

# LAKE SIDE

SPORTS & PAIN CLINIC

Welcome to the office of Mark Wheaton, MD. We look forward to meeting you and serving you to the best of our abilities. During your first visit you can expect to spend approximately 45-60 minutes with the physician and his staff. We will begin by reviewing your history of pain and previous treatments. Dr. Wheaton will then examine you and discuss the results of his exam and recommendations for treatment.

Prior to your appointment, we would request that you fill out the following information and then bring the completed forms with you to your first visit. If any films or tests, including x-rays, MRIs, EMGs or CT scans have been performed within the past 3 years, please arrange to bring these with you, or at the very least a copy of the reports.

Please be sure and review our Financial Policy before signing it. Our goal is to keep you well-informed of your treatment options and the costs involved.

**You are currently scheduled to see**

**Dr. Wheaton on \_\_\_\_\_ at \_\_\_\_\_ am / pm.**

Items to bring with you to your first visit:

- Your completed forms
- Your insurance card or claim information
- X-ray or MRI films (or at least the report)
- Cash, check or credit card to pay for your copay or any non-covered services

Should you have any questions please free feel to contact our office at (952) 593-0500.

## *Personal Information*

**Name** \_\_\_\_\_ **SS#** \_\_\_\_\_  
Last First M.I.

**DOB** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Sex:** Male Female

**Home Address** \_\_\_\_\_ **Phone** Home ( ) \_\_\_\_\_  
Street / Apt # Work ( ) \_\_\_\_\_  
City State Zip Cell ( ) \_\_\_\_\_

*Do we have your permission, during the process of providing medical care, to release health information to one of the following:*

**Spouse** Yes or No; or **Nearest Friend / Relative** Yes or No?

**Spouse's Name** \_\_\_\_\_ **Work phone** ( ) \_\_\_\_\_  
or Friend/Relative

**Whom Should We Contact in Case of Emergency?** \_\_\_\_\_

## *Insurance Information*

**Insured's Name** \_\_\_\_\_ **DOB of Insured:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(This may not be the patient in some cases, but is the name of the person who has the insurance or is responsible for the bill)

**Insurance Company Name** \_\_\_\_\_ **Insurance Phone** ( ) \_\_\_\_\_

**Address for Claim Submission** \_\_\_\_\_ (see back of card for address)

**Policy / Group #** \_\_\_\_\_ **Claim / ID #** \_\_\_\_\_





**Circle any symptoms you have been experiencing**

- |                        |         |                         |              |                      |                    |                     |      |
|------------------------|---------|-------------------------|--------------|----------------------|--------------------|---------------------|------|
| 1. Chills              | Fatigue | Fever                   | Night sweats | Weight gain          | Weight loss        | Weakness            | None |
| 2. Chest pain          |         | Irregular heartbeat     |              | Leg swelling         |                    |                     | None |
| 3. Itchy skin          |         | Rash                    |              |                      |                    |                     | None |
| 4. Cold intolerant     |         | Hair loss               |              | Heat intolerant      |                    |                     | None |
| 5. Anxiety             |         | Depression              |              | Insomnia             | Bleeding           | Bruising            | None |
| 6. Blurred vision      |         | Facial pain             | Headache     | Hoarseness           | Nasal Congestion   | Ringing in the ears | None |
| 7. Abdominal pain      |         | Constipation            |              | Diarrhea             | Heartburn          | Loss of appetite    | None |
| 8. Dizziness           |         | Memory loss             |              | Muscle weakness      |                    |                     | None |
| 9. Chest pain          |         | Cough                   |              | Recent infections    |                    |                     | None |
| 10. Frequent Urination |         | Urge incontinence       |              | Urinary incontinence |                    |                     | None |
| 11. Asthma             |         | Environmental allergies |              | Food allergies       | Seasonal allergies |                     | None |

**Please comment on any other health issue that should be brought to our attention:**

---

---

*Medical / Family / Social History*

**Circle any history of the following conditions in your health or your immediate family's health & state who has the condition.**

Heart Disease who? \_\_\_\_\_ Cancer: What kind? \_\_\_\_\_ who? \_\_\_\_\_  
Stroke who? \_\_\_\_\_ High Blood Pressure: Is it under control ? Y N who? \_\_\_\_\_  
Other \_\_\_\_\_ Diabetes: Is it under control? Y N who? \_\_\_\_\_

**List any pertinent surgeries and the date of the procedure.**

1. \_\_\_\_\_ / / 3. \_\_\_\_\_ / /  
2. \_\_\_\_\_ / / 4. \_\_\_\_\_ / /

**Marital Status?** Single Married Widowed Divorced Separated

**Do you have children?** Yes or No **Number of sons** \_\_\_\_\_ **Number of daughters** \_\_\_\_\_

**Do you have a religious affiliation?** Yes No N/A **What religion?** \_\_\_\_\_

**Does this religion play an important part in your life?** Yes No N/A

*Employment*

**Are you working?** Full-time Part-time Unemployed Off-Work due to injury

**What is your occupation?** \_\_\_\_\_ **Who is your employer?** \_\_\_\_\_

**Give a brief job description** \_\_\_\_\_

**Do you have any current work restrictions due to your injury?** Yes No

**If so, please list them here:** \_\_\_\_\_

How active are you?    sedentary            moderate exercise            vigorous exercise

What type(s) of exercise to you participate in regularly? \_\_\_\_\_

How often do you exercise?    Never    Occasionally    2-3 times per week    3-4 times per week    daily

#### *Tobacco Use*

Do you use tobacco?    Yes    No    Quit                      What type?    Chew    Cigar    Cigarettes    Pipe    Smokeless    Snuff  
How many packs per day?    .25    .5    1    2    3                      Number of years smoked? \_\_\_\_\_                      Year quit? \_\_\_\_\_

#### *Alcohol Use*

Do you drink alcohol?    Yes    No    Quit                      What type?    Beer    Wine    Liquor    Hard liquor    Methanol  
How much at a given time? \_\_\_\_\_                      How often? \_\_\_\_\_                      Year quit? \_\_\_\_\_

#### *Caffeine Use*

Do you use caffeine?    Yes    No    Quit                      What type?    Chocolate    Coffee    Soda    Tea    Tablets  
How much at a given time? \_\_\_\_\_                      How often? \_\_\_\_\_                      Year quit? \_\_\_\_\_

\*\* I would like to have a female employee present during my examination / treatment.    Yes    or    No

## **FINANCIAL POLICY**

*In our commitment to serving you, we strive to keep you informed of all costs involved in your care. This financial policy outlines our guidelines, please review and sign this agreement before proceeding with treatment. If you have any questions, please ask us to assist you in understanding this policy.*

### *Major Medical / HMO / PPO*

Dr. Wheaton is enrolled as a provider in most insurance groups in Minnesota. If he is a provider for your insurance company your office visit charges will be submitted by our billing department. You will NOT be charged for this at the time of service. Each insurance company varies in their payments for our charges. We agree to accept their discounts and their payment for the charges. However, your agreement with your insurance company may require that you pay a certain percentage of the charges (such as a copay, deductible, or a percentage of the services provided). In this case **you agree to be fully responsible for your portion of your bill.**

Pre-authorizations or referrals to be seen or treated at this clinic are your responsibility. You are responsible for knowing what your plan will cover. If you have questions, please contact your insurance company.

In some cases you may be treated with services that are considered “alternative”, “investigational” or “medically unnecessary” by your insurance company, treatments such as prolotherapy. Charges for these services will not be submitted to your insurance company. **Non-covered procedures are charged at the time of service, while covered services will be billed to your insurance company.** This policy/agreement serves as notice that the procedure, prolotherapy, will not be billed to your insurance, unless authorized in writing, in advance of treatment. By signing this agreement, you agree that you have been informed that this is not a covered procedure and that you will be responsible for the full payment at the time of service.

**Worker’s compensation** may cover prolotherapy in some cases, but this must be pre-authorized and presented in writing prior to treatment. We will assist you with this pre-authorization process.

**Auto insurance** companies often cover prolotherapy when your claim is open and active. However, we require full payment at the time of your visit. You will then be given all the necessary paperwork for you to submit these charges to your auto insurance for reimbursement.

**Copays** All copays are due at the time of service. You may pay these by cash, check or credit card. We accept both VISA and MASTERCARD.

**No Insurance** Any patients without current health care coverage will be required to pay their charges in full at the time of service. We do have payment options available through Care Credit, simply ask for an application or apply online at [www.carecredit.com](http://www.carecredit.com). They offer various interest-free plans.

**Medicare** Five years ago Dr Wheaton made the difficult decision of opting-out of the Medicare system. Dr. Wheaton is not currently a Medicare provider (under the Social Security Act), he has again chosen to opt-out of the current two year period of 2010 & 2011. **Therefore, as required by Medicare, all Medicare patients must enter into a private contract with Dr. Wheaton.** You may choose to seek care from a participating physician, or if you do enter a private contract with Dr Wheaton this will not affect your status with other participating Medicare physicians. This contract states that you will be responsible for the full amount of all charges at the time of service, as Medicare will not make payment for any services. Medicare limits may not apply to our charges. As a Medicare beneficiary you agree to not submit any claims to Medicare from our office, or ask us to submit claims as this would be a violation of our agreement with Medicare.

Medigap plans do not, and other supplemental insurance may elect not to make payments for services not paid for by Medicare. Most require that a claim must first be processed by Medicare. Because Dr. Wheaton is not a Medicare provider we cannot submit claims to Medicare, so supplemental insurance often will not pay for these services either.

If services are provided due to an emergency, no private contract with the patient is required.

You will be provided with an estimate of all costs involved in your care with Dr Wheaton

**Payment** Payment may be made by cash, check, VISA, MASTERCARD or Care Credit. If you pay by check and the bank returns your check unpaid, a \$20 fee will be assessed.

Care Credit is a “credit card” for medical expenses. This gives us the ability to offer you several payment options including 6, 12 or 18 month interest-free plans, as well as 24, 36, 48, and 60 month extended-payment options at a fixed interest rate. If you are interested in this option we will be happy to explain it to you and assist you in applying and using this payment plan, or you can review this option online at [www.carecredit.com](http://www.carecredit.com).

*Your signature indicates that you agree to the above policy and will not allow your account to become delinquent. This agreement applies to all dates of service in this office for up to one year. You may revoke your signature at any time, in writing, but will be held responsible for any bills due prior to the revocation date.*

Signature

Date

---

---

**In summary, all covered services will be submitted to insurance and you will be responsible for your portion of these services based on your agreement with your insurance company. All non-covered services must be paid at the time of service. All Medicare beneficiaries enter into this private contract with Dr Wheaton.**