



JOHN C. MILANI, M.D., P.A.

John C. Milani, M.D.
Richard A. Espey, M.D.
1341 W. Mockingbird Lane, Suite 710E
Dallas, Texas 75247
(214) 630-7494
FAX (214) 630-2228

To Our Patients:

We would like to ensure that your office visit with us is pleasant and productive. Please have the enclosed Patient Information Forms completed before your appointment in order to reduce your waiting time. If you need assistance with some of the questions, the office staff will be happy to help when you arrive.

It is your responsibility to bring all films and/or CD's of X-rays, MRI's, CT Scan's, Discograms, Myelograms, EMG results and medical records pertaining to your current problem. This information is crucial in determining your diagnosis and treatment. Without these, there is a possibility that your appointment will be rescheduled, or your diagnosis and treatment recommendations may be delayed.

Please note that your co-pay is due at the time of your visit.

Thank You,

Diana Davila
Intake Coordinator

Appointment Date: _____
Appointment Time: _____

General Information

Today's Date _____

Referring Physician _____ Phone Number _____

1. Legal Name _____ 2. Age _____

3. Date of Birth _____ 4. Race _____ 5. Gender Male Female

6. Address _____
(Street) (Apt) (State) (Zip)

7. Home Ph# _____ Cell Ph# _____

Work Ph# _____ 8. Email address: _____

9. Social Security # _____ 10. Drivers License # _____

11. Marital Status: Single Married Widow
 Divorced Separated

12. Highest grade completed in school _____

13. Occupation _____

14. Currently Employed Yes No

15. Employer _____

16. Employer Address _____

17. Guarantor Name _____

18. Guarantor Address _____

19. Date of Birth _____ 20. Relationship _____

21. Guarantor Employer _____

22. Employer Address _____

23. Spouses Name _____ 24. Work/Cell Phone _____

25. Spouse SS# _____ 26. DOB _____ 27. Employer _____

28. In case of emergency, contact: _____ 29. Relationship _____
(Name)

30. Home Phone _____ Work Phone _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

PATIENT NAME: _____ SS# _____

I wish to be contacted by John C. Milani, M.D., P.A. in the following manner:

Home Telephone:

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

Work Telephone:

- Ok to leave message/voice mail with detailed information
- Leave message/voicemail with call back number only

Written Communication:

- Ok to mail to my home address
- OK to mail to my work address
- OK to fax to _____

I hereby give permission to John C. Milani, M.D., P.A. to disclose and discuss any information related to my medical condition to the following people. (relatives or close personal friends):

Name	Relationship
Name	Relationship
Name	Relationship

OR

_____ I DO NOT choose to allow my information to be shared with any additional family members, relatives or personal friends.

The duration of this authorization is indefinite unless otherwise revoked in writing by the patient. I understand that the request for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information. THIS IS NOT A REQUEST TO RELEASE MEDICAL RECORDS.

✓

Signature of Patient or Legal Representative

Date

Medication policy

John C. Milani, M.D., P.A.
1341 W. Mockingbird Lane # 710E
Dallas TX 75247

Our goal is to provide you with the best treatment possible in a pleasant and caring manner. We are sensitive to the pain you may be experiencing and for that reason you may be given medication to help with your pain. The following medication policy is intended for the safety of our patients and to limit the chance of drug interactions.

- Medications are to be taken as prescribed by the physician.
- Patients should use one pharmacy for their medications and refills.
- We are available to refill prescription medications during the following hours:

Monday – Thursday 8:30 a.m. to 5:00 p.m.
Friday 8:30 a.m. to 3 p.m.*

- *Please allow 24 hours for all refill requests to be processed by the office.
- Medications will not be filled on weekends or after hours.
- Patients should contact their pharmacy for refills.
- Failure to comply with this policy may result in delayed or denied medication refills.
- This office does not prescribe long term narcotic pain medications.
- Those patients requiring long term pain medications will be referred to a pain management specialist for all medication needs.

I certify this policy has been fully explained to me, that I have read it, or have had it read to me, and that I understand it.

Patient Name (print)

Date

✓

Patient Signature

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.

JOHN C. MILANI, M.D., P.A. has adopted the following privacy policies:

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations. Your health information may be used as necessary to support the day-to-day activities and management of JOHN C. MILANI, M.D., P.A. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. the right to request restrictions on the use and disclosure of your Protected Health Information;
2. the right to receive confidential communications concerning your medical condition and treatment;
3. the right to inspect and copy your Protected Health Information;
4. the right to amend or submit corrections to your protected health information;
5. the right to receive an accounting of how and to whom your protected health information has been disclosed;
and
6. the right to receive a printed copy of this notice.

JOHN C. MILANI'S, M.D., P.A. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy Protected Health Information be submitted in writing. You may obtain a form to request access to your records by contacting Diana Davila, Receptionist, or Jude Hammett, Privacy Official.

Complaints and Contact Person

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Jude Hammett, R.N., Nurse Manager
John C. Milani, M.D., P.A.
1341 W. Mockingbird #710-E
Dallas, TX 75247

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This Notice is effective on or after April 14, 2003.

I acknowledge the opportunity to review this Notice of Privacy Rights and give my permission to JOHN C. MILANI, M.D., P.A. to use and disclose my health information in accordance with it.

✓ **Patient Initial** _____

Consent to Treat

I understand that I have presented myself to John C. Milani, M.D., P.A. for evaluation and/or treatment for my orthopedic problem. I am aware that I may require an aspiration, injection, implanted pump medication refill, EMG testing, physical therapy, DME application/adjustments or other form of necessary treatment during my episode of care. I further understand that all options will be discussed prior to the administration of such treatment.

✓ **Patient Initial** _____

Please send a copy of my medical record report to: **(Records will not be sent without complete addresses).**

Physician/ Attorney/Case Manager/Rehab Consultant/Other

1. _____
Name _____ Phone# _____

Address _____

Physician/ Attorney/Case Manager/Rehab Consultant/Other

2. _____
Name _____ Phone# _____

Address _____

Physician/ Attorney/Case Manager/Rehab Consultant/Other

3. _____
Name _____ Phone# _____

Address _____

I authorize the release of any medical information necessary for my medical care and to process medical claims. I understand that all fees incurred in the course of my treatment by John C. Milani, M.D., P.A. and/or its authorized agent(s) are my responsibility. I hereby authorize the insurance companies to make payment directly to the above said party(ies) for those fees I have not previously paid. Additionally, I agree that all charges not paid by my insurance company(ies) are ultimately my responsibility.

I hereby authorize John C. Milani, M.D., P.A. to release a copy of my medical records to the parties that I have indicated on this form. Furthermore, I have read, understand and agree to the statements that appear herein.

Printed Name _____ Relationship to Patient _____

✓ **Signature** _____ Date _____

Financial Responsibility Agreement

Patient Name: _____ Date: _____

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance coverage is a contract between you, your employer and the insurance company. We are not party to your contract. (This does not pertain to carriers with whom we have HMO/PPO contracts.)

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab Testing, X-ray, EKG and any other Screening service or Diagnostic testing ordered by the physician or physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG or any other Screening Service or Diagnostic testing ordered by the physician or staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expenses to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance Company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Workers Compensation Patients only:

I understand and agree that if I am being treated for a Workers Compensation injury, it is my responsibility to inform this office of any denials, disputes, changes in compensability or settlements.

✓ **Patient Initial** _____

Responsible Party Name _____

✓ **Signature** _____ **Date** _____

(Please sign here—Patient or Responsible Party)

15. Do you have weakness of any body parts? Yes No

If yes, where is the weakness located? _____

16. Do you have normal control of bowel and bladder? Yes No

17. Do you have erection problems or sexual dysfunction? Yes No

If yes, type of problem _____

18. Have you had any of the following?

Myelogram Yes No Date _____ Where _____

CAT Scan Yes No Date _____ Where _____

MRI Scan Yes No Date _____ Where _____

EMG Yes No Date _____ Where _____

Discogram Yes No Date _____ Where _____

ESI
(Epidural Steroid Injection) Yes No Date _____ Where _____

How many ESI's? _____

Were they helpful? Yes No

Other types of Injections Yes No What type? _____

Physical Therapy Yes No Date Started _____ Date Ended _____

Kinds of Physical Therapy treatments:

Heat Massage Ultrasound Exercise

Traction Ice Chiropractic Manipulation

19. Have you had BACK, NECK or SPINE surgery? Yes No

If yes, please complete the following:

Name of Back Operation Date Hospital Doctor

20. Have you had any other kinds of surgery? [] Yes [] No

Operation

Date

_____	_____
_____	_____

21. Have you ever had any complications of surgery or anesthesia? [] Yes [] No

If yes, please explain:

Medications

22. Please list all medications you are CURRENTLY TAKING for your NECK and/or BACK, including any over the counter medications:

Medication	Dose	Frequency	Date Prescribed	Prescribing MD
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

23. Please list all OTHER MEDICATIONS you are CURRENTLY TAKING, including any over the counter medications, birth control pills, vitamins, etc.:

Medication	Dose	Frequency	Date Prescribed	Prescribing MD
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergies

24. Are you ALLERGIC to **ANY MEDICATIONS**? Yes [] No []

If yes, please list: _____

Review of Systems

25. Have you had or been told you have any of the following: (Circle any that apply and give dates if possible):

HEAD/BRAIN/NERVOUS SYSTEM: any disease or disorder of the eyes, ears, nose or throat? Any dizziness, fainting, headaches, seizures, convulsions, epilepsy, paralysis or stroke? Any injury or disorder of the brain or spinal cord? _____

HEART/CIRCULATORY SYSTEM: Chest pain or tightness, palpitations, irregular heart beat, rheumatic fever, heart murmur, phlebitis, blood clot, high blood pressure, heart attack or any other disease or disorder of the heart or blood vessels? Any anemia, leukemia, sickle cell anemia, hemophilia, AIDS or any blood disorder? _____

LUNGS/RESPIRATORY: shortness of breath, hoarseness or cough, spitting up blood, bronchitis, pleurisy, asthma, emphysema, TB caner or any chronic respiratory disorder?

GASTROINTESTINAL SYSTEM: Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, pancreatitis, hepatitis, gallstones or any diseases or disorder of the stomach, intestines, liver or gallbladder? _____

KIDNEYS/URINARY SYSTEM: Sugar, blood or pus in the urine, venereal disease, kidney or bladder infections, kidney stone, enlarged prostate or any disorder of the kidneys, bladder or prostate? FEMALES: any disease or disorder of the breast, ovaries or uterus? _____

SEXUAL FUNCTION: Any increased pain, problem with erection or ejaculation since the injury? _____

SKIN: any disease or disorder of the skin, lymph glands, cyst, tumor or cancer?

METABOLIC: diabetes, thyroid or endocrine disorders? Any changes (more than 10 lbs.) in weight in the past year (indicate weight gain or loss)? _____

MUSCLES/BONES/JOINTS: Other than your present problem, have you had neuritis, sciatica, rheumatism, arthritis, gout? Any disease or disorders of the muscles or bones, including the spine, back or joints? Any fractures, deformities, lameness or amputation?

MENTAL STATUS: Any depression, mental or nervous disorder, alcoholism or drug use? _____

Have you had any illness, injury, physical or mental disorder not mentioned?

Have you been a patient in the hospital in the last five years? _____

OB/GYN HISTORY
(FEMALE PATIENTS)

Do you think you may be pregnant? Yes [] No []

Date of last menstrual period: _____

Date of last Pap smear: _____

How many living children do you have? _____

HABITS

26. TOBACCO USE: Do you smoke? Yes [] No []

Number of packs per day: ½ [] 1 [] 1 ½ [] 2 [] 3 or more []

How many years have you smoked? _____

If you are a FORMER SMOKER, when did you quit and how many years did you smoke? _____

27. ALCOHOL USE: Do you drink alcoholic beverages? Yes [] No []

If yes, number of drinks per week? 1-3 [] 4-7 [] 8-14 [] 15 or more []

28. RECREATIONAL DRUG USE: Yes [] No [] Type? _____

FAMILY HISTORY

29. Does anyone in your immediate family (mother/father, sister/brother, son/daughter) have or had any of the following medical problems?
Please circle all that apply and ****note relationship****

High Blood Pressure	_____	Heart Attack	_____
Stroke	_____	Diabetes	_____
Tuberculosis	_____	Arthritis	_____
Kidney Disease	_____	Cancer (type)	_____
Bleeding Tendency	_____	Asthma	_____
Psychiatric Disorder	_____	Gout	_____