North Houston SPECIALTY PHYSICIANS

Vincent Talosig D.O.
Patient Registration Form

Date:_____

Patient Name:_____

(Last) (First) (Middle) (Maiden)

Date of Birth:_____ Social Security#:_____

Sex: ____Female ____Male Marital Status: S M W D

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Other:_____

Email Address:_____

Employer:_____ Phone:_____

Employer Address:_____

Emergency Contact:

1._____ Relationship:_____ Phone:_____

2._____ Relationship:_____Phone:_____

Family Physician:_____ Phone:_____

Referring Physician:_____Phone:_____

Complete Below for Patients UNDER 18 ONLY

Fathers Name:_____ Date of Birth:_____SS#:_____

Address (if different from child)_____

City:_____ State:_____ Zip:_____

Phone:_____ Employer:_____ Phone:_____

Mothers Name:_____Date of Birth:_____SS#:_____

Address (if different from child)_____

City:_____ State:_____ Zip:_____

Phone:_____ Employer:_____ Phone:_____

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How did you hear about us? (Please check all that apply)

___Insurance ___Work ___Patient ___Radio ___Mailer ___Search Engine ___Family ___Hospital ___Physician ___Friend ___Newspaper ___Our Web Site ___Yellow Pages

Pharmacy Information

DO NOT leave this section blank. All of our medications are sent electronically.

Pharmacy Name:_____ Phone:_____

Pharmacy Address:_____

Insurance Information

Primary Insurance:_____ Phone:_____

Policy Holder:_____ Date of Birth:_____

Relationship to patient:_____Policy Holders SS#:_____

ID#:_____ Group#_____

Secondary Insurance:_____ Phone:_____

Policy Holder:_____ Date of Birth:_____

Relationship to patient:_____ Policy Holders SS#:_____

ID#:_____ Group#:_____

North Houston SPECIALTY PHYSICIANS

FINANCIAL POLICY

Thank you for choosing North Houston Specialty Physicians as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company once claims have been processed.**
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your

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insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

- **It is your responsibility to provide us with your most current billing information.**
- You must provide your most current billing address, all available telephone numbers and any other important contact information.

If your address or contact information changes, it is your responsibility to contact us with the updated information.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due.
- If you are not able to pay the balance due in full, you must contact our office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at North Houston Specialty Physicians. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

_____ Date:_____

Signature of Responsible Party

_____ Relationship to Patient:_____

Print

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Medication Refill Notification

If you are prescribed a narcotic medication by Dr. Vincent Talosig and are in need of a refill, please contact your pharmacy and allow 48 hours for your request to be approved or denied.
*NO Refills will be authorized Friday thru Sunday.

I, _____, certify that I have read and understand the policy for narcotic medication refills for North Houston Specialty Physicians.

_____ _____
Patient Signature Date

Appointment No Show Policy

To better serve our patients, we are asking that you give us a 24 hour notice if you are unable to make your scheduled appointment. We may charge you a "No Show" fee of $25 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date. We understand that emergencies happen and will determine if charges are applicable.

I, _____, certify that I have read and understand the policy for No Show appointment for North Houston Specialty Physicians.

_____ _____
Patient Signature Date

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Dr. Vincent Talosig, D.O.

Patient Name:_____ Date of Birth:_____

Consent To Treat

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to North Houston Specialty Physicians unless revoked by me orally or in writing.

_____

Signature of Patient or Guardian Date

_____

Print Name

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my Protected Health Information (PHI) will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Guardian Date

_____

Print Name

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Dr. Vincent Talosig, D.O.

HIPAA

Authorization to release protected health information to designated representatives

I,_____, give my authorization to release my protected health information with the following names of people. Who I would like to be involved in or have access to my protected health information on a routine basis. I give permission for North Houston Specialty Physicians to share my protected health information with:

Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#

_____May Not be given to anyone other than myself.

_____ _____

Patient Signature Date

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Authorization to Release Medical Records

Dr. Vincent Talosig, D.O.

Patient Name:_____ DOB:_____

To/ From: North Houston Specialty Physicians
800 Peakwood Drive, Suite 2E
Houston, Texas 77090
Phone: 281-377-1000
Fax: 281-866-0344

To/ From: Physician Name:_____
Address:_____
_____
Phone:_____ Fax:_____

The information that may be disclosed under this authorization includes:

☐ Last 3 Office Visit Note
☐ Any Operative Reports
☐ All Diagnostic Reports (MRI & CT, X-rays etc.)
☐ Current Lab Results
☐ Consultation Reports
☐ Medication List
☐ All Records
☐ Other:_____

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date_____

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Initial Pain Questionnaire

Dr. Vincent Talosig, D.O.

Date:_____

Name:_____ Date of Birth:_____ Age:_____

Referring Physician:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

What is the main problem for which you are seeking treatment?_____

_____

How long have you had this current pain problem? ____ Years ____ Months

---

In general, over the past month the intensity of my pain has been:

□ Mild □ Moderate □ Moderate-Severe □ Severe

- With 10 being the most severe, Rate your pain from 0-10:_____
- With 10 meaning your pain greatly interferes with your activities of daily living and 0 meaning the pain does not interfere with activities of daily living, rate your pain from 0-10:_____

Medications

Please list any current medications that you are taking for pain:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are these pain medications providing relief?

□None of the time □Some of the time □Most of the time □All of the time

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All other current medications (Other than pain medications):

Name	Dose	Frequency

Please list any Allergies to medications that you may have:

☐ NO Known Drug Allergies

Medication	Type of Reaction

Review of Systems

Please check Yes or No for each System

Constitutional:	Yes	No
Chills	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Insomnia	☐	☐
Night sweats	☐	☐

Gastrointestinal:	Yes	No
Change in bowel habits	☐	☐
Constipation	☐	☐
Nausea	☐	☐

Metabolic/Endocrine:	Yes	No
Weight loss	☐	☐

Neurological:	Yes	No
Dizziness	☐	☐
Incoordination	☐	☐
Pareshtesias (numbness)	☐	☐

Respiratory:	Yes	No
Shortness of Breath (Dyspnea)	☐	☐

Cardiovascular:	Yes	No
Chest Pain	☐	☐
Irregular heartbeat	☐	☐
Palpitations	☐	☐

Genitourinary:	Yes	No
Decreased urine output	☐	☐
Hesitancy	☐	☐

Psychiatric:	Yes	No
Anxiety	☐	☐
Depression	☐	☐

Dermatological:	Yes	No
Rash	☐	☐
Pruritus	☐	☐

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Musculoskeletal:	Yes	No
Back Pain	☐	☐
Bone/Joint symptoms	☐	☐
Muscle weakness	☐	☐
Neck stiffness	☐	☐

Hematological:	Yes	No
Easy bleeding	☐	☐
Easy bruising	☐	☐

Immunological:	Yes	No
Environmental allergies	☐	☐
Food allergies	☐	☐

Past Medical History

(Have you had any of the following?(Please check all that apply)

☐Alcoholism ☐Depression ☐High Cholesterol ☐Seizures/Epilepsy
☐Anxiety ☐Diabetes ☐Hypertension ☐Stomach ulcers
☐Asthma or wheezing ☐Emphysema ☐Kidney Disease ☐Stroke
☐Bleeding problem ☐Fibromyalgia ☐Liver Disease ☐Thyroid disease
☐Chest pain/Angina ☐Gerd/Reflux ☐Psychiatric problem
☐Coronary artery disease ☐Heart attack

Name of Psychiatrist/Therapist:_____ Phone:_____
Arthritis(Specify location):_____
Cancer(Specify Type):_____
Other(Specify):_____

Social History

☐Employed Full-Time ☐Unemployed ☐Retired ☐Student
☐Employed Part-Time ☐Homemaker
Employers Name:_____ Phone:_____
Current Occupation:_____

Are you unemployed or employed part-time due to your present pain condition?☐Yes ☐No

Do you Smoke? ☐Yes ☐No
How much nicotine per day?_____
Previous smoker:Last Cigarette?_____
Do you use recreational drugs?_____

Do you drink alcohol? ☐Yes ☐No
☐Beer ☐Wine ☐Liquor
How many glasses per week?_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated
Do you live alone? ☐Yes ☐No Who do you live with?_____
Are you pregnant? ☐Yes ☐No ☐N/A How many weeks?_____

Patient signature:_____ Date:_____