this information, your request will be denied. If your physician approves your request, we will not use or disclose your health information unless it is needed to provide emergency treatment or required by law.

To request a restriction, please submit your written request to our Privacy Officer. Your request must include:

- The information you wish to restrict
- If you want to limit Point Performance use, disclosure, or both
- To whom the limits should apply

Right to Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we have made (if any) of your health information, which do not fall under the routine disclosures stipulated for payment, treatment and/or healthcare operations or for which you have not additionally authorized in writing. To request an accounting of such disclosures, please submit your written request to our Privacy Officer. Your request must include a time period of not longer than six years. Please indicate in your request how you would like this information provided to you, for example, on paper, electronically, etc. We will provide you one free copy. You will be charged for any additional accountings. We will notify you of the cost involved with additional requests. At that time, you may choose to withdraw or modify your request before any costs are incurred.

Right to Confidential Communications from Point Performance. We will accommodate reasonable requests for confidential communications. We reserve the right to condition your request based on information you provide regarding your management of payment and our ability to reach you at an alternative address or other method of contact. To request confidential communications, please send your written request to our Privacy Officer and specify how or where you wish to be contacted.

Right to Have your Physician Amend your Protected Health Information: This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases we may deny your request for an amendment. If we do so, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

Right to Obtain an Electronic Copy of This Notice Upon request, and at any time, we will provide you with an electronic copy of this Notice. To request a paper copy of this notice, please contact our Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, contact our Privacy Officer, without fear of retribution. All complaints must be submitted in writing and will be handled confidentially. The Privacy Officer will contact you within 10 business days of receipt of your complaint.

Should you feel further assistance is warranted, you may contact the Office for Civil Rights/U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Rm 509F HHH Building, Washington, D.C. 20201 or call the Office of Civil Rights (OCR) at 1-800-368-1019.