HUMAN PERFORMANCE CENTER
PHYSICAL MEDICINE & REHABILITATION

CHART ACCT #_____

PATIENT DEMOGRAPHIC INFORMATION					
Patient: Last Name	**First Name:**		**MI**	**SS#:**	
Birth date: mm/dd/yy	**Age :**	**Sex: ____ Male ____Female**	**Marital Status: ___Married ____Single ____ Widowed ____Divorced ____ Separated**		**Cell Phone:**
Patient Address: Street	**City**	**State**		**Zip Code:**	**Home Phone:**
Employer Name:	**Employer Address:**			**Zip Code:**	**Bus Phone:**

MEDICAL INFORMATION	
Primary Care Physician	**Area Code: Bus Phone:**
Referring Physician Name:	**Area Code: Bus Phone:**
Other Referring Source:	

GUARANTOR/RESPONSIBLE PARTY INFORMATION					
Guarantor: Last Name	**First Name:**		**Middle Name:**		
Guarantor's Address: Street	**City**	**State**	**Zip Code:**	**Area Code**	**Home Phone:**
Employer:	**Employer Address: (Street, City, State)**		**Zip Code:**	**Area Code**	**Bus Phone:**
Relation to Patient:	**Date of Birth: mm/dd/yy**	**Guarantors SS#:**			
_____Self Pay					

ADDITIONAL INFORMATION

Our office scheduling system has the capabilities of sending electronic appointment reminders. By providing our office with your information you authorize our office to send electronic messages in reference to any terms that assist the practice carrying out treatment, payment or health care operations, such as appointment reminders, insurance items and any calls pertaining to your clinical care including diagnostic results. You may also provide pharmacy information for electronic processing. In the event of an emergency, please provide us with an emergency contact.

Email Address: (example yourname@yahoo.com)	**Pharmacy and Phone Number: (example CVS -123-456-7890)**
Emergency Contact Name and relationship:	**Emergency Contact Phone Number:**

Consent for Use and Disclosure of Protected Health Information

By signing this form I agree that the above information is correct and that I am the individual stated in this application. By signing I authorize treatment and acknowledge full responsibility for all services and fees provided by John Cianca, MD/Human Performance Center.

Patient/Guardian Signature:_____ Date_____

Revised 09/12/16

HEALTH QUESTIONNAIRE
Confidential Data

Human Performance Center - John C. Cianca, M.D.

Name _____ **DOB** _____ **Date** _____

Reason for visit: (**Please list your symptoms, problems and/or concerns**)

_____

_____

ALLERGIES/INTOLERANCES

Allergen Name	Reaction	Intolerance or Allergy	Start Date

MEDICATIONS – List all prescription medications you currently take

Medication	Start Date	Strength	How Often	Reason

SUPPLEMENTS – List all vitamins, hormones, alternative remedies or over the counter medications you currently take

Supplement	Start Date	Strength	How Often	Reason

HEALTH HISTORY – Are you being treated for or have you ever had any of the following health conditions?

Please check if applicable. Addition space is provided below for details or other health condition not listed.

☐	Allergies	☐	Congestive heart Failure:	☐	Headaches	☐	Kidney stones	☐	Sleep Apnea
☐	Alcohol problems	☐	*Systolic*	☐	Heart:	☐	Low back pain	☐	Stroke
☐	Anemia	☐	*Diastolic*	☐	*Arrhythmia*	☐	Lupus (SLE)	☐	TIA
☐	Aneurysm	☐	Crohn's disease	☐	*CAD (MI)*	☐	Mental illness	☐	Tremors
☐	Anxiety	☐	Colitis	☐	*Defibrillator*	☐	Mood disorder	☐	Tuberculosis
☐	Arthritis:	☐	Constipation	☐	*Failure*	☐	MRSA infections	☐	Urinary:
☐	*Osteoarthritis*	☐	COPD	☐	*Pacemaker*	☐	Narcolepsy	☐	*Frequency*
☐	*Degenerative*	☐	Dementia	☐	*Palpitations*	☐	Neuropathy	☐	*Incontinence*
☐	*Psoriatic*	☐	Depression	☐	*Stents*	☐	Nervous system disease	☐	*Infections*
☐	*Rheumatoid*	☐	Diabetes	☐	*Valvular disease*	☐	Osteoporosis/osteopenia	☐	*Retention*
☐	Asthma	☐	Diarrhea	☐	Hepatitis A B C	☐	Obesity	☐	Varicose veins
☐	Atrial fibrillation	☐	Diverticulosis/Diverticulitis	☐	High blood pressure	☐	Peptic ulcers	☐	Weight problems
☐	Bleeding problem	☐	Eating disorder	☐	HIV/AIDS	☐	Peripheral vascular disease	☐	Other:
☐	Blood clots	☐	Emphysema	☐	Hyperthyroidism	☐	Pleurisy	☐	
☐	Blood transfusion	☐	Fertility issues	☐	Hypothyroidism	☐	Pneumonia	☐	
☐	Bronchitis	☐	GERD	☐	Irritable bowel	☐	Prostate problems	☐	
☐	Cancer:	☐	Glaucoma	☐	Kidney disease	☐	Seizure disorder	☐	
☐	*Type*	☐	Gout	☐	Kidney failure	☐	STD	☐	

MAJOR ILLNESS/PAST PROCEDURES/SURGERIES – List surgical procedures, reasons for hospitalization and the year			
Procedure/Illness	**Approximate Date**	**Procedure/Illness**	**Approximate Date**

SOCIAL HISTORY

Smoking Status: __Current every day smoker __Current someday smoker __Former smoker __Never smoked

__Smoker, current status unknown

If current or quit within 12 months, __Cigarettes __Cigars __Pipe __Snuff __Chew **Amount** _____ **Duration** _____

Preferred Language: _____ **Ethnicity:** __ Hispanic or Latino __Not Hispanic or Latino __Declined

Race: __White __Black/African American __American Indian/Alaskan __Asian __Hawaiian/Pacific Islander

__Other_____ ___Declined

Alcohol: __Yes __No __Rarely Amount _____ per day/ week/ month _____

Caffeine: __Yes __No Amount _____ cups per day/ week/ month _____

Do you use or have you had a problem with drug use: __Yes __No If yes, list type _____ frequency _____

Do you exercise: __Yes __No If yes, list type _____ frequency _____

FAMILY HISTORY						**Have any of your grandparents, parents or siblings ever had any of the following diagnosed illnesses**			
	Age	**State of Heath**	**Occupation**	**Age of death**	**Cause of death**	**Condition**	**Yes**	**No**	**Relationship**
Father						**High blood pressure**			
_GM _GF						**Heart disease**			
Mother						**High cholesterol**			
_GM _GF						**Diabetes**			
Brothers						**Cancer**			
						Stroke			
Sisters						**Tuberculosis**			
						Arthritis			
Spouse						**Epilepsy**			

Additional Comments or Information:

_____

_____

HUMAN PERFORMANCE CENTER
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5959 West Loop South, Suite 260
Bellaire. TX 77401
T. 713.627.3156 F. 713.627.0393

Practice Policies

You are important to us and we make a commitment to provide you with excellent care and personal service. In order to do so it is important that you understand the policies of our practice as outlined below.

Appointments
The office is open for appointments from 8:30am – 4:30pm on Mon, Wed, Fri and Tues & Thurs from 1:30pm – 4:30pm. Phones are answered from 8:30am – 5:00pm. We are closed on weekends and for most major holidays.

New patient and follow up appointments are generally scheduled in advance. Same day appointments may be available and we will make every effort to see you if you have an acute medical need during our regular business hours.

New patients should bring prior medical records, including MRI reports, X-ray reports and diagnostic reports that are pertinent to your current illness or condition. Please bring a current list of medication, including dosage and directions. This list should include prescriptions, over the counter medications and supplements.

Inclement Weather
In the event of inclement weather we will make every attempt to notify you as soon as possible if our office will be closed. If you have not heard from us, please call the office at 713-627-3156.

No Show/Cancellations
As a patient in our office we ask that you be responsible for showing up to your scheduled appointments on time. Additionally, we ask that you cancel appointments with enough time to allow us to accommodate schedule changes. This is to ensure that we can provide the best possible service to you and all of our patients. Our office will make every effort to provide an electronic appointment reminder if an email is provided or a reminder call will be attempted.

Late Arrivals
In order to continue to provide prompt attention to all of our scheduled patients it is necessary to have a late arrival policy. The office will consider a "no show appointment" any time a patient has not given advance notice or has failed to arrive within 15 minutes of their appointment time. If a patient arrives 15 or more minutes late, you may be asked to reschedule. If you anticipate that you will be late to your appointment, please call the office and we may be able to accommodate a later appointment.

Telephone Calls
Calls are answered by the doctor's assistant during business hours. If you have a question or need to speak to the physician, please provide as much information to the assistant as possible. The assistant will forward your message to the physician. Your call will be returned by the end of the business day. Non-emergency calls, such as appointments, medication refills, and test results should be made between 8:30am and 4:00pm Monday – Friday. After hour calls will be answered by the end of the next business day. Please see the Patient Portal handout for additional ways to communicate with our office.

Emergencies
If you have a true medical emergency call 911 or go to the nearest Emergency Center. The emergency treating physician may contact our office during business hours at 713-627-3156 or they may contact your primary care physician.

Test Results
The results of laboratory and radiology test are very important for the continued evaluation and management of your care. Some types of tests are performed in our office and others are sent out for processing. It may take several days to get these test results back to our office. When having radiology test, scans, or any other procedures outside our office, please know that we will make every effort to obtain the results as soon as possible. However, it could take 48 hours to a week for those results to reach us. A follow up appointment may be necessary to discuss results or referrals. Our office will contact you to schedule these appointments.

Request for Prescription Refills
Refills for medications, including those medications that have no remaining refills or request for new prescription, should be called directly to your pharmacy. Your pharmacy will contact our office for refill authorization, if necessary. Refills that need authorization from our office will be processed during regular business hours only, not on weekends or major holidays.

Request for Medical Records
If you are in need of your medical records or if you wish to have a copy sent to another physician, we will be happy to make these available. Please allow 24-48 hours for records request to be processed once a "Disclosure of Medical Records" form is signed and received in our office.

Limited medical records are available through our electronic patient portal using the secure login we provide you. If you have questions you can contact us through the patient portal or call the office. If you would like to use the patient portal, please make sure our office Web Enable has a valid email address. Once you are Web Enabled our office will send you an electronic message of the web site link and your password needed for your log on. (See page 3 to sign up for Patient Portal)

Commercial and Private Insurance
Human Performance Center/John Cianca, M.D. is currently an out-of-network provider for commercial insurance plans. We will provide you with a superbill/receipt that you can submit to your insurance company for reimbursement.

Payment for Services
We recognize the need for a clear understanding between you and our office regarding payment for services. Charges for professional services and treatment depend upon the complexity of your diagnosis and treatment needed. Full payment is collected at time of your visit. We accept cash, checks, Visa, MasterCard, Amex, and Discover. You may also use your HSA (health saving account) and FSA (flexible spending account) cards with the Visa or MasterCard logo. (**Standard** new visit appointment fee is $325. **Standard** follow up visit fee is $135.)

We honor the doctor-patient relationship and encourage you to take an active role in your health. Communication is vitally important between the doctor and our patients. Monitor how you are feeling and document any changes you notice so you can inform the doctor. By staying organized, you are helping yourself remain in control of your illness and condition.

Patient Portal

It provides a way for you to communicate with our practice, securely and efficiently during business hours.

Using the patient portal will allow you to do the following:

- View your personal health records and update as needed.
- View your lab results
- Request for appointments or changes to appointment date or check date/time of upcoming appointments.
- Request a prescription refill from pre-populated list of current refillable prescriptions in your records.
- Manage your personal information.
- Send emails or messages to our staff during business hours.

Patient Portal is just a click away for you once you have been Web Enabled by our staff.

If you would like to be Web Enabled, please enter your email address below.

_____.
Email address

If you decline to be Web Enabled, please sign and date below.

_____ _____
Signature Date

By initialing, you are acknowledging receipt of practice information notice:

_____ _____
Please Initial Date

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Patient Liability Form for Non-Participating Insurances

This is to acknowledge that the below named person understands that we are non-participants of his/her (primary/secondary) insurance company and he/she still willingly wishes to see John Cianca, M.D.

Under these conditions, the below named person understands that he/she is liable for any charges incurred and understands that payment is due in full upon check out.

By signing this agreement, you accept the above conditions and consent to service provided by John Cianca, M.D.

Print Name: _____ Date: _____

Patient/Guardian Signature: _____

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Authorization for Release of Information to Family Members

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, partners, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to disclose this information to anyone without the patient's consent. If you wish to have your medial or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below. **I authorize Human Performance Center/John Cianca, M.D. to release my medical and/or billing information to the following individual(s).**

1. _____ Relation to patient: _____

2. _____ Relation to patient: _____

3. _____ Relation to patient: _____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Print Name: _____ Date: _____

Patient/Guardian Signature: _____

Joint Notice of Privacy Practice

Effective Date: April 14, 2003

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.

Protecting Your Health Information:

John C. Cianca, M.D. and The Human Performance Center have developed this Privacy Notice to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the privacy regulations of Texas. HIPAA was enacted by Congress to establish standards for protecting the confidentiality and security of your health information.

We realize that your medical information is important to you and for that reason we are committed to protecting the privacy of your Protected Health Information ("PHI"). PHI is medical or payment information that identifies you. As part of our efforts to protect your PHI, we are providing you with this Joint Notice of Privacy Practice ("Notice"). This Notice explains how, when and why we will use and disclose your PHI. This Notice also explains the rights and obligations you have regarding the use and disclosure of your medical information. We are required by law to follow the privacy practice regulations and the provisions described in this Notice.

We reserve the right to make any changes to our privacy policies and this Notice at any time. Any changes to this Notice will only apply to current PHI. You may request a copy of the Notice from the Human Performance Center office.

How Information From A PHI May Be Disclosed Without An Authorization:

For Treatment: We may use and disclose PHI about you to other physicians, nurses, therapists, medical students, or others who are directly involved in your care. We may also disclose information to family members who are responsible for your direct care once you are discharged from our facility.

For example:

- The doctor who has taken your history and physical may share some of that information so that the proper care can be administered.
- If you are referred to our facility for treatment, copies of some of your medical record will be shared with the referring physician as part of continuing treatment.
- A patient's name on the door of the patient's room is permitted.
- Along with the doctor, a rehabilitation team may discuss your progress with other members of your treatment team in order to establish your treatment plan.

To obtain payment for treatment: We may use and disclose PHI about you in order to bill and collect payment for the treatment and services provided to you.

For example: Our billing department may have to give medical information to your insurance company so the insurance company will be able to process the claim and reimburse John C. Cianca, M.D. and the Human Performance Center for the services provided to you.

For health care operations: We may use and disclose your PHI in order to perform the functions of the facility.

For example:

- We may use information about you and other patients in order to evaluate how well our facility provides services to patients.
- We may also use and disclose your information to doctors, nurses and therapists for learning purposes.

For business associates: There are some services provided in our organization through contracts with business associates.

For example: Transcription services and copy services we use when making copies of your health record. When these services are used, we may give your health information to our business associates so that they can perform the job we've asked them to do and bill you or your insurance company for services provided. This information is kept confidential.

For a disclosure that is required by federal, state or local law, judicial or administrative proceedings, or law enforcement: We may disclose your PHI for court hearings, to police or law enforcement authorities, or as required by law. We may disclose your PHI to a law enforcement agent in order to avoid the threat of harm to a person or yourself.

For public health activities: We may disclose your PHI as required by law to public health or legal authorities charged with preventing or controlling disease, injury or disability.

For health oversight activities: We may use or disclose PHI to assist in oversight activities required by law such as licensure or administrative investigations of health care providers, criminal or civil investigations, or other activities that require the oversight of health care activities.

To coroners, medical examiners and funeral directors: We may use or disclose health information of a deceased individual to the coroner, medical examiner or funeral director for the purpose of identification, determining cause of death, or as required to carry out their duties.

Group Health Plans: A group health plan, or a health insurance issuer or HMO on behalf of a group health plan, may disclose PHI to the sponsor of the plan.

For purpose of organ, eye or tissue donation: We may notify organ donation organizations in order to assist them in organ or tissue donations as required by law.

For research purposes: In certain circumstances, we may provide PHI in order to conduct approved medical research or contact you regarding participation in research.

For government functions: We may disclose PHI about you to authorized federal officials for intelligence, counter-intelligence, national security, or to protect the President.

For workers' compensation purposes: We may disclose PHI about you in order to comply with workers' compensation laws.

For appointment reminders or treatment alternatives: We may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services that may be of interest to you.

Uses and Disclosures That You Have The Right To Restrict:

Fundraising activities: Information may be disclosed about you in an effort to raise money for the facility. You have the right to decline being contacted for this purpose. **(It is not the practice of the Human Performance Center to solicit for this purpose.)**

Directory information: Unless instructed otherwise, hospitals will use your name, location in the facility, general condition and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. **(Your patient information will not be used for directory purposes at the Human Performance Center.)**

Communication with family: Health professionals, using their best judgment, may disclose to a family member, close personal friend, or others your identify, health information relevant to their involvement with your care or payment related to your care, unless you object otherwise.

Your Health Information Rights:

You have the right to:

- Request a restriction on certain uses and disclosures of your information. However, the Human Performance Center is not required to agree to a requested restriction.
- Receive confidential communications of protected health information.
- Obtain a paper copy of the Privacy Notice upon request, regardless if you have agreed to receive the Notice by mail.
- Inspect and obtain a copy of your health record. We may charge a reasonable fee to cover costs.
- Request changes to your health record. Requests for changes must be in writing.
- Obtain an accounting of disclosures of your health information, except for disclosures of treatment, payment and health care operations, disclosures for public health purposes or as required by law, and disclosures authorized by you. If you make more than one request in a 12-month period, we may charge a reasonable fee to cover costs.
- Request communications of your health information by alternative means or alternative locations. For example, only send appointment messages by mail. No phone messages.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken. Revocations must be in writing.

Disclosures That Require an Authorization:

Any uses and disclosures not described in this Notice will be made only with the individual's written authorization

Questions: If you have any questions and would like additional information, you may contact the Human Performance Center at 713-627-3156.

Complaints: If you believe your rights to privacy have been violated, you can file a complaint with John C. Cianca, M.D. at the Human Performance Center at 713-627-3156, or with the Secretary of Health and Human Services at 200 Independence Avenue, S. W., Washington, D.C. 20201. There will be no action taken against you for filing a complaint.

Acknowledgement of Receipt of Privacy Notice

By signing this form, you are agreeing that you have received a copy of the Human Performance Center Privacy Notice, which describes how we may use and disclose your health information. You have the right to refuse to sign this Acknowledgement, in which case we must document our good faith effort to obtain your acknowledgement and the reason why it was not obtained.

Receipt of Privacy Notice acknowledged by:

_____ _____ _____

Signature Date Print name

Relationship to patient:

☐ Self ☐ Other:_____

*** Patient, spouse, legal representative, or beneficiary (Patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where patient is to be an enrolled spouse or dependent under the policy or plan).***

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Physician-Patient Private Contract ("Agreement")
(Medicare Opt-Out)

Even though you, the patient, and I, the physician, are entering into a private agreement outside of Medicare, because I have opted out of Medicare, Medicare REQUIRES your agreement to the following terms MEDIARE HAS SPECIFIED, before we can proceed with care. This Agreement protects Medicare from payment responsibility for services you receive directly from me. If requested by Medicare, this Agreement will be provided to resolve any misunderstanding and clarify our intent. This Agreement must be signed before I can see you as a patient. Please review the following and sign this Agreement to confirm your acceptance of the terms of this Agreement:

The undersigned patient/Medicare beneficiary (or the Medicare beneficiary's legal representative) (either is referred to as "Medicare Beneficiary") is signing this Private Contract to evidence his or her understanding and agreement regarding payment for all services to be provided by John C. Cianca, M.D. ("Physician"). Physician's practice entity is known as Human Performance Center (also referred to as "Physician").

Physician hereby certifies that Physician is not and has not been excluded from participation in the Medicare program under section 1128 or other applicable sections of the Social Security Act.

Physician further certifies that the effective date of Physician's opt-out is August 1, 2017, and the opt out status is effective for two years and automatically extends at the end of every two year period unless the Physician notifies Medicare in writing at least 30 days prior to the start of the next two year opt out period.

By executing this Private Contract, Medicare Beneficiary acknowledges and agrees as follow with respect to all items or services provided by Physician to Medicare beneficiary:

1. That Medicare beneficiary will not submit claim, or request Physician to submit a claim, for payment under Medicare, even if such items or services would otherwise be covered under Medicare.

2. That Medicare beneficiary agrees to accept responsibility for full payment at the time of service, in accordance with Physician's current fee schedule, whether Medicare beneficiary is reimbursed through private insurance or otherwise, for payment for all such items or services.

3. Medicare beneficiary understands that NO reimbursement can or will be provided by Medicare for such items or services provided by Physician.

4. That Physician is not limited by Medicare in the amount that he or she may charge Medicare beneficiary for the items or services provided, and that Medicare beneficiary will pay Physician's charges in full at time of service.

5. That Medigap plans do not make payment and other Medicare supplemental insurance plans may choose not to make payment, for items or services furnished by Physician.

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6. That Medicare beneficiary has the right to have the items or series sought from Physician to be provided by other physicians or practitioners whose items or services would be covered by Medicare.

7. That Medicare beneficiary is not in an emergency or urgent health care situation.

8. That Medicare beneficiary agrees to reimburse Physician for any cost, collection fees, and reasonable attorney's fees that result from violation of this Agreement by Medicare beneficiary.

9. That Medicare beneficiary acknowledges a copy of this Agreement has been provided to Medicare beneficiary.

10. That Medicare beneficiary signs this Private Contract voluntarily and upon full understanding of its terms.

Date: _____

Signature of Patient/Medicare beneficiary:

X_____

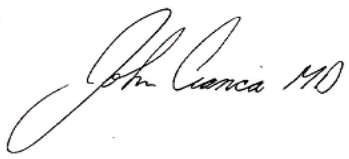
Print Name: _____

Signature of Legal Representative:

X _____

Print Name: _____

Relationship to Patient/Medicare beneficiary: _____



Physician's signature: _____ _____

John C. Cianca, M.D.