OrthoTexas
Orthopedics & Sports Medicine

Established Patient Forms

"I've been a patient at OrthoTexas for a long time, why am I asked to complete new forms?"
If it's been over one (1) year since your last visit, your Physician would like an update of your medical history, medications, and current problem that you are being seen for. We understand that completing these forms (again) is a lot of work, but we want the most current information to treat you. Also, obtaining new patient information (address, insurance, phone numbers, etc.) is key to make sure you haven't moved, changed insurance, and that we have correct information in order to contact you.

Please remember to:

- Bring your Driver's License/Government-issued ID and insurance card (if applicable) to your visit.
- Arrive 30 minutes prior to your scheduled appointment time.
- Complete the attached forms thoroughly—this will help us with your registration process and help reduce your wait time.
- Assist our Physician by bringing your Radiologist reports and images for any X-rays, MRI, CT, or other scans you may have had.

You may receive a survey link via email three (3) days after your visit. Our goal is to be completely patient-focused and improve our service. We appreciate you taking the time to let us know your thoughts, suggestions, or areas we can improve.

Patient Portal: If you do not have access to your Patient Portal, please advise our staff and they will set up your account. This will assist you with timely access to a summary of your visit, secure messaging to email your Provider a question, and for you to update your address and contact information.

We thank you for choosing OrthoTexas!

Sincerely,

The OrthoTexas Team

Patient Information

Patient Name: _____ _____
First MI Last Preferred Name

SS#: _____ Birth Date:____/____/____ Age:_____ Sex (on birth certificate): Male ☐ Female ☐ Undefined ☐

Height:_____Weight:_____ Gender Identity: _____

Address: _____ _____ _____ _____ _____
Street Address Apt. # City State Zip

Patient lives in: ☐ Home ☐ Apartment ☐ Nursing Home

Cell #: _____ Work #: _____ Home #: _____

Email Address: _____ Driver's License #: _____

Patient's Employer: _____ Address, City, Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referred by: _____ Family Physician: _____ Phone: _____

Guardian Information (If patient is a Minor/under the age of 18)

Name: _____ Relationship to Patient: _____

SS#: _____ Birth Date:____/____/____ Phone: _____

Address: _____ _____ _____ _____ _____
Street Address Apt. # City State Zip

Section I. Primary Insurance (If you do not have insurance, please skip to Section II.)

Primary Company: _____Insured's Name: _____

Policy #: _____Group#: _____Insured's Date of Birth:_____

Patient's relationship to Insured: ☐Parent ☐Spouse ☐Self ☐Child ☐ Other: _____

Secondary Insurance

Secondary Company: _____Insured's Name: _____

Policy #: _____Group #: _____Insured's Date of Birth:_____

Patient's relationship to Insured: ☐Parent ☐Spouse ☐Self ☐Child ☐ Other: _____

Section II. Self-Pay Agreement (Complete if you do NOT have insurance.)

I agree to pay for medical services rendered at OrthoTexas. I understand that there are payment plans available at my request.

X_____ Date: _____

Section III. Release of Information: I authorize OrthoTexas to release medical information requested by my health insurance, Medicare or third-party payers in order to assist in the payment of claims.

X_____ Date: _____

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Patient Name: _____

DOB: _____ Height: _____ Weight: _____

Date of Injury: _____ Referred by: _____

Family Physician: _____ Phone: _____

Details of Injury: (How? Where? Any Treatment?) _____

_____

Body part being seen for: _____

Side of body: (circle) ☐ Right ☐ Left ☐ Both Dominant Hand (circle one): ☐ Left ☐ Right

Date symptoms began: ____/____/____ Current Symptoms: _____

If there is pain, where is it located? _____ Pain Level (1-10; 10 being worst): _____

Medical History (High Blood Pressure, Diabetes, Emphysema, Gastric Reflux, etc.) _____

_____

_____

_____

Patient Medications: ☐ See Attached List _____

_____

Pharmacy: _____ Address: _____

HOSPITALIZATIONS/SURGERIES	YEAR	SURGEON/HOSPITAL

Patient Drug Allergies: _____

_____

_____ ☐ No Known Allergies

FAMILY HISTORY			
Member	Alive/Deceased	Age	Health Status
Grandmother (mom's)	☐ A ☐ D		
Grandfather (mom's)	☐ A ☐ D		
Grandmother (dad's)	☐ A ☐ D		
Grandfather (dad's)	☐ A ☐ D		
Father	☐ A ☐ D		

FAMILY HISTORY			
Member	Alive/Deceased	Age	Health Status
Mother	☐ A ☐ D		
Sister/Brother	☐ A ☐ D		
Sister/Brother	☐ A ☐ D		
Sister/Brother	☐ A ☐ D		
Sister/Brother	☐ A ☐ D		

Review of systems (please check if you are currently or have had problems with these and describe)

Eyes _____ Diabetes _____ Arthritis _____

Ears, Nose, Throat _____ Infection _____ Stroke _____

Lungs, Breathing _____ Bleeding/ Blood Clots _____ Liver/ Hepatitis _____

Chest Pain/Heart _____ Balance _____ Non-Healing Wounds _____

High Blood Pressure _____ Numbness/Tingling _____ Kidney Disease _____

Stomach/Bowel _____ Blackout/Fainting _____ Cancer _____

Acid Reflux/Ulcers _____ Seizures _____ Depression/Anxiety _____

Bladder/Urinary _____ Other: _____

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Common Law Marriage

Work Status: ☐ Working Full-time ☐ Working Part-time ☐ Retired ☐ Student ☐ Disabled ☐ On Leave

Occupation: _____ Employer: _____

Do you drink alcohol? ☐ No alcohol consumption ☐ Yes, consumes alcohol ☐ Social Drinker ☐ Previous Alcoholism

Do you use tobacco? ☐ Never ☐ Currently (everyday) ☐ Currently (some days) ☐ Formerly

Do you overuse/abuse? ☐ Never ☐ Currently ☐ In the past

Exercise regularly? ☐ Yes ☐ No Times per week and type: _____

Do you use an assistive device for ambulation (cane, walker, etc.)? ☐ Yes ☐ No Type: _____

Patient Signature: _____ Date: _____

Per government requirements certain information is now required to update your medical record. Please complete the information below. (PLEASE PRINT ALL INFORMATION)

Primary Language (Check One)

☐ English ☐ Spanish ☐ Other: _____

☐ Decline to Answer

Ethnicity (Check One)

☐ Not Hispanic or Latino ☐ Hispanic or Latino

☐ Decline to Answer

Race (Check One)

☐ White ☐ Black / African American ☐ Asian ☐ Hispanic / Latino ☐ American Indian or Alaskan Native

☐ Native Hawaiian or other Pacific Islander ☐ Other: _____ ☐ Decline to Answer

Consent to Obtain RX History

☐ Yes ☐ No I consent for OrthoTexas to download my Prescription History if available. This consent is to help your physician make a better decision when prescribing any medication for you.

How Did You Hear About Us?

☐ Online Appointment Request
☐ Physician Referral
☐ Urgent - Acute Care
☐ Hospital ER
☐ Internal OrthoTexas Referral
☐ Internet Search
☐ Social Media
☐ High School Affiliation
☐ Professional - College Sports Affiliation
☐ Magazine - Newspaper - Print Ad
☐ Insurance Carrier Referral
☐ Workers Compensation
☐ Friends - Family - Word of Mouth
☐ Other: _____

Was there an injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No Car Accident? ☐ Yes ☐ No

Sports Related? ☐ Yes ☐ No

Attorney Involved? ☐ Yes ☐ No

I understand and agree that I am responsible for all services rendered in the event this is work related and my claim is denied when filed to worker's compensation. I understand that OrthoTexas does not file any third-party insurance for motor vehicle or other accidents.

By signing below, I am verifying that the information provided is complete and accurate.

_____ _____

Signature of Patient / Responsible Party Date

_____

Printed Name

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Authorization for Disclosure of Medical Information

With my initials below, I authorize OrthoTexas to disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to OrthoTexas' notice of privacy practices for a more complete description of such uses and disclosures. I have the right to review the notice of privacy practices at any time.

With my consent (please initial only one of the following paragraphs):

_____ (Initials) OrthoTexas may call my home and/or cell phone to leave a message on my answering machine/ voice mail. OrthoTexas may also send mail or email to me in reference to any items that assist the practice, OrthoTexas, in carrying out treatment, payment or operations such as appointment reminders, billing information, insurance items and any call pertaining to my clinical care including examination and test (laboratory, etc) results.

_____ (Initials) I direct that OrthoTexas not leave any voice mail messages on my answering machine or speak to anyone in my household other than myself.

I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations. I understand and have been provided with a notice of patient privacy handout that provides a more complete description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office and I must agree on the use and disclosure of my protected health information. A photocopy or fax of this consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance.

Signature of Patient	**Date**
Printed Name	**Date of Birth**

Who may we speak to regarding your treatment?

I give permission to OrthoTexas to release my private health information, including appointment day/time, to the following person(s); spouse, family member, etc.: ☐ **Only disclose to me**

Individual authorized to receive your health information	Relationship/Telephone Number
Individual authorized to receive your health information	Relationship/Telephone Number

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Summary Financial Policy:

I agree to assign insurance benefits to OrthoTexas Physicians and Surgeons, PLLC. We bill all insurance companies that we are contracted with as "network" providers as a courtesy to our patients. If you have two insurance plans, we will also bill the secondary plan.

I understand that my personal payment (co-payment, deductible and/or coinsurance) is required at the time services are received. Payment can be made in cash, personal check (in-state), credit card (Visa, MasterCard, Discover or American Express), or Care Credit. We will estimate your total payment responsibility at the conclusion of your medical appointment. This amount includes co-payments, deductibles, coinsurance and items not covered by your insurance plan. We will bill you any remaining balance based on your insurance plan's Explanation of Benefits (EOB), which is also sent to you.

Please visit with or call our Business Office (972.395.2220) if you are unable to pay the amount due when billed. We offer payment plans to our patients. If your account is sent to our collection agency, you are responsible for the outstanding balance and the fee charged by the agency. Again, please call us if you cannot make a payment. OrthoTexas makes every attempt to work with each patient.

I authorize OrthoTexas to contact me via current and any future cellular phone number(s) or wireless device(s) to receive general information from OrthoTexas or to collect a past due account owed to OrthoTexas. I authorize OrthoTexas and its agents and representatives (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls in their effort to contact me.

I understand that I can access, view and/or print the full OrthoTexas Financial Policy on our website at www.orthotexas.com.

Summary Notice of Privacy Practices:

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our "Notice of Privacy Practices" policy manual, which explains how your medical information may be used and disclosed, is available for your review on our website at www.orthotexas.com or you are welcome to request a copy.

General Release of Information:

I authorize OrthoTexas to release information regarding my care to my insurance company, pharmacist and to any physician involved with my care. I understand that I may withdraw this consent at any time.

Missed Appointments:

If you cannot make your appointment, please call us immediately so that we can offer the appointment to another patient.
If your appointment is not canceled at least 24 hours in advance of your appointment time or you no show, you may be charged a $50 no show fee for clinical visit; $250 for surgical procedures in a surgery center/hospital.

Consent of Treatment:

I authorize OrthoTexas Physicians and the Physician's Assistants to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care.

I have read and understand the above policies.

Patient or Guardian Signature	Date

NOTICE TO PATIENTS

DISCLOSURE OF PHYSICIAN OWNERSHIP

To better serve you, many of the physicians at OrthoTexas Physicians and Surgeons, PLLC ("OrthoTexas") have ownership interests in various healthcare facilities in North Texas. These facilities and our physicians are committed to providing clinical services to our patients in a safe, high quality environment. Their ownership interest in these facilities often provides them a voice in administration and in clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service.

The following is a current list of facilities (individually a "Facility") with whom one or more OrthoTexas physicians have an ownership financial interest:

- Baylor Surgicare at Plano Parkway
- Direct Orthopedic Care
- Frisco Medical Center, LLP d/b/a Baylor Medical Center at Frisco
- Metrocrest Surgery Center, LP d/b/a Baylor Surgicare at Carrollton
- Physicians Medical Center, L.L.C. d/b/a Texas Health Center for Diagnostics & Surgery - Plano
- Surgery Center of Plano
- West Plano Surgery Specialist
- Carrollton OR Surgical Affiliates

Patients of OrthoTexas always have the option of utilizing an alternate health care facility. OrthoTexas physicians welcome any questions regarding this aspect of their patient's care.

As nationally recognized leaders in orthopedic care, OrthoTexas physicians are at the forefront of advancements designed for patients with orthopedic problems. OrthoTexas physicians are frequently sought out by medical device manufacturers and other healthcare companies and organizations (individually, a "Company") to participate in research, development, education and other healthcare initiatives. These organizations realize that physicians are important contributors to the ongoing advancements in healthcare. As such, these companies sometimes offer ownership interests to physicians which is common industry practice. Some of these healthcare companies or organizations may be used in your medical treatment. However, a physician's decision as to which product, device or provider, if any, to be used in your care and treatment is made upon the physician's clinical judgment and what is in your best medical interest.

The following is a current list of companies with whom one or more OrthoTexas physicians have ownership relationships. Please feel free to ask your OrthoTexas physician any specific questions or concerns you may have about a company, product or your physician's ownership with OrthoTexas.

4Web	Flexion Therapeutics	Micro-Imaging Solutions
Axiom Regenerative Therapies	Gramercy Extremity Orthopedics	PIN
Bio2 Technologies	In2Bones	RevelationMD
Breg	Iroko Pharmaceuticals	Trice Medical
Cymedica	Kiowa Neuromonitoring	TX CIN

We hope this helps clarify the nature of our ownerships with other healthcare companies and organizations in orthopedic care. We are very proud to be leaders in technological innovation that we believe ultimately results in better patient care.

Please review carefully the information contained in this Notice.

1. During the course of our physician/patient relationship, I may refer you to a Facility or one or more other physicians who provide specialized medical services or refer the use of a Company product, device or provider.

2. I want to inform you that I am aware of the services, devices and/or products provided at a Facility or a Company when I have an ownership interest in it. Further, if I refer you to another physician for specialized medical services, that physician also may have an ownership or financial interest in a Facility or a Company.

3. I am providing this information to help you make an informed decision about your health care. You have the right to choose your health care provider. Therefore, you have the option to use a health care facility other than our Facility (as previously defined) or physicians or a product, device or provider other than from a Company (as previously defined) to whom I might refer you from time to time to.

4. I will not be treating you differently if you choose to obtain health care at a facility other than our Facility and, if you desire, I will be happy to provide you information about alternative health care facilities.

If you have any questions, please do not hesitate to ask. We welcome you as a patient and we value our relationship with you.

By signing below, you acknowledge that you have read and understand this notice, and that you are aware of an ownership interest in a Facility or a Company. Should you be referred to a Facility, Company or to another physician who holds an ownership interest in a Facility or a Company, you acknowledge your decision to decline the option to have your health care provided at another health care facility. You further acknowledge that you signed this notice prior to any referral of you to a Facility, a Company or another physician.

Signature of Patient	Signature of Parent or Guardian, (if applicable)
Printed Name	Date of Birth