OrthoTexas
Orthopedics & Sports Medicine

Patient Name: _____ _____
First MI Last Preferred Name

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

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

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

Patient's Employer: _____ Email Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Dominant Hand: ☐Right ☐Left ☐Both Height:_____Weight:_____

Have you *EVER* been diagnosed with any of the following conditions (check all that apply)?

☐ Cancer	☐ Depression	☐ Heart Problems	☐ Lung/Respiratory Problems
☐ Diabetes	☐ Stroke	☐ Osteoporosis	☐ High Blood Pressure
☐ Multiple Sclerosis	☐ Rheumatoid Arthritis	☐ Osteoarthritis	☐ Blood Clots

Are you latex sensitive? ☐Yes ☐No Do you smoke? ☐Yes ☐No

Do you have a pacemaker? ☐Yes ☐No Are you pregnant? ☐Yes ☐No

Do you have metal implants (i.e. screws, pins, plates) ☐Yes ☐No

What is your reason for attending therapy? _____

What date (roughly) did your present symptoms start?_____

How did the injury/problem occur? _____

Is this injury or condition related to work, an automobile accident, or other third-party claim? ☐Yes ☐No

Occupation, including activities that comprise your workday: _____

Are you on a work restriction from your doctor? ☐Yes ☐No

Have you had surgery for this injury? ☐Yes ☐No Date of Surgery: _____

List of previous surgeries: _____

Treatment received for this problem (chiropractic, injections, etc) _____

Have you previously had therapy for this condition? ☐Yes ☐No Date: _____

Please list tests performed for this problem (x-ray, MRI, labs, etc) _____

Leisure activities, including exercise routines: _____

Is there any other information you would like us to know? _____

Patient Signature: _____ Date: _____

_____**(Initial) CONSENT TO REHABILITATION EVALUATION AND TREATMENT** I request and consent for OrthoTexas Physicians and Surgeons, PLLC (OrthoTexas) to perform a rehabilitation evaluation and treatment as prescribed by my physician and/or recommended by my therapist. I understand and am informed that rehabilitation may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment. I understand that I need to provide the therapist with accurate and pertinent information concerning my condition. I have carefully read and fully understand this consent to treatment statement and understand I will have the opportunity to discuss my condition with the treating therapist before the evaluation and treatment. I consent and authorize OrthoTexas, to perform an evaluation and administer treatment based on this evaluation.

_____ **(Initial) SCHEDULING POLICY** I understand the facility requests 24-hour notice for any cancellation. **I acknowledge that there will be a $15 fee for no show or late cancellations less than 24 hours.** I also understand that I may be discharged from their care if more than 2 no shows and/or late notice cancellations occur. Arriving excessively early will not ensure you begin your therapy session early. **Tardiness of more than 15 minutes shall automatically cancel your appointment and may require rescheduling of the visit.**

_____ **(Initial) OWNERSHIP** I understand and acknowledge that this facility is owned by OrthoTexas Physicians and Surgeons, PLLC.

_____ **(Initial) CHILDCARE** I understand this facility is not equipped for childcare and is not an appropriate setting for children due to safety reasons. If the child plays with equipment or distracts other patients, you will be asked to reschedule your appointment when you have appropriate childcare.

_____ **(Initial) TREATMENT OF MINORS** I, as parent/guardian of a minor receiving treatment at OrthoTexas, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

_____ **(Initial) LIABILITY FOR PERSONAL VALUABLES** OrthoTexas is not responsible for loss or damage to personal valuables or belongings.

_____ **(Initial) NOTICE OF PRIVACY** I acknowledge receipt of Notice of Privacy Practices. I understand I will receive communication from OrthoTexas via text, call, or email regarding appointment reminders or to obtain feedback on my experience with the healthcare team. If at any time I wish to revoke the consent to receive that communication, I understand I have the right to notify the OrthoTexas office of that request.

_____ **(Initial) TREATMENT AREA** I understand only patients are allowed in the treatment area for privacy and safety concerns. The treating therapist must grant permission for any other person to attend the session.

_____ **(Initial) CELL PHONES** I understand that my cell phone should be silenced and used for emergencies only.

_____ **(Initial) VIDEOS AND PHOTOS** I understand that no videos or photos will be taken during the treatment session or while in the facility without prior consent of the therapist.

_____ **(Initial) INSURANCE BENEFITS** I understand that OrthoTexas verifies benefits and files insurance as a courtesy for each patient with health insurance. I acknowledge that the insurance benefits are not created or designed by OrthoTexas and are based on what was purchased by me, my employer, or responsible party. I understand that the facility will collect an estimated payment based on these benefits quoted by my insurance company. I acknowledge that it is my responsibility to understand and know my benefits. I understand that it is my responsibility to know the limitations on my insurance plan, and to monitor when I have reached my therapy coverage limits.

TO BE COMPLETED BY OFFICE: **Estimated** from my insurance company:

Primary Insurance:
Deductible:_____ Deductible Met:_____ OOP Max:_____ OOP Max Met:_____
Co-Pay:_____ Coinsurance %:_____ Visit/Dollar Limit:_____ Medical Review:_____

Secondary Insurance:
Deductible:_____ Deductible Met:_____ OOP Max:_____ OOP Max Met:_____
Co-Pay:_____ Coinsurance %:_____ Visit/Dollar Limit:_____ Medical Review:_____

_____ **(Initial) AUTHORIZATION OF PAYMENT** I hereby assign all benefits directly to OrthoTexas and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for services I receive, I will be financially responsible for payment.

_____ **(Initial) PAYMENT POLICY** I understand that payment is due at time of service. I acknowledge that there will be a returned check fee of $35 for any returned check. If I am unable to make payment at the time of service, I will inform a staff member as to make payment arrangements, obtain payment plan information and schedule therapy accordingly. All deductibles, co-pays, and co-insurance portions, including non-covered services are my financial responsibility. I understand overpayments will be refunded upon written requests to the responsibility party within thirty days upon receiving the request.

Please do not hesitate to ask any questions regarding your care or bill. Thank you for choosing OrthoTexas.

Patient Signature:_____Date: _____

To support the local community, OrthoTexas Physicians and Surgeons contributes to the Children's Advocacy Center of Collin County (CACCC). This is a 501 (c)(3) organization that provides services to abused and neglected children in our area. Please indicate below if you wish to donate any credit balance of $5.00 or below that you may have on your account when your treatment is completed.

Note: this consent remains valid with no expiration date unless it is revoked in writing by the patient or patient's guarantor. Please notify the office if you wish to revoke this consent at any time.

☐ I AUTHORIZE ORTHOTEXAS TO DONATE ANY CREDIT BALANCE OF $5.00 OR LESS AT THE COMPLETION OF MY TREATMENT TO CACCC.

☐ I DO NOT AUTHORIZE ORTHOTEXAS TO DONATE ANY CREDIT BALANCE TO CACCC AND WISH TO RECEIVE ANY AMOUNT THAT IS OWED.

Patient or Guarantor's Signature: _____

Printed Name: _____

Patient's Name: _____

Patient's Date of Birth: _____

Date: _____