



# NOBLE

PAIN MANAGEMENT  
& SPORTS MEDICINE

**\*\*\*PATIENT REGISTRATION SHEET\*\*\***

**Please complete the ENTIRE form and sign where indicated.  
Please provide the receptionist with your insurance card.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: TX Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: Unknown

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If you were not referred by a physician, how did you hear about us? \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: TX Zip: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Secondary Insurance:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: TX Zip: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Person responsible for payment: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Notification: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Signature of Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Meaningful Use Patient Questionnaire

To improve the quality of care or patients receive, Noble Pain Management and Sports Medicine has implemented an electronic health record and is participating in the Meaningful Use Initiative. The data we are collecting below will help Noble efficiently and safely care for you, reduce health disparities, and improve care coordination between Noble, your primary care physician and local hospitals. Please take a moment to answer the following very important questions regarding you and your overall healthcare. Thank you for choosing Noble.

### Please select your race:

- American Indian or Alaska Native    Asian    Native Hawaiian or Other Pacific Islander
- Black or African American    White    Other Race    Other Pacific Islander    Declined to Specify
- Other: \_\_\_\_\_

### Please circle your ethnic background:

- Hispanic or Latino    Not Hispanic or Latino    Declined to Specify    Other: \_\_\_\_\_

What is your preferred language? \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_



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PAIN MANAGEMENT  
& SPORTS MEDICINE

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**CONSENT TO TREAT:** I consent to the administration of health care by Noble Pain and sports Medicine (Noble). I understand that I may set conditions or limitations on my treatment and care and that if I wish to provide such conditions, I will be given the opportunity to write those in a separate document. I have been informed and acknowledge that I may withdraw my consent at any time upon written notice to Noble. I am giving my consent to the administration of health care by Noble voluntarily, and that hereby knowingly and voluntarily enter into this Health Care Consent for Treatment. Noble is an interventional Pain Management and Sports Medicine clinic only. Noble encourages all patients to obtain a Primary Care Physician.

**AGREEMENT FOR BENEFIT ASSIGNMENT AND FINANCIAL RESPONSIBILITY:** I agree to pay for all services rendered to me by a Noble Pain and Sports Medicine (Noble) physician and/or other qualified healthcare provider employed by Noble. I agree that I am responsible to provide timely information about my insurance coverage and changes in coverage as they occur. **I am responsible for keeping any required insurance referrals current and up to date.** I agree to respond promptly to requests for information from my insurance company as they occur. I assign Noble Pain and Sports management (Noble) benefits due to me or become due to me as a result of the medical services I shall receive from a Noble physician or other qualified healthcare provider. I further authorize the payments to be paid directly to Noble. I also understand that I am responsible to Noble for any payments made directly to me for services Noble provided to me. If this account is not paid in accordance with Noble’s policies, I agree and guarantee to pay collection costs, including reasonable attorney fees, collection agency fees and interest from the date of demand. We also can arrange payment plans for balances.

**IF MEDICARE** or other similar government program should determine that I am not eligible for coverage or that the treatment is not covered, I will be responsible for payment, unless prohibited by law.

**IF NO INSURANCE, THIRD-PARTY INSURANCE, or MOTOR VEHICLE ACCIDENTS** you will be responsible for all charges associated with your care. Any balance on your account is your responsibility to pay in full at the beginning of the office visit. Likewise, any associated medical procedure will require a prepayment of 100% of the physician’s fee and any balance from additional services will be billed to the patient. We do not file insurance to third-parties or insurance carriers and do not accept liens. You will be responsible for all charges as well as billing appropriate carriers as you like. For the patients without insurance, we are able to offer a self-pay discount due to required payment in full at the time of service. There are no discounts for third-party carriers.

**ACKNOWLEDGEMENT OF PRIVACY POLICIES / HIPAA:** I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changes at any time and I have the right to request new copies at any Noble location during regular business hours.

ACCEPTED  DECLINIED \_\_\_\_\_ Patient’s Initials

By my signature below, I am acknowledging receipt of this document and agree to the terms under all five sections of this document. Agreement Consent to Treat, Benefit Assignment and Financial Responsibility and receipt of Privacy Policies / HIPAA.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



Summary of HIPAA Notice of Privacy Practices  
Effective March 1, 2014

**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.**

A full version of this Privacy Notice is available to you at the front desk of our locations.

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, a revised notice will be made available to you within 60 days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (817) 518-1112.

**How We May Use or Disclose Your Health Information**

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written consent or authorization, and you may revoke such authorization in writing at any time.

***Treatment:*** We may use or disclose your health information to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record and that record may be shared with other providers involved in your care.

***Payment:*** We may use or disclose your health information in order for services you receive at our office to be paid by your insurance carrier. For example, we may disclose appropriate information for reimbursement, collection, or payment purposes.

***Health Care Operations:*** We may use or disclose your health information for health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, underwriting, premium rating, management, and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

***Business Associates:*** There may be instances where services are provided to our office through contracts with third party “Business associates”. Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

***Required by Law:*** We will disclose medical information about you when required to do so by federal, state, or local law.

***Communication with Family or Friends:*** Our professionals, using their best judgment, may disclose to a family member, other relative, close friend, or any other person you identify, health information relevant to that person’s involvement in your care or payment related to your care. The office may also disclose your condition to family or friends who accompany you to our offices.

***Coroners, Medical Examiners and Funeral Directors:*** We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

***Public Health:*** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## HIPAA Policy

Noble Pain and Sports Medicine  
431 E. State Highway 114  
Suite 120  
Southlake, TX 76092  
(p)817-518-1112 (f)817-518-1113

According to the Texas State Law and per HIPPA policy, our practice is not allowed to release any of your information without your permission. Please list any individuals that you are giving permission to receive or to pick up any scripts written by the doctor. Please list any individuals that you are giving permission to receive information in regards to you as a patient at our practice.

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### CHECK ALL THAT APPLY

Preferred method for communication and appointment reminders:

Home                       Cellular (Voice)                       Cellular (Text)

#### Home Phone

- Okay to leave a message with detailed information
- Leave message with call back number only

#### Cellular Phone

- Okay to leave a message with detailed information
- Leave message with call back number only

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



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PAIN MANAGEMENT  
& SPORTS MEDICINE

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Office Policies

### 1. Cancellation / No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, or do so in a timely manner, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

**If an appointment is not cancelled at least 24 hours in advance, you will be charged a thirty-five-dollar (\$35) fee; this will not be covered by your insurance company. Appointments must be cancelled during normal business hours.**

### 2. Pain Contracts

As a condition of your pain contract, you will only receive controlled substances if you are under direct medical supervision. This means that you will need to keep your regularly scheduled appointments.

**If you No Show or have two instances where you did not give at least a 24-hour notice, then you will not receive medication refills. A third No Show/Less than 24 Hour Cancellation is grounds for dismissal from the practice. (These do not need to be consecutive, but in total).**

### 3. Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

**If surgery is not cancelled at least one day in advance, you may be charged a seventy-five-dollar (\$75) fee; this will not be covered by your insurance company.**

### 4. Copays and Account Balances

Copays and balances will be collected prior to your appointment. Failure to comply will result in the appointment being rescheduled. Patients who have questions about their bills or who would like to discuss a payment plan option may call 972-991-9950 and ask to speak to a billing representative with whom they can review their account and concerns. To avoid missing your scheduled appointment, please have this completed prior to your appointment. Patients with balances over \$100 must make payment arrangements prior to future appointments being made.

### 5. Verbal and Physical Abuse

At Noble we value our patients as well as our staff. Verbal or physical abuse will not be tolerated and will result in termination of the relationship.

### 6. Phone Calls

Our office works hard to diligently assist the doctor in clinic as well as return phone calls in a timely manner. Many calls require consulting the doctor. Please refrain from multiple calls and voicemails as these take time to process and result in delaying the process. Please request refills of non-controlled substances through your pharmacy directly and they will send us the request for review. Will respond to the pharmacy directly and ask that you allow 24 to 48 hours for processing. An after-hours service is available for emergencies. Please do not call after hours for refill or appointment issues.

### 7. FMLA/Disability Paperwork

There is a \$100 minimum fee for all paperwork. Please visit our front desk for our questionnaire and allow 14-21 days for processing.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Brief History of Problem: \_\_\_\_\_

Approximate Onset of Problem: Number (#) of: \_\_\_\_ days, \_\_\_\_ weeks, and/or \_\_\_\_ years?

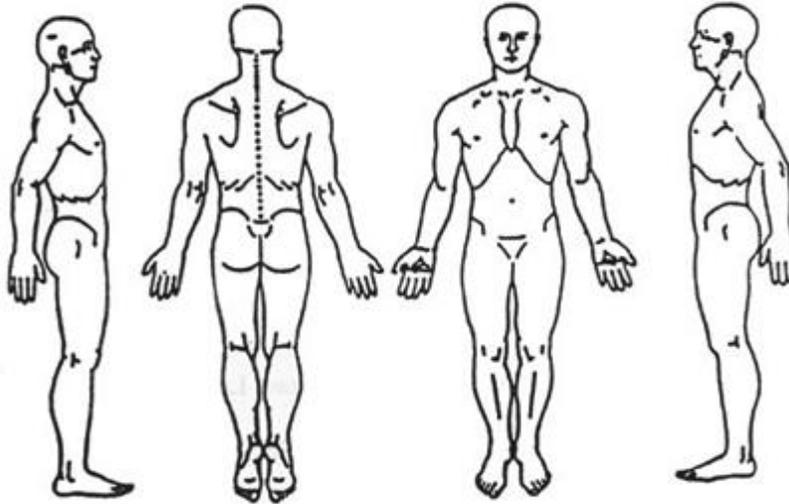
Did you have an injury?  Yes  No

If yes, did the injury occur at work?  Yes  No  
(Please Note: We do not take Workman's Comp or accident injury)

Rate Severity of Pain from 0-10 (0=None, 10=Worst Possible): 0

Pain Diagram

**Location of Pain:**  
Mark or circle  
your location of  
pain



How often does your pain occur:  Intermittent  Continuously  Activity Dependent  At Rest

Relieves Pain:  Rest  Activity  Other: \_\_\_\_\_

Increases Pain:  Rest  Activity  Other: \_\_\_\_\_

How are you currently treating your pain? \_\_\_\_\_

Have you had pain management in the past?  Yes  No

Do you have a letter of good standing?  Yes  No

Have you had tried any of these in the past for your current condition:

Injections What kind? \_\_\_\_\_

Pain Medications What kind? \_\_\_\_\_

Physical therapy For how long? \_\_\_\_\_

Review of Systems: [Check Any That Apply]

- |  |                                     |  |   |   |
|--|-------------------------------------|--|---|---|
| <input type="checkbox"/> Weakness to _____   | <input type="checkbox"/> Fatigue    | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Vision Changes                 | <input type="checkbox"/> Poor Balance     |
| <input type="checkbox"/> Numbness to _____   | <input type="checkbox"/> Nausea     | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Chills/Fever                   | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Tingling to _____   | <input type="checkbox"/> Depression | <input type="checkbox"/> Dependence          | <input type="checkbox"/> Skin Problems                  | <input type="checkbox"/> Insomnia         |
| <input type="checkbox"/> Skin Problems _____ | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of bowel/bladder function |   |

Past Medical History: [Check Any That Apply]

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Fibromyalgia   | <input type="checkbox"/> Stroke/TIA              | <input type="checkbox"/> Liver Disease           |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> COPD           | <input type="checkbox"/> Previous Heart Attack   | <input type="checkbox"/> Lupus                   |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Sleep Apnea             | <input type="checkbox"/> Implanted Devices _____ |
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Renal Disease (Kidneys) | <input type="checkbox"/> Other: _____            |

Please list any medications you currently take, including anything over the counter (OTC):

Medication Name:	Dosage:	Directions:

Have you had problems with addiction or medication dependence?  Yes  No

\*Please list any known allergies\*:

No Known Drug Allergies  Food Allergies  Medication Allergies  Other:

Have you had any recent Hospitalizations?  Yes  No

If so, when and what for? \_\_\_\_\_

Please list ANY past surgical procedures and the date they occurred:

\_\_\_\_\_

Have you had any recent images?  MRI  CT  XRAY  EMG  Bone Scan

Family History:

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Substance Abuse	Medication Dependence
Father	<input type="checkbox"/>						
Mother	<input type="checkbox"/>						
Maternal Grandfather	<input type="checkbox"/>						
Maternal Grandmother	<input type="checkbox"/>						
Paternal Grandfather	<input type="checkbox"/>						
Paternal Grandmother	<input type="checkbox"/>						

Social History:  Single  Married  Widowed  Divorced

Do you smoke:  Yes  No If so, how often: \_\_\_\_\_

Do you drink:  Yes  No If so, how often: \_\_\_\_\_

Name	Signature	Date
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