PATIENT INFORMATION **(PLEASE PRINT)** **DATE**_____

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #
DATE OF BIRTH SEX MARITAL STATUS	HM PHONE #	WORK#	CELL #
ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER			PHONE #
BUSINESS ADDRESS	CITY	STATE	ZIP CODE

TREATING PHYSICIAN (Dr Bindal is not your treating physician)	PHONE #
REASON FOR VISIT	
IS THIS RELATED TO AN ACCIDENT? TYPE OF ACCIDENT?	DATE OF INJURY
YES NO AUTO EMPLOYMENT RELATED OTHER	

IN CASE OF EMERGENCY, CONTACT **(Name of friend or relative – not living with you)**

LAST NAME	FIRST NAME	MI	RELATIONSHIP
ADDRESS	CITY	STATE	ZIP CODE
HOME #	WORK #	CELL#	

HEALTH INSURANCE INFORMATION (Please provide copies of all insurance cards)

PRIMARY INSURANCE	POLICY #		PHONE #
GROUP #	POLICY HOLDER	DATE OF BIRTH	RELATIONSHIP

SECONDARY INSURANCE	POLICY #		PHONE #
GROUP #	POLICY HOLDER	DATE OF BIRTH	RELATIONSHIP

TERTIARY INSURANCE	POLICY #		PHONE #
GROUP #	POLICY HOLDER	DATE OF BIRTH	RELATIONSHIP

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR PAYMENT OF DOCTOR'S FEES WITHIN 30 DAYS, REGARDLESS OF INSURANCE COVERAGE OR STATUS OF INSURANCE CLAIM(S). EXTENSION OF CREDIT BEYOND 30 DAYS MUST BE DISCUSSED AND APPROVED BY THE BUSINESS OFFICE IN ADVANCE. INSURANCE PAYMENTS RECEIVED WILL BE APPLIED TO YOUR ACCOUNT BALANCE OR PROMPTLY REFUNDED TO YOU. NECESSARY FORMS WILL BE COMPLETED AND FORWARDED TO THE ABOVE INSURANCE COMPANIES IN ORDER TO EXPEDITE INSURANCE CARRIER PAYMENTS. YOU ARE RESPONISIBLE FOR COLLECTION FEE CHARGES ON ANY UNPAID BALANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I HEREBY AUTHORIZE AJAY K. BINDAL, M.D.,P.A. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

SIGNATURE _____ **DATE** _____

MEDICAL HISTORY

GENERAL INFORMATION

NAME: _____ DATE _____

AGE: _____ ☐ MALE ☐ FEMALE

Height: _____ Weight: _____ ☐ RIGHT-HANDED ☐ LEFT-HANDED

NAME OF FAMILY DOCTOR: _____

REASON FOR OFFICE VISIT

☐ Injury/Date of Injury _____

☐ Illness/Date Illness Began _____

☐ Symptoms/Date symptoms began _____

☐ Second Opinion/IME _____

How would you describe your symptoms since they began?

☐ BETTER ☐ WORSE ☐ NO CHANGE

What symptoms do you have today? _____

_____

How did this problem begin? (Give details) _____

_____

_____

Do you have urinary or fecal incontinence?

☐ NO ☐ YES

Do you have foot drop or paralysis?

☐ NO ☐ YES

Were you treated or seen at a hospital emergency room or urgent care center for this injury/illness?

☐ NO ☐ YES Where? _____

When? _____

Have you received further treatment for this injury/illness?

☐ NO ☐ YES

Check any of the following tests or treatments you have had for this illness or injury? (Specify when and where tests or treatments were done.)

☐ Blood tests or lab tests _____

☐ X-Rays _____

☐ CT or MRI scan _____

☐ Physical therapy _____

☐ Chiropractic care _____

☐ Epidural Steroid Injections _____

PATIENT NAME_____ DATE_____

REASON FOR OFFICE VISIT (continued)

Are you able to do everything you did before the injury/illness? (Explain NO answers)

	YES	NO	
Drive	☐	☐	_____
Housework	☐	☐	_____
Yard work	☐	☐	_____
Sports	☐	☐	_____
Hobbies	☐	☐	_____
Second job	☐	☐	_____
Sex	☐	☐	_____

Have you ever seen a doctor for neck or back problems?

☐ YES If yes, specify problem, doctor, date, and any surgery. _____

☐ NO _____

MEDICATIONS

Are you taking any medications for this injury/illness, including medications from a doctor or over-the-counter medications such as aspirin, Tylenol, or Advil?

☐ YES If yes, specify medications. _____

☐ NO _____

Are you taking medications now for any other reason (including vitamins, birth control pills)?

☐ YES If yes, specify medications. _____

☐ NO _____

Do you drink or eat any beverages or food that contain caffeine?

☐ YES If yes, specify. ☐Coffee ☐Tea ☐Colas ☐Chocolate

☐ NO How much per day? _____

FAMILY HISTORY

Has anyone in your family had any of the following conditions (please explain who and what they had)?

	NO	YES	
Cancer	☐	☐	_____
Heart problems	☐	☐	_____
Diabetes	☐	☐	_____
Kidney disease	☐	☐	_____
Depression/mental problems	☐	☐	_____
Alzheimers/Memory loss	☐	☐	_____
High blood pressure	☐	☐	_____
Stroke/brain tumor/aneurysm	☐	☐	_____
Lung problems	☐	☐	_____
Parkinson's	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Other Problems	☐	☐	_____

PATIENT NAME_____ DATE_____

PERSONAL MEDICAL HISTORY

Do you have a history of medical problems or surgery of the following (please explain)?

	NO	YES	
Eyes	☐	☐	_____
Ears	☐	☐	_____
Skin	☐	☐	_____
Heart	☐	☐	_____
Circulation/Blood flow	☐	☐	_____
Lungs/Asthma	☐	☐	_____
Stomach	☐	☐	_____
Bowels/Intestines	☐	☐	_____
Kidneys	☐	☐	_____
Uterus/Prostate	☐	☐	_____
Depression/Mental problems	☐	☐	_____
Arthritis/Joints	☐	☐	_____
Blood clots/other problems	☐	☐	_____
High blood pressure	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Brain seizures/Epilepsy	☐	☐	_____
Headaches/Migraines	☐	☐	_____
Dizziness/Fainting	☐	☐	_____
Hepatitis	☐	☐	_____
Other problems	☐	☐	_____

Have you ever had any neck or back operation/surgery?

☐ YES When/Where? _____

☐ NO _____

Is there any reason you cannot receive blood or blood products?

☐ YES Explain. _____

☐ NO _____

Do you have any allergies (medication, iodine, tape, latex, creams, dust, food, animals, pollen, etc.)?

☐ YES Specify allergies. _____

☐ NO _____

Do you have problems falling asleep or staying asleep?

☐ YES Explain. _____

☐ NO _____

FEMALE PATIENTS

Are you pregnant?	☐	NO	☐	YES	Due date? _____
Have your periods stopped?	☐	NO	☐	YES	
Have you had your uterus and/or ovaries surgically removed?	☐	NO	☐	YES	
Do you take hormones?	☐	NO	☐	YES	

PATIENT NAME_____ DATE_____

LIFESTYLE/SOCIAL

Do you use any tobacco products?

☐ YES Specify: ☐ Cigarettes ☐ Snuff ☐ Tobacco ☐ Cigars ☐ Pipe

☐ NO How much per day? _____ How many years? _____

Did you use any tobacco products in the past?

☐ YES Specify: ☐ Cigarettes ☐ Snuff ☐ Tobacco ☐ Cigars ☐ Pipe

☐ NO How much per day? _____ When did you quit? _____

Do you drink alcohol?

☐ YES Specify: ☐ Beer ☐ Wine ☐ Liquor

☐ NO How much per day? _____ How many years? _____

Did you drink alcohol in the past?

☐ YES Specify: ☐ Beer ☐ Wine ☐ Liquor

☐ NO How much per day? _____ When did you quit? _____

Have you ever received treatment for drug and/or alcohol problems?

☐ YES Specify when and where? _____

☐ NO _____

Indicate your marital status: ☐ Single ☐ Married ☐ Widowed ☐ Other

Do you live alone? ☐ YES ☐ NO

Do have any children? If yes, indicate age(s) and whether they live at home.

☐ NO ☐ YES Age(s)? _____

Do you have a relative with a physical or mental health problem living at home? If yes, indicate whether you take care of this relative.

☐ NO ☐ YES Explain. _____

Do you exercise regularly? If yes, indicate the activity and how often you do it.

☐ NO ☐ YES Explain. _____

WORK INFORMATION

EMPLOYER _____ Length of employment? _____

JOB TITLE _____ How long have you done this job? _____

Does your job require you to perform the following activities:

☐ Lift _____ pounds ☐ Sit ☐ Use a computer

☐ Lift over head ☐ Bend ☐ Drive a truck or forklift

☐ Reach over head ☐ Stand

Are you working now?

☐ YES ☐ NO If no, how long have you been off work? _____

If you are married, does your spouse work?

☐ YES ☐ NO If no, how long has he/she been off work? _____

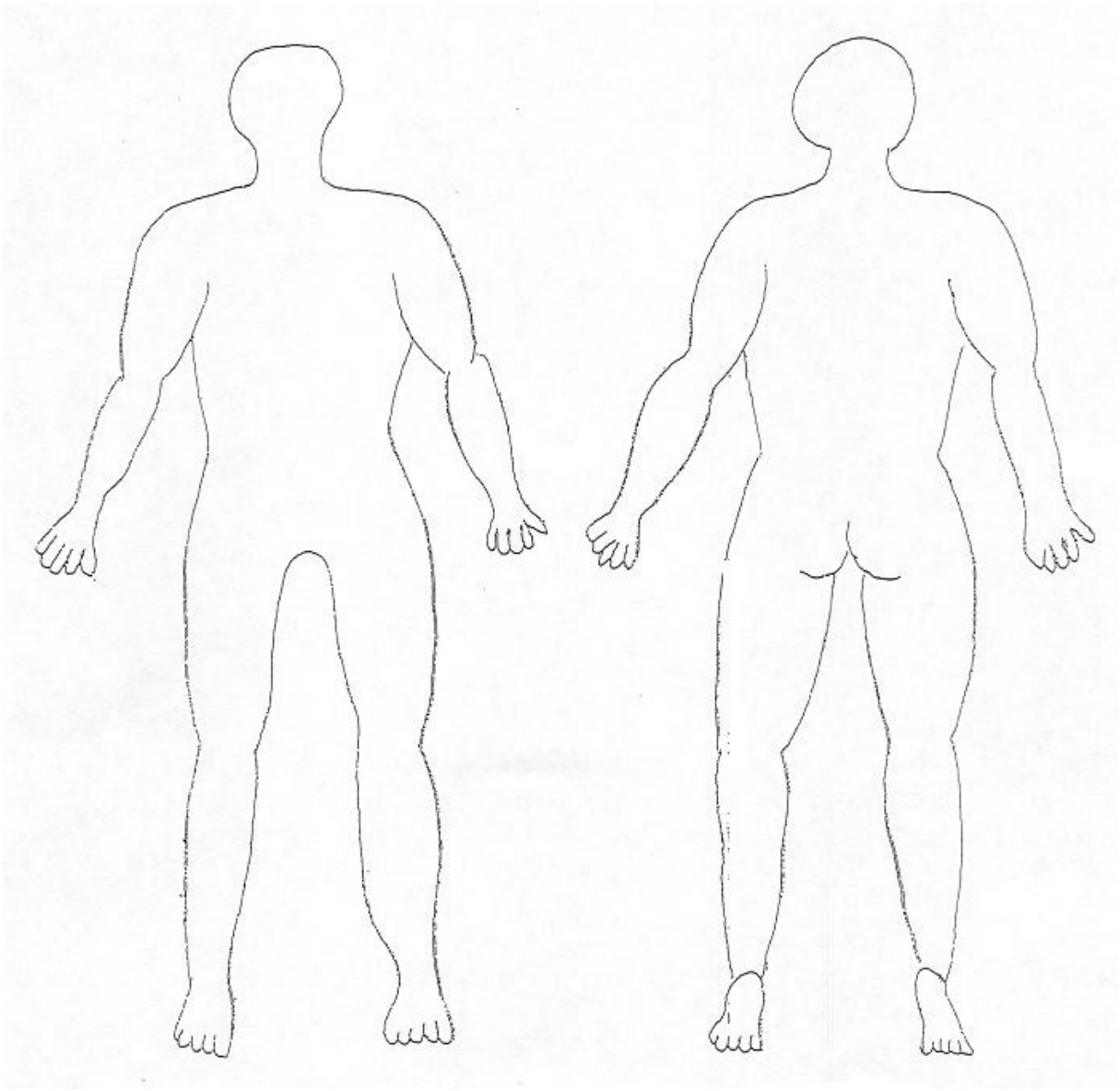
Patient's signature _____ Date _____

Physician's signature _____ Date _____

Name _____ Date _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation, include all affected areas. Please draw in your face.

	------		OOOO		XXXX		////	^^^^
Numbness	------	**Pins & Needles**	OOOO	**Burning**	XXXX	**Stabbing**	////	**Ache** ^^^^
	------		OOOO		XXXX		////	^^^^



Right side Left side Right side

FRONT BACK

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone number: _____

Please list Primary Care and referring Physicians' name, address and phone number

Name: _____

Address: _____

_____

Phone number: _____

Name: _____

Address: _____

_____

Phone number: _____

Name: _____

Address: _____

_____

Phone number: _____

Notice of Privacy Practices

Ajay K. Bindal, M.D., P.A.

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 practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, software programmers and/or hardware vendors updating the computers.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- ***The information wasn't created by this practice or the physicians in this practice.***
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

7737 SW Freeway #230
Houston, TX 77074
Phone Number: 713-752-0001 Fax Number: 713-752-0005
This notice is effective April 14, 2003.

Acknowledgement of Review Of
Notice Of Privacy Practices.

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient Or Personal Representative

_____
Description of Personal Representative Authority