PATIENT REGISTRATION FORM

Title	☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss	**Marital Status**	☐ Single ☐ Married ☐ Widowed ☐ Divorced
Name*		**Social Security #***	
Address*		**Birth Date***	
City*		**Preferred Pharmacy***	
State*		**Pharmacy Phone**	
Zip*		**Pharmacy Address**	
Work Phone		***Patient Email****	
Home Phone		**Primary Care Physician**	
Mobile Phone*		**PCP Office Phone#**	

Have you been in an accident? ☐Yes ☐No Date of Injury _____ State in which Injury Occurred ___

Have you been injured at work? ☐Yes ☐No Date of Injury _____ State in which Injury Occurred ____

Check Only Those Which Apply

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

RACE: ☐American Indian/Alaska Native ☐Asian ☐Black/African American☐White/Caucasian

Employment: ☐Full-Time Employed ☐Part-Time Employed ☐Full-Time Student ☐ Part-Time Student ☐ Retired ☐Self-Employed ☐ Unemployed ☐ Disabled

WORK COMP		WORK COMP	
Insurance Company Name		**Adjustor Name**	
Address		**Adjustor Phone#**	
Claim Number		**Adjustor Email**	
Office Phone			
Office Fax		**EMERGENCY CONTACT**	
Case Manager Name		**Name***	
Case Manager Phone		**Phone #***	
Case Manager Email		**Relationship**	

Please present all insurance information to receptionist

PRIMARY INSURANCE		EMPLOYER	
Insurance Name		**Employer Name***	
Subscriber ID#		**Employer Address***	
Insured's Name		**Phone**	
Birth Date		**Occupation***	
Insured's SS#		**REFERRING PHYSICIAN****	

Patient Authorization

I authorize the release of this medical information or other information necessary to process this claim.

Patient/Guardian Signature: _____ Date _____

Relationship to patient (if guardian) _____

JOHN H. PELOZA, MD

VERIFICATION OF INSURANCE

I, _____, do not have private health insurance.

_____ _____

Patient Signature Date

********** **OR** **********

I, _____, do have private health insurance and I do not have my member ID card with me.

_____ _____

Patient Signature Date

JHP Spine, LLC
JOHN H. PELOZA, MD
14825 N. Outer 40 Rd, Ste 310
Chesterfield, MO 63017

JOHN H. PELOZA, MD

Assignment of Benefits

Please Read:

I, _____, hereby authorize my insurer to assign and transfer any and all applicable plan or policy benefits and rights to JHP Spine, LLC and any appointed business associates working with them for the sole purpose of making sure all protected rights and benefits under my plan are administered accurately, including the right to all remedies, disclosures, rights' of appeal, administrative reviews and litigation on my behalf. This authorization includes any and all other rights permissible under state and federal laws. **I understand under all applicable state and/or federal regulatory guidelines that I, having the right and authority, designate payment to be made and mailed directly to the provider listed above for all services rendered**.

Furthermore, I understand that some insurance companies will not pay my bill if I do not select one of their participating doctors. It is my responsibility to determine if the doctor I have chosen to see participates in my plan. Payment or co-payment is due at the time of service. I, being the patient or guardian, am responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, I agree to pay all costs of collection, including reasonable attorney fees. By signature below, I, as the patient or guardian, agree that the jurisdiction and venue for said action shall be the County of St. Louis and State of Missouri.

Patient Name: _____

SIGNED (Patient or Guardian):_____ Date: _____

Authorization and Assignment

I authorize JHP Spine, LLC, Dr. John H. Peloza to release information regarding my treatment to my insurance company, to health care providers who have referred me to Dr. John H. Peloza and to parties who are involved in my treatment if I have a work-related injury. **I also authorize my insurance benefits to be paid directly to JHP Spine, LLC, Dr. John H. Peloza**. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and in the event JHP Spine, LLC and/or Dr. John H. Peloza is served a Subpoena for production of records, the undersigned authorizes JHP Spine, LLC and/or Dr. John H. Peloza to produce such records under a Business Records Affidavit without the necessity of attendance at a deposition. This above Authorization can only be withdrawn or revoked by written notification to JHP Spine, LLC.

I hereby also acknowledge that JHP Spine, LLC is a subsidiary company of Midwest Orthopedic and Spine Specialists, LLC.

SIGNED (Patient or Guardian):_____ Date: _____

JOHN H. PELOZA, MD

JOHN H. PELOZA, MD
14825 North Outer Forty Road, Ste 310
Chesterfield, Missouri 63017

NOTICE OF DOCTOR'S LIEN

Patient _____

Date of Accident _____

This lien does not supplement my own responsibilities for outstanding medical bills but is given as protection to said doctor and in consideration of his willingness to await payment for services rendered. I understand that payment for all outstanding fees to said doctor are payable upon demand and are not contingent on the receipt of an award through settlement, judgment, or verdict. In the event there is no recovery on my accident claim, I understand that I am responsible for those services rendered by the doctor. I understand that I will receive regular monthly statements but will not be sent to collections until this issue has been resolved.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

I do hereby authorize John H. Peloza, M.D. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the injuries I sustained as a result of the above-noted accident.

I hereby authorize and direct you, my attorney, to pay directly to said doctor all monies owed them in consequence of this accident, as well as any other settlement made in this case prior to disbursement to any other individual or facility.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated _____ _____

Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to protect and fully compensate said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs. Attorney further waives delivery of this Notice by registered mail with return receipt requested as required by R.S.Mo. 430.240.

Dated _____ _____

Attorney's Signature

Please sign, date and return one copy to the doctor's office. Keep one copy for your records.

Doctor's Signature _____

Doctor's Tax ID 88-2892252

JOHN H. PELOZA, MD

JOHN H. PELOZA, MD
14825 North Outer Forty Road, Ste 310
Chesterfield, Missouri 63017

ATTENTION PATIENTS:

We experienced a substantial increase in the number of request(s) for completion of medical-care related forms, such as those for *disability, FMLA, or other insurance claims*. Completing these forms is very labor intense and, after much consideration, we must impose a charge to offset the cost for each form we complete. The practice **cannot bill this charge to your health, or work comp, insurance carrier nor can we include the charge in any lien balance**. The patient is responsible for payment.

Completion of Forms:

- We charge a fee of **$50.00** to complete any forms not related to health insurance claims (disability, FMLA, injury, for example).
- Payment is due each time you deliver a form for completion. For forms received by fax or mail, we must receive your payment prior to returning the form to the requestor.
- We cannot bill you for this service.
- Please allow 7-10 Business days for completion from the time of payment is received in our office.

We appreciate your understanding and cooperation.

PATIENT NAME DATE

PATIENT SIGNATURE

COMMUNICATION AUTHORIZATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ **Social Security Number-Last 4 Digits** _____

I authorize the providers and staff of JHP SPINE, llc to discuss and disclose my Protected Health Information (PHI) to the person(s) named below.

ATTORNEY

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I authorize the providers and staff of JHP SPINE, LLC to leave messages:

☐ Initials — On my **home** answering machine / voice mail. _____ Phone Number

☐ Initials — On my **cell phone** voice mail. _____ Phone Number

HIPAA: NOTICE OF PRIVACY PRACTICES

I acknowledge that Dr. John. H. Peloza, medical assistants and other staff may use and share my confidential health information with others in order to 1) treat me, 2) to arrange for payment of my bill, and 3) for issues that concern JHP Spine, LLC operations and responsibilities.

This authorization remains in force until revoked in writing. The purpose of this disclosure/use is for continued medical care.

Signature of Patient, Guardian, Personal Representative Relationship Date

Print name of person authorized under state law to act in the patient's behalf,
if the patient is deceased, or his personal representative, or if none, of his child, parent or sibling.

MEDICARE PRIVATE CONTRACT

This Contract is entered into by and between John H. Peloza, M.D., ("Physician") whose principal medical office is located at 14825 N. Outer Forty Road, Suite 310, Chesterfield, Missouri, 63017 and _____ _____ ("Medicare Beneficiary"), who resides at _____, and shall become effective on this ___ day of _____, 20_____ and shall expire on the _____ day of _____ _____, 20____ (the "Opt-Out Period"), unless otherwise renewed in accordance with 42 U.S.C. § 1395a; 45 C.F.R. § 405, Subpart D.

- I Physician have not been excluded from Medicare under Sections 1128, 1156 or 1892 of the Social Security Act.
- I the Medicare Beneficiary or my legal representative accept(s) full responsibility for payment of charges for all services furnished by Physician.
- I the Medicare Beneficiary or my legal representative understand(s) that Medicare limits do not apply to what the Physician may charge for items or services furnished by the Physician.
- I the Medicare Beneficiary or my legal representative agree(s) not to submit a claim to Medicare or to ask the Physician to submit a claim to Medicare.
- I the Medicare Beneficiary or my legal representative understand(s) that Medicare payment will not be made for any items or services furnished by the Physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- I the Medicare Beneficiary or my legal representative enter(s) into this Contract with the knowledge that I have the right to obtain Medicare-covered items and services from physicians who have not opted-out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians who have not opted-out.
- I the Medicare Beneficiary or my legal representative understand(s) that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- I the Medicare Beneficiary or my legal representative understand(s) that this Contract cannot be entered into during a time when I, the Medicare Beneficiary, require emergency care services or urgent care services. (However, a physician and/or practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with Chapter 15, § 40.28 of the Medicare Benefit Policy Manual (2003); 42 C.F.R. § 405.440).
- I the Medicare Beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this Contract, before items or services are furnished under the terms of this Contract.
- Physician will retain the original Contract (original signatures of both parties required) for the duration of the Opt-Out Period.
- Physician will supply CMS with a copy of this Contract upon request.
- Physician understands that this Contract remains in effect for two-years. If Physician again opts-out of Medicare, Physician will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

PHYSICIAN	**MEDICARE BENEFICIARY/ LEGAL REPRESENTATIVE**
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:

_____

Last First MI

Maiden _____

Date of Birth: _____ Social Security Number: _____

I Authorize and Request:

_____

_____

_____

Office Phone Office Fax

To Release to: **JHP Spine**
John H. Peloza, MD
14825 N Outer 40 Rd, Ste 310
Chesterfield, MO 63017

JOHN H. PELOZA, MD

Medical Records covering the periods of healthcare from _____ to _____

Date Date

Please check, and initial, the types of records you <u>do not</u> want released.

- ☐ HIV Testing/Treatment Records
- ☐ Substance Use/Abuse History
- ☐ Psychiatric Evaluation
- ☐ Other (please specify) _____

The Medical information is needed for: _____

ATTENTION: Once this information has been released pursuant to the Authorization, it may no longer be protected by Federal, and/or State law/regulations and may no longer be deemed "confidential".

I understand that neither John H. Peloza, MD, JHP Spine, or any of its affiliated healthcare providers can make me sign the Authorization as a condition to be getting treatment, making payments on any bills, or gaining or eligibility in any health insurance plan, unless the Federal Privacy Regulation allow it. I agree that I have received a signed copy of this Authorization, if so requested.

I understand that I may revoke the Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will **<u>expire one (1) year</u>** from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax, or bring the letter to the address or fax number at the top of the page.

If you are signing on the behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's Death Certificate.

_____ _____

Signature of Patient (if the patient is incompetent, of his guardian or other) Relationship Date

_____

Printer name of person authorized under State law to act on the patient's behalf, if the patient is deceased, or his personal representative or if none, of his child, parent or sibling

JHP Spine, LLC
Review of Systems

PATIENT NAME:_____ **DATE:**_____

*****Please be advised that Dr. Peloza is a spine specialist and does not practice general medicine.*****
All new and/or chronic symptoms not pertaining to Musculoskeletal/Neurological conditions should be disucssed with your primary care physician

PLEASE CHECK ALL THAT APPLY.

Constitutional Symptoms
□Weight loss or gain
□Fatigue/Malaise/Lethargy
□Fever or chills
□Weakness
□Trouble sleeping
□Unexplained Falls
□Itch/Rashes
□Lumps/Bumps/Masses
□Dryness of skin
□Color changes in skin
□Hair and nail changes

Eyes
□Vision Loss/Changes
□Droopy Eyes
□ RT □ LT
□Redness in eyes
□Blurry or double vision
□Flashing lights
□Specks
□Glaucoma
□Cataracts
□Last eye exam
□Headache
□Head injury
□Neck Pain

Ears, Nose, Mouth, Throat
□Decreased hearing
□Ringing in ears /Tinnitus
□Earache/Pain
□Drainage from ears
□Stuffiness in nose
□Discharge from nose
□Nosebleeds
□Sinus pain
□Bleeding in mouth
□Dentures
□Sore tongue
□Dry mouth
□Sore throat
□Pain with swallowing
□Hoarseness
□Thrush
□Non-healing sores

Psychiatric
□Nervousness
□Stress
□Depression
□Memory loss

Cardiovascular
□Chest pain or discomfort
□Tightness in chest
□Palpitations
□Shortness of breath with activity
□Difficulty breathing lying down
□Exercise Intolerance
□Sudden awakening from sleep with shortness of breath
□Claudication/Reduced blood flow
□Loss of consciousness
□Calf pain with walking
□Leg cramping

Respiratory
□Cough
□Sputum
□Coughing up blood
□Shortness of breath
□Wheezing
□Painful breathing
□Exercise Intolerance

Gastrointestinal
□Swallowing difficulties
□Abdominal pain
□Heartburn/Indigestion
□Change in appetite
□Nausea/Vomiting
□Change in bowel habits
□Rectal bleeding
□Constipation
□Diarrhea
□Yellow eyes or skin/ Hepatitis History
□Ulcers

Urinary
□Frequency changes in urinating
□Urgency changes in urinating
□Burning or pain with urination
□Blood in urine
□Change in urinary strength
□Kidney stones

Integumentary/Breasts
□Lumps
□Pain
□Discharge
□Breast-feeding

Allergic/Immunologic
□Difficulty breathing
□Swelling or pain in groin
□Food, medication, or latex allergy
□Swollen glands

Musculoskeletal
□Muscle or joint pain
□Stiffness
□Back pain
□Redness of joints
□Swelling of joints
□Decreased range of motion
□Trauma
□Arthritis
□Lumps in neck
□Swollen glands
□Pain in neck area
□Stiffness in neck area

Neurological
□Dizziness
□Fainting
□Seizures
□Headache
□Weakness in Limb
□Numbness in Limb
□Tingling in Limb
□Pins and needles in Limb
□Poor balance
□Tremor

Endocrine
□Heat or cold intolerance
□Sweating
□Frequent urination
□Thirst
□Menopause
□Change in appetite
□Diabetes

Hematologic/Lymphatic
□Anemia
□Ease of bruising
□Ease of bleeding
□Use of anticoagulant/antiplatelet drugs
□Family history of hempphilia
□Refuses blood transfusions
□HIV Positive

For Office Use Only
Height: _____
Weight: _____
BP: _____
Pulse: _____
Notes: _____

Patient Signature _____ Date _____

Midwest Orthopedic and Spine Specialists

JOHN H. PELOZA, MD

PATIENT'S NAME:_____ HEIGHT: _____ WEIGHT: _____

TODAY'S DATE: _____ Have you been treated by any other physicians for this condition? _____

MEDICAL INFORMATION

It is important for us to have this information in your file, in case you need emergency care or hospitalization.

PAST MEDICAL HISTORY

GENERAL STATE OF HEALTH:

How do you rate your current overall health (please circle one)? Excellent Good Fair Poor

If you are an current patient, are there any significant changes since your last visit? Yes No

If so, please explain:_____

GENERAL MEDICAL (Have you had any of the following?)

Past Illnesses:

Ulcers	Yes	No	*Kidney Disease*	Yes	No	*Diabetes*	Yes	No
Heart Disease	Yes	No	*Liver Disease*	Yes	No	*Cancer*	Yes	No
High Blood Pressure	Yes	No	*Claustrophobia*	Yes	No	*Stroke*	Yes	No

Other Medical Problems: _____

Surgeries/Hospitalizations:

Reason: _____ Admit/Release Date: _____

Reason: _____ Admit/Release Date: _____

Did you have any complications? Yes No If Yes, Please explain: _____

List any MEDICATIONS and the DOSAGE that you currently take: (Please include any over-the-counter medications)

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

Do you have any known allergies to environmental, food, or drugs? If so, please also list reaction.

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

FAMILY HISTORY

Are your parents still alive? Yes No **If not, please list cause of death:** _____ **Age at death:** _____

Are/Were your parents, grandparents, or siblings ever diagnosed with any of the following:

High Blood Pressure	Yes	No	***Kidney Disease***	Yes	No	***Diabetes***	Yes	No
Heart Disease	Yes	No	***Liver Disease***	Yes	No	***Cancer***	Yes	No

SOCIAL HISTORY

Marital Status: (Please circle one) Single Married Divorced Widowed Other

Children? Yes No **If so, how many children?** _____

Are you employed? Yes No **If so, your current employe is?** _____ **Years employed?**_____

Are you disabled? Yes No **If so, when did your disability begin?** _____

Do you smoke? Yes No **Years?** _____ **If so, how many packs per day?** _____

How many alcohol beverages do you drink per week? 0 1 2-5 6 or more

REASON FOR VISIT TODAY:

Describe accident or illness: _____

Is this a work-related injury? Yes No **Date and Time of Injury**: _____

Was an automobile involved? Yes No **First date of treatment**: _____

Was accident/injury reported? Yes No **List providers seen for this illness**: _____

Were x-rays taken? Yes No **Where were x-rays taken?** _____

To the best of my knowledge, the above is a true an accurate account of my medical history:

JOHN H. PELOZA, MD

PATIENT STATEMENT OF RESPONSIBILITY MEDICAID INSURANCE COVERAGE

Patient Name _____ Date of Birth _____

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING

My name is _____.

- I am completing this form to confirm my full knowledge that Dr. John H. Peloza and JHP SPINE, LLC are not contracted providers for any ***Medicaid insurance plan***. This means that Dr. John H. Peloza and JHP SPINE, LLC, cannot, by law, bill Medicaid, and that I accept personal responsibility for any charges incurred in relation to the medical treatment I receive from this entity.

- I understand I will be financially responsible for services provided from this date forward.

- In the event that the entity, JHP Spine, LLC, must take legal action to pursue payment from me, I understand that I will bear financial responsibility for any cost(s) incurred by JHP Spine, LLC to recoup payment owed.

- I understand that I have informed JHP Spine, LLC I am seeking medical treatment because of the effects of an accident in which I was recently involved, and that the matter is currently in litigation. I understand that JHP Spine, LLC is willing to forego any collection attempts, and is willing to place my account on hold until this litigation matter settles, prior to proceeding with any collection attempts.

- I understand that regardless of the outcome of this litigation matter, I am fully and personally responsible for all charges accrued on my behalf.

- I understand that if I have any questions, I may contact PMBA, LLC (billing agency for Dr. John H. Peloza and JHP Spine, LLC) at 636-778-3641.

_____ _____

Signature, Patient or Legal Guardian Date

JOHN H. PELOZA, MD

Consent to Release Information

I, _____, authorize JHP Spine, LLC, Dr. John H. Peloza, and his staff of JHP Spine, LLC to discuss my medical treatment and/or any billing issues with the following people.

Please list any family members, friends, or legal counsel with whom we may discuss your treatment or billing records.

	ATTORNEY
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Patient Signature Parent/Guardian Signature if a Minor	Date

JOHN H. PELOZA, MD

PATIENT STATEMENT OF RESPONSIBILITY

PLEASE READ CAREFULLY BEFORE SIGNING

Dear Patient:

My name is (patient name) _____. I am completing this form with my full knowledge that Dr. Peloza is not a provider for (_____ NAME OF INSURANCE insurance plan. This means that your health insurance may not cover all of the services rendered by our office.

I have been advised that although Dr. Peloza's office will submit their bill directly to my insurance company for the services provided to me by their office, my insurance company might send payment directly to me instead of sending the payment to Dr. Peloza's office.

I understand that in the event that I receive a payment from my health insurance company for services rendered by Dr. Peloza's office, and to keep my account current with Dr. Peloza's office, I will endorse the back of the check and remit the payment, along with the insurance company's explanation of payment, to Dr. Peloza's attention.

I understand I will be financially responsible for any services not covered in accordance with the guidelines outlined in my plan for today's services as well as any other dates of service from this day forward. I agree to be personally and fully responsible for payment to Dr. Peloza for any amounts that my insurance plan does not cover.

I understand that any discounts Dr. Peloza's office has negotiated with me will become invalid if I cash the checks, I receive from my insurance company for services rendered by Dr. John H. Peloza.

I understand that in the event that Dr. Peloza's office has to take legal action to pursue payment from me, I understand that any cost incurred by Dr. Peloza's office will also be my financial responsibility.

Our address is:

John H. Peloza M.D.
JHP Spine, LLC
14825 North Outer 40 Drive Suite 310
St. Louis, MO 63017

If you have questions, please contact our office at 314-530-6350.

_____ _____

Signature of Patient/Guardian Date