Barry D. Malina, D.O., P.L.L.C.

Dear Patient:

Welcome! Thank you for giving me the opportunity to provide you with medical care. I am pleased to have you as a new patient and look forward to meeting you.

I provide osteopathic manipulation for auto-related injuries, personal injuries, and ongoing care for neck pain, back pain, and headaches. I offer neurofascial release, a manipulative technique not often available in medical offices.

Additional information is available on my website at: www.osteopathicaz.com . I discuss several topics, including answers to frequently asked questions.

Please complete the following pages, with black ink, and bring them with you to your first appointment.

A 24-hour advance notice is required to cancel any appointment.

On the day of your office visit, we suggest wearing comfortable, loose fitting clothing. Please avoid articles of clothing that have items with sharp edges, such as decorative zippers. In courtesy to other patients, please refrain from wearing products that contain fragrance, such as lotion, perfume, and after-shave.

The office is located on the **southwest corner of the 101 Freeway and Warner Road, in Warner Century Plaza.**

My office hours are: Monday through Friday, 8:00 a.m. - 5:00 p.m.

If you have any questions prior to your appointment, please feel free to give us a call.

Sincerely,

Barry D. Malina, D.O.

2165 E. Warner Rd., Suite 101 • Tempe, AZ 85284 • (480) 899-8885 • Fax (480) 899-9726

Barry D. Malina, D.O., P.L.L.C.

PATIENT REGISTRATION

Mr. Mrs. Ms. Dr. DATE_____

NAME_____ AGE_____ BIRTHDATE_____
First M.I. Last

ADDRESS_____
Number Street Apt. # City State Zip

PHONE: HOME (____)_____ CELL (____)_____ WORK (____)_____

WHERE DO YOU PREFER TO BE CALLED?_____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT_____

I AUTHORIZE YOU TO CONTACT THIS PERSON IN THE EVENT OF AN EMERGENCY:

NAME_____ RELATIONSHIP_____

ADDRESS_____
Number Street Apt. # City State Zip

PHONE: HOME (____)_____ CELL (____)_____ WORK (____)_____

CANCELLATION POLICY: If I do not cancel more than 24 hours before my appointment, I will be billed for the fee for an office visit. A total of three missed appointments may result in dismissal from the practice.

SCOPE OF PRACTICE: The practice is limited to osteopathic manipulation and homeopathy. I understand that I am expected to continue under the care of my primary care physician for all health-related problems. Dr. Malina maintains a separate practice from any other practitioners at this location.

PAYMENT POLICY: In order to provide health care at a reasonable cost, it is necessary to receive payment at the time services are rendered unless other arrangements have been made in advance. This office accepts cash, check, or credit/debit cards. I understand that records are kept for patient care and may not meet insurance company documentation guidelines and coding requirements. Some services may be denied by my insurance company as medically unnecessary. I have also been informed that homeopathic procedures and products are not covered by my insurance. I further understand that this office is unable to guarantee the decisions that my insurance company will make concerning payment. It is my responsibility to confirm coverage for the services provided, and I agree to be personally and fully responsible for payment to the physician even if my insurance company does not reimburse me for my treatment.

WORKERS COMPENSATION CLAIMS: I understand that Dr. Malina is not an industrial care provider. I further understand that my health insurance company may not reimburse me for treatment for any injury/injuries sustained at work. If I am receiving care from physicians in connection to my workers compensation claim, I have chosen to seek additional care from Dr. Malina. I understand that because this is a medical office, Dr. Malina and his staff do not provide legal advice regarding workers compensation claims. Therefore, if I have any questions concerning workers compensation claims, I will consult with the Industrial Commission of Arizona or an attorney or legal adviser of my choice.

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AHCCCS PATIENTS: I understand that Dr. Malina is not an AHCCCS provider, and the services he provides are not covered by AHCCCS. I understand that payment will be my responsibility. I acknowledge that the approximate cost for Dr. Malina's services has been provided to me. I have been advised that I may seek covered services from an AHCCCS participating clinician at no cost, other than any required copay. This agreement covers all dates of service provided by Dr. Malina.

TRICARE PATIENTS: I understand that Dr. Malina is not a TRICARE Authorized Provider, and the services he provides are not covered by TRICARE. I understand that payment will be my responsibility. I agree not to submit a claim for services received by Dr. Malina to TRICARE, and I acknowledge that I understand this agreement. This agreement covers all dates of service provided by Dr. Malina.

MEDICARE PATIENTS: I understand that Dr. Malina is an opted out physician with MEDICARE. I understand that it is my responsibility to notify Dr. Malina immediately if I am a MEDICARE recipient or become a MEDICARE recipient during the course of my treatment.

I am a MEDICARE/MEDICARE DISABILITY recipient: YES NO (please circle one)

PRIVACY NOTICE: I acknowledge that Dr. Malina has provided me with a copy of his Notice of Privacy Practices.

DATE_____ PATIENT NAME_____
Signature

_____
Please Print

CONSENT TO TREAT MINOR WITH OSTEOPATHIC MANIPULATION AND/OR HOMEOPATHY

I, the undersigned parent or legal guardian of the above child, hereby give my consent for Dr. Malina to treat my child with osteopathic manipulation and/or homeopathy. In order to revoke my consent, I agree that my request must be submitted in writing.

DATE_____

FATHER_____ _____
Signature Please Print

MOTHER_____ _____
Signature Please Print

GUARDIAN_____ _____
Signature Please Print

BARRY D. MALINA, D.O., P.L.L.C.
Practice Limited to Osteopathic Manipulation

Name _____ Today's date _____

Your age _____

How did you hear about our office? _____

Is this a job related injury? _____

_____

What is the MAIN HEALTH PROBLEM you are here for today? _____

_____

Is this the first time you've had this problem? _____ If not, how long have you had it? _____

Please complete if you or any family member (be specific about who it is) have ever been told you/they had:

Self	Family Member		Self	Family Member	
____	_____	Arthritis	____	_____	Cancer
____	_____	High Blood Pressure	____	_____	Urinary/Kidney Problems
____	_____	Heart Problems	____	_____	Prostate Problems
____	_____	Stomach Ulcers	____	_____	Gallstones
____	_____	Tuberculosis	____	_____	Emphysema/Asthma
____	_____	Diabetes	____	_____	Thyroid
____	_____	Alcoholism	____	_____	Psychiatric Problems
____	_____	Headache/Migraine	____	_____	Cholesterol Problems

Have you had OTHER problems with your health? If so, list them:

_____

_____

_____

_____

_____

_____

_____

If you take any MEDICINE, please list them (include all medicines and vitamins, not just prescription drugs).

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

If you are ALLERGIC to anything, please list below: (Please say what type of reaction you had, such as "skin rash".)

_____

_____

_____

If you have had any OPERATIONS, please list WHAT WAS DONE, and the YEAR:

_____

_____

_____

If you have been in the hospital for other NON-surgical ILLNESSES, please list the ILLNESS for which you were hospitalized, and the YEAR:

_____

_____

_____

_____

_____

Have you ever smoked cigarettes? _____ If yes, how many years did you smoke? _____ How many packs a day? _____ If you have QUIT smoking, what year? _____

Do you smoke a pipe? _____ Cigars? _____

How much alcohol do you drink? _____ Have you ever been told you have an alcohol problem? _____

What type of work do you do? _____

(or, if you are retired, what type of work you used to do?) _____

_____

Who do you live with? _____

Signature _____

Respond to those which apply to you:

GENERAL

Recent fever or chills_____ Excessive tiredness_____
Weight gain or loss of more than 10 lbs. in past year_____

HEENT

Do you wear eyeglasses/contacts?_____Date of last eye exam_____
Excessive headaches_____ Ringing in ears_____
(what area of head)_____ Sore throat or gums_____
Blurring of vision_____ Earache_____
Sinus congestion or discharge_____ Wheezing_____
Productive cough or colored sputum_____ Persistent cough_____
Reddish or rust colored sputum_____

CARDIOVASCULAR SYSTEM

Feeling of pressure over chest_____
Band-like constriction about chest_____
Pain radiating from chest to arms or neck_____
Shortness of breath_____ History of high blood pressure_____

GASTROINTESTINAL SYSTEM

History of ulcer_____ Abdominal pain_____
History of hernia_____ History of hemorrhoids_____
Change in habits of bowel movements_____
History of gallbladder disease_____
History of black tarry stools_____
History of whitish, clay-colored stools_____

GENITOURINARY STYSTEM

History of burning with urination_____ Blood in urine _____
History of frequency of urination_____ Pain over kidneys_____
Excessive urination_____ Swelling of fingers or about eyes_____
Get up at night more than once to void_____

NEUROMUSCULAR SYSTEM

Aches or pains in muscles or joints_____
Swelling or redness of joints_____

ENDOCRINE SYSTEM

History of thyroid trouble_____ History of diabetes_____
Intolerance to hot or cold weather_____
Change in texture or skin or hair_____
Use of thyroid medication in past_____

Signature_____

WOMEN ONLY

Have You Ever been Told You Had:

___ Known or suspected cancer or tumors of the breast, uterus, cervix, vagina or liver
___ Vaginal Bleeding of unknown cause

___ Blood Clots with blood vessel inflammation (Thrombophlebitus)

___ Previous problems with Estrogen pills
___ Abnormal mammogram

___ Could you be pregnant now?

___ Stroke

___ Heart disease (chest pain, heart attack)
___ Jaundice (turning yellow) with pregnancy or previous use of birth control pill
___ Over 65 years old

___ Liver disease now

___ Diabetes (difficult to control)

___ More than 30% above your ideal body weight

___ Heart or kidney problems made worse by fluid retention

___ Gall bladder disease

___ Liver disease (in the past)

___ High blood pressure

___ Diabetes (easily controlled)

___ High calcium in the blood

___ Migraine headaches

___ Family history of cancer of breast or reproductive organs

___ Smoke 15 or more cigarettes a day
___ Asthma

___ Seizure disorders

___ Family history of early onset blood vessel or heart disease

Date of last menstrual period_____
Age you started your period_____
Do you have one period every month____
How many days between periods_____
Days of menstrual flow_____
Trouble with periods (specify)_____
_____
Bleeding between periods_____
Age periods stopped (menopause)_____
Spotting after menopause_____
Total number of pregnancies_____
Weight of largest baby_____
Number of premature pregnancies_____
Number of miscarriages_____
Number of abortions_____
Number of living children_____
Do you use any method to prevent pregnancy?_____
When was your last pap smear_____
Have you ever had an abnormal pap smear?_____
Have you ever had an abnormal breast exam?_____

Have you ever had a mammogram?____
Date of last exam_____
Was the mammogram ever abnormal? (please explain)_____
_____
Do you do a self breast exam_____
How often_____
Vaginal discharge or irritation____
History of pelvic infection (specify)_____
_____
History of pelvic diseases (specify)_____
_____

Patient Signature_____

Barry D. Malina, D.O., P.L.L.C.

INFORMED CONSENT FOR TREATMENT WITH OSTEOPATHIC MANIPULATION

Thank you for selecting our office for evaluation and treatment with osteopathic manipulation. We look forward to serving you.

WHAT IS AN OSTEOPATHIC PHYSICIAN, A "D.O."?
An osteopathic physician is fully trained and licensed. His/her education combines the traditional methods of diagnosis and treatment, along with osteopathic manipulation.

WHAT IS OSTEOPATHIC MANIPULATION?
Osteopathic manipulation is a form of treatment that is based on the concept that the structure of the human body influences its function. The goal of this treatment is to improve your body's structure so that its function can improve, thereby reducing your pain and helping your body to better fight disease. No specific results are guaranteed.

The physician will first ask several questions. He will next perform a physical examination with his hands. He will evaluate muscles, joints, and bones to detect abnormalities, such as areas of tenderness, asymmetry, restricted range of motion, and abnormal changes in the muscles. The physician offers treatment to patients who have abnormal findings that he feels can be improved with osteopathic manipulation. The physician uses techniques that utilize light touch or the application of gentle pressure with his hands to the abnormal areas.

TREATMENT RISKS
Osteopathic manipulation is usually safe, but it is not completely without risks. There are rare reports of instances where patients have suffered worse pain after treatment, numbness or weakness, fractures (broken bones), spread of preexisting conditions such as undetected cancer, the breaking loose of blood clots, stroke, and tears in blood vessels. Although these complications are rare, patients should be aware of them and that some of them may be serious. Utilizing gentle techniques reduces the occurrence of these rare complications. In addition, osteopathic manipulation may alter the results of surgical, cosmetic, or dental reconstruction. More commonly, patients may experience some muscle soreness that can feel similar to the muscle soreness following sports activities or a flu-like illness. If you have any specific questions or concerns regarding the risks and benefits of this type of treatment and the alternatives available, please address them to the physician before signing this Consent.

PAYMENT
I understand that my insurance company may not reimburse for all or part of the physician's services, and I will be personally responsible for any unpaid balance.

CONSENT FOR TREATMENT
I understand the above and agree to be treated by Barry D. Malina, D.O.

_____ _____
Patient Signature Date

I understand the above and agree to have my child treated.

_____ _____
Parent/Guardian Date

_____ _____
Witness Date

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