Today's Date:

Welcome to the esteemed practice of Stanley C. Jones, MD

Dr. Jones and the professional team affiliated with Stanley C. Jones, MD are dedicated to helping you achieve your wellness goals. Please complete the information below so we may help you begin a path of wellness.

Full Name: ______________________ Nickname or Preferred Name: ______________

Address: ______________________ City: __________ Zip Code: ________

Best Phone # to Reach You: ______________ E-Mail: ______________________

Date of Birth: __________ Social Security #: ______________________ Sex: ____

Driver's License Number: ______________________ State: __________

Marital Status: ________ Spouse's Name: ______________ Spouse's Date of Birth: ________

Please Check: Caucasian: ____ Hispanic: ____ African American: ____ Asian: ____

Native American: ____ Middle Eastern: ____ Other: ____ Prefer Not to Answer: ____

Please Check: Highest Level of Education: High School/GED: _____ Associate Degree: _____

Bachelor Degree: _____ Master Degree: _______ Doctoral Degree: _______

Employer: ______________________ Your Occupation: ______________

Address: ______________________ City: ______________ Zip Code: __________

Primary Care Physician: ______________________ Phone #: ______________

Last Visit Date: ________ Do we have permission to update your physician regarding your treatment? _____

Emergency Contact:

Name: ______________________ Relationship: ______________ Phone #: __________

Primary Insurance Company: ______________ Full Name of Card Holder: ______________

Card Holder Date of Birth: __________ Card Holder's Social Security #: ______________

Policy Number: ______________ Group Number: __________ Id Number: __________

Patient's Relationship to Card Holder: ______________________

Is this Plan: Medicare: ____ Medicaid: ____ Disability: ____ Cobra: ____ Workman's Comp: ____

Patient Name: ______________________________

DOB: ____________________

Reason You Are Here Today: ______________________________ *(For Nurse Only)* Ht: _____ Wt: ____ BP: ____/____

Approximate date that your symptoms appeared: ____

Did this happen: Suddenly: ____ Gradually: ____ Lifting: ____ Bending: ____ Pushing: ____ Pulling: ____

Twisting: ____ Falling: ____ Other (please explain): ____________________________

Pain Scale of 1-10 (with 10 being the worst): __________ Location of Pain: ______________________________

Duration of Pain: Continuous: ______ Comes & Goes ______ Other (please explain): ___________________

Is your pain the result of: Work Injury: _____ Auto Accident: _____ Sports: _____ Other (please explain): __________

What makes your pain worse: Sitting: ____ Lying: ____ Walking: ____ Prolonged Standing: ____ Pushing: ____

Pulling: ____ Squatting: ____ Bending Forward: ____ Bending Backward: ____ Night Pain (in bed): ____

Other (please explain): _________________________________

What reduces your pain: Sitting: ____ Standing: ____ Walking: ____ Medication: ____ Lying Down: ____

Shifting/Changing Position: ____ Other (please explain): _________________________

Have you been treated by another provider for this condition? No: ____ Yes (please explain): _________________

Have you had any type of treatment for this condition? No: ____ Yes (please explain): _____________________

Have you had a fluctuation in your weight? No: ____ Yes (please explain): ______________________________

Have you ever received Epidural Steroid Injections? No: ____ Yes: ____ How many injections? __________

Have you ever received Facet Joint Injections? No: ____ Yes: ____ How many injections? __________

Are you using a brace, cane, or other mobility device? No: ____ Yes: ____ Dates used: _________________

Do you currently smoke? No: ______ Yes: ______ Are you willing to quit? No: ______ Yes: ______

Do you drink alcohol? No: ______ Yes: ______ Daily: _____ Weekly: _____ Monthly: _____ Socially: ____

Do you use recreational drugs? No: ______ Yes: ______ Daily: ______ Weekly: ______ Monthly: ______

Do you exercise? No: _______ Yes: _______ How often do you exercise? _______________

What type of exercise do you do? ____

Describe other Symptoms:

____

____

____

____

____

S C J
Regenerative Health & Wellness
Stanley C. Jones M.D

Patient Name: ______________________________

DOB: ___________________

Indicate the percentage of pain that you are currently feeling in your legs, arms, neck, and back.
(Example: Leg Pain 20 %, Arm Pain 0%, Neck Pain 10%, Back Pain: 70%)

Leg Pain: ____

Arm Pain: _____

Neck Pain: _____

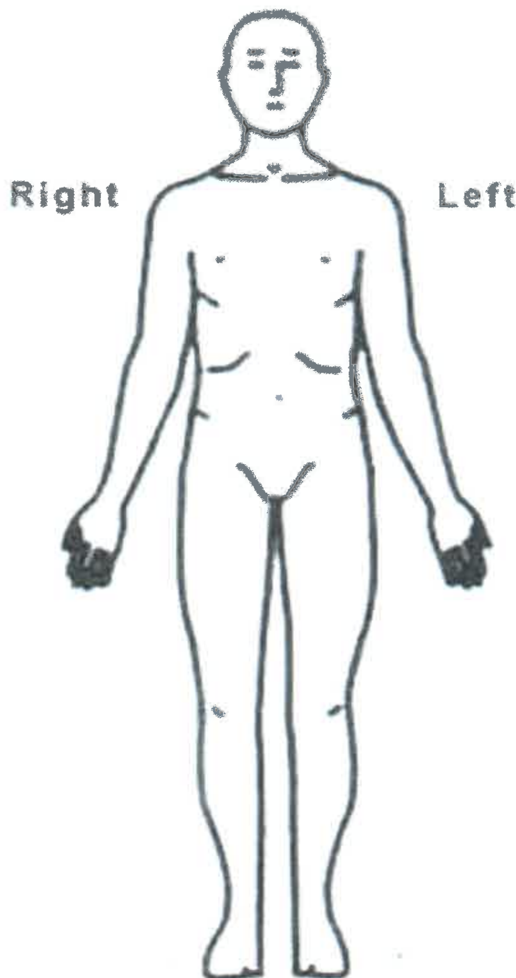
Back Pain: _____

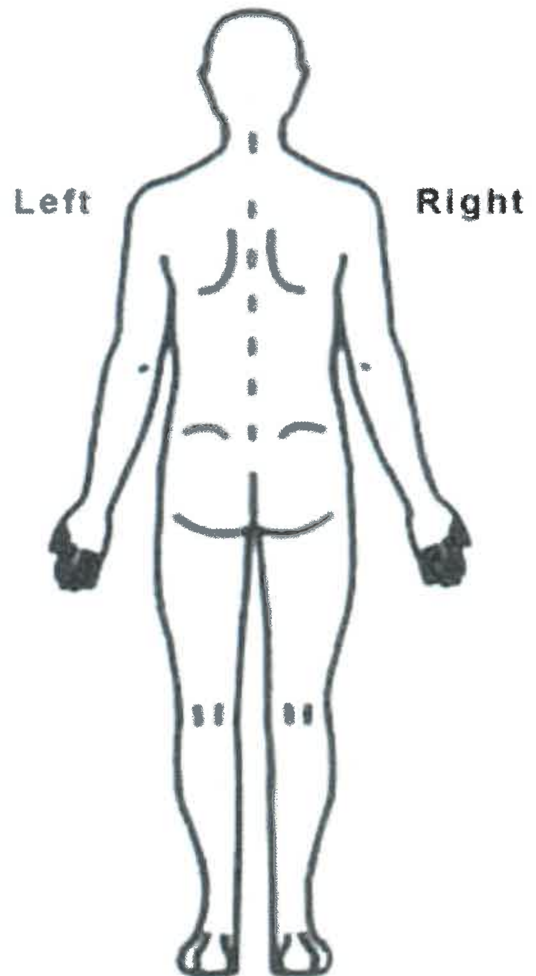
Total: 100%

On the diagrams below, please:

Place an "X" where you have pain. Place an "O" where you have numbness.

Place a "T" where you have tingling. Place an "S" where you feel stabbing pain.





NobilisHealth

Patient Name: ______________________________

DOB: __________________

Have you ever been hospitalized? No: ____ Yes (please explain): ________________________________

Please list all previous surgeries and/or therapies relating to your current condition

Surgery or Therapy	Date

Please list all known medical allergies

Medical Allergy	Reaction

I have NO medication allergies: (please check): ____________ Initials: __________________

Please list all current medications (including vitamins)

Name of Medication	Dosage	Frequency	Reason

Family Medical History

Medical Condition	Relationship	Medical Condition	Relationship
Diabetes Mellitus		Alcoholism	
High Blood Pressure		Thyroid Disorder	
High Cholesterol		Cancer	
Obesity		Blood Disorder	
Stroke		Kidney Disease	
Heart Disease		Lung Disease	
Depression		Other: ______________	

SCJ
Regenerative Health & Wellness
Stanley C. Jones M.D

Patient Name: ______________________

DOB: ______________

Have You Been Diagnosed With Any Of The Following?

Medical Condition	Yes	No	Medical Condition	Yes	No
High Cholesterol			High Triglycerides		
High Blood Pressure			Heart Disease		
Chest Pain			Heart Attack		
Irregular Heart Rate			Murmur		
Congestive Heart Failure			Mitral Valve Prolapse		
Have you ever had a stress test?			Cardiac Catheterization (Cath)?		
Diabetes- Type (1)			Diabetes-Type (2)		
Thyroid Problems			COPD		
Obstructive Sleep Apnea			If yes, Do you use a CAP machine?		
Bronchitis			Daytime Fatigue		
Snoring			Emphysema		
Shortness of breath with exertion			Shortness of Breath at rest		
Have you ever had a chest x ray			Difficulty Urinating		
Severe Urination Urgency			Frequent Urination		
Stress Incontinence			Poor Urine System		
Kidney Failure			Blood in Urine		
Infertility			Kidney/ Bladder Infection		
Gender Reassignment			Kidney Stones		
Sexually Transmitted Disease			HIV/ AIDS		
History of Cancer			Cancer Type		
Anemia			Bleeding Problems		
Sickle Cells			Bruise Easily		
Leukemia/ Lymphoma			Moles, recent changes		
Rashes			Leg Swelling		
Joint Pain			Blood Cot		
Arthritis			Varicose Veins		
Chronic Pain			Hip Pain		
Knee Pain			Ankle Pain		
Foot Pain			Osteoarthritis		
Rheumatoid Arthritis			Gout		
Unplanned Weight Loss			Dizziness		
Chronic Sinusitis			Sinus Headache		
Hearing Loss/ Problems			Neuropathy		
Migraines			Alzheimer's Disease		
Tensions Headaches			Stroke		
Seizures			Tremors		
Glaucoma			Multiple Sclerosis		
Fainting Spells			Numbness		
Weakness/ Paralysis			Other:		

PATIENT PRIVACY RIGHTS

Policy

It is the policy of Stanley C. Jones, MD to implement the following policies and procedures that will ensure patient privacy rights in accordance with the Privacy Regulations promulgated under HIPAA. 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.

Availability of Stanley C. Jones, MD's Privacy Notice: The patient has the right to receive our privacy notice in a timely manner. Upon request, the patient may at any time receive a paper copy of our privacy notice, even if he or she earlier agreed to receive the notice electronically. We must also post our privacy notice in a prominent location.

Requesting restrictions on certain uses and disclosures: There are circumstances not requiring prior patient authorization to release information, i.e., related to treatment, payment, emergency situations, public health entity requests, etc. The patient has the right to object to, and ask for restrictions on, how his or her health information is used or to whom the information is disclosed, even if the restriction affects the patient's treatment or our payment or health care operation activities. The patient may want to limit the health information that is included in patient directories, or provided to family or friends involved in his or her care or payment of medical bills. The patient may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to the patient's requested restriction.

Our practice provides information to our patients via multi-media services, i.e., appointment reminders via phone, voicemail, email communication, etc., and patients have the right to place restrictions on these services.

Receiving confidential communication of health information: The patient has the right to ask that we communicate his or her health information to them in different ways or places. For example, the patient may wish to receive information about their health status in a special, private room or through a written letter sent to a private address. We must accommodate requests that are reasonable in terms of administrative burden. We may not require the patient to give a reason for the request.

Access, inspection and copying of health information: With a few exceptions, patients have the right to inspect and obtain a copy of their health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge the patient a reasonable fee for copies of their health information.

Requesting amendments or corrections to health information: If the patient believes their health information is incomplete or incorrect, they may ask us to correct the information. The patient may be asked to make such requests in writing and to give a reason as to why his or her health information should be changed. However, if we did not create the health information that the patient believes is incorrect, or if we disagree with the patient and believe his or her health information is correct, we may deny the request. We must act on the request within 60 days after we receive it, unless we inform the patient of our need for a one-time 30 day extension.

Receiving an accounting of disclosures of health information: In some limited instances, the patient has the right to ask for a list of the disclosures of their health information that we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must furnish the patient with a list within 60 days of the request, unless we inform the patient of our need for a one-time 30 day extension, and we may not charge the patient for the list, unless the patient requests such list more than once in a 12 month period. In addition, we will not include in the list of disclosures made to the patient, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

Complaints: Patients have the right to file a complaint with us and with the Federal Department of Health and Human Services if they believe their privacy rights have been violated. We will not retaliate against the patient for filing such a complaint. To file a complaint with either entity, the patient should contact Stanley C. Jones, MD's Privacy Officer, who will provide the patient with the necessary assistance and paperwork.

Procedures: Should the law regarding patient privacy rights under HIPAA change, we will update our organization's policies and procedures regarding those rights, if applicable. All new staff of Stanley C. Jones, MD shall receive a copy of this document at employee orientation and be directed at orientation as to how to access more detailed privacy policy and procedure documents. All current staff of Stanley C. Jones, MD shall receive a copy of this document as part of our HIPAA compliance training session, and upon request.

2-19-16
10-7-17

2311 W Alabama St.
Houston, TX 77098
Phone: 713-773-2273
Fax: 877-796-4284

Acknowledgement of Receipt of Privacy Notice

By signing this form, you acknowledge that Stanley C. Jones, MD has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us.
If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

- ☐ I have received Stanley C. Jones, MD's Privacy Notice.
- ☐ Stanley C. Jones, MD has given me the chance to discuss my concerns and questions about the privacy of my health information.

______________________________ ______________
Patient's signature Date

______________________________ ______________
Patient's printed name Date of birth

Staff at Stanley C. Jones, MD should complete if this Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice? ☐ Yes ☐ No

Please explain why the patient was unable to sign this acknowledgement form and Stanley C. Jones, MD 's efforts to obtain the patient's signature:

____

____

Patient Name: ______________________________

Consent to Release Information
Orally To Family or Friends for Purposes of Treatment, Payment, and Health Care Operations

Patient Name (Please Print): ____

Stanley C. Jones, MD has my permission to release my confidential health information
to the following individuals who are involved with my care:

Name	Relationship
______________________________	________________________
______________________________	________________________
______________________________	________________________

I understand that I have the right to revoke this permission, in writing, at any time and that disclosures made in good faith may have already occurred and withdrawal of permission cannot be applied retroactively.

Print Name: _________________________ Signature: __________________________ Date: _______________

FMLA and Disability Documentation

Stanley C. Jones, MD requires a fee of $75.00 for the completion of any FMLA or Disability Documentation requested or required by the patient. If an addendum is required for an FMLA or Disability Document, a $50.00 fee will be required. The forms will not be completed until payment is made in full. If medical records are requested, in addition to the documentation, we will abide by the policies of the state of Texas Health and Safety Codes.

I have read and understand these charges for FMLA and Disability Documentation:

Print Name: _________________________ Signature: __________________________ Date: _______________

Financial Policy Statement

Stanley C. Jones, MD requires payment at the time service is rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. If we have not received payment form your insurance company with sixty days of the date of service, you may be expected to pay the balance in full. Please be advised that we do not treat automobile accident injuries, workman's compensation injuries/claims, or injuries that are involve in litigation. If my insurance company denies payment for any reason, I understand that I am financially responsible for all services rendered by Stanley C. Jones, MD.

Print Name: _________________________ Signature: __________________________ Date: _______________

Patient Name: ______________________________

Please tell us how you heard about the practice of Stanley C. Jones, MD, as we would like to thank them.

Radio (station name):

____

Television (station name):

____

Newspaper (name):

____

Magazine (name):

____

Mailed Post Card (approximate date received)

____

Physician (name):

____

Friend (name):

____

Other (please be specific):

____

Are there any questions or concerns that you would like to specifically discuss with Dr. Jones?
Please let us know:

____

____

____

____

Thank you for taking the time to fill out this information carefully.
Our goal is to make you fee better as quickly as possible.

Patient Responsibility:

I understand and agree that I am financially responsible for all charges and all services rendered. This includes in-office visit consultations, medical services, surgical injections, and x-rays ordered or performed by the doctor and staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that Dr. Stanley C Jones is NOT a medical provider and that I am financially responsible for all charges and services rendered by the physician. However, I still need to provide the office both my Medicare ID card and my secondary ID card in case a procedure or surgery is needed to be scheduled at a Medicare facility.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Spine Care provides this form to comply with the Health Insurance Portability and Accountability of 1996 (HIPAA).

Printed Patient Name	Patient Signature	Date

Spine Care Witness

I give permission to communicate my Private Healthcare Information to:

Name	Relationship

FORM OF PHYSICIAN DISCLOSURE

NOTICE TO PATIENTS

As required by Section 102.006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services:

- Spine Care PA
- Persona Medical Spa
- Celltex Therapeutics Corporation
- Hospital for Surgical Excellence @ Oak Bend
- SCJ Monitoring, PLLC
- Medical Diagnostics Management Services, LLC
- NeuroTex

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation with the foregoing healthcare provider(s) for whom, I, the patient am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving healthcare services from any healthcare provider and/or facility that I choose.

Patient Signature:________________________

Patient Name: __________________________

Date: ________________________________