NTOS
NORTH TEXAS
ORTHOPAEDIC & SPINE

Please do not leave anything blank. Mark n/a if not applicable.

PATIENT INFORMATION					
Patient's last name:	First:	Middle:	Marital status:		
Is this your legal name? ❑ Yes ❑ No	Former name, if applicable:	Social Security No:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Apt. #:	**Home Phone #:**	**Cell Phone #:**		
City:	State:	ZIP Code:	Email:		
Employer/Occupation:		Race:	Primary Language:		
Employer Address:					
Referring Physician:					
Primary Care Physician:					
How did you hear about us?					
Person responsible for bill (if patient is a minor):					
Phone Number:	**DOB:**	**Address:**	**Relationship to patient:**		

INSURANCE INFORMATION			
(Please give your insurance card and driver's license to the receptionist.)			
Primary Insurance:	Subscriber's name:	ID number:	Group number:
Insured party name & DOB:			
Secondary Insurance:	Subscriber's name:	ID number:	Group number:

Consent to Release Claims Information and Assignment of Benefits

- I hereby assign, transfer and set over to NTOS, LLC all my rights, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company(ies).
- I hereby consent for NTOS, LLC or any of its employees or agents to release and disclose any information required about me (or the above-named patient) to my insurance carrier, claims administrator, managed care company, or review agency, their employees or agents for the purpose of treatment, healthcare operations, and evaluating claims for payment.
- I understand insurance billing is a service provided as a courtesy and that I am always personally responsible for any fees not covered by my insurance carrier. Should any insurance payment be made directly to me or to the insured for monies due on this account, I agree to immediately pay over these funds to NTOS, LLC. I also acknowledge I am responsible for any deductible, copay or other balance not covered by my insurance carrier.
- I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by NTOS, LLC, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient Name:_____ **Date:** _____

***Patient Signature (parent or guardian if patient under 18):** _____

Communication Preferences

May we contact you by phone for appointment reminders?	YES NO	HOME WORK	BOTH

Please let us know who we may share your information with:

Please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like **North Texas Orthopaedic & Spine** to list as your ***Emergency Contact*** .

_____ _____ _____
Emergency Contact Relationship to Patient Contact Phone Number

_____ _____ _____
Contact Name Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information**

_____ _____ _____
Contact Name Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information**

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's ***Billing Account*** and ***Medical Conditions*** to the patient or legal guardian. The duration of this authorization indefinite unless otherwise revoked in writing. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Acknowledgement of The Receipt of North Texas Orthopaedic & Spine Notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIIPPA) is a federal government of regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. NTOS, LLC will furnish you with a notice (by request only) which provides information about how NTOS, LLC may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have been informed /offered a copy of NTOS, LLC Notice of Health Information Practices.**

***Patient Signature**:_____ Date: _____

NARCOTIC POLICY

Certain narcotic medications can only be filled/refilled with a handwritten prescription or token code sent over by the physician. Therefore, prescriptions will only be written or sent during normal business hours and we CANNOT accommodate walk-in requests. You will need to call in and allow up to 48 business hours for us to obtain a signature/token. We will call when your prescription can be picked up or has been sent in to the pharmacy. Beginning September 1, 2019, the Texas Legislature passed a bill limiting opioid prescriptions to 10 days.

By signing below, I understand that if I do not list someone to pick up my prescription on my behalf below, they will NOT be allowed to pick it up on my behalf.

I authorize_____and/or_____(full legal name) to pick up narcotic prescriptions on my behalf. I and they understand they will be required to show valid ID before the office will release the prescription.

***Patient Signature**:_____ Date: _____

North Texas Orthopaedic & Spine – Office Policies

Appointments & Office Hours

- Our office hours are 8:30am to 5:00pm Monday through Friday.
- For urgent matters after 5:00pm, please call our main phone number, 214-592-9955 for the provider on call**. In an emergency, call 911 or go directly to the nearest emergency room.**
- **We can only see you for one condition per visit due to increased regulated documentation requirements.**

Financial Policy

- ***Payment is due at time of service. We accept cash, Visa, MasterCard or Discover.***
- For patients with health insurance, co-payments, co-insurance and/or deductibles will be collected at the time services are rendered. Your insurance policy is a contract between you and your insurance company. In the event of denials, errors, service caps, policy exclusions or non-covered services, the patient is responsible for payment of all services rendered. **It is the patient's responsibility to know whether our providers are in-network with their insurance plan.** Patient will be responsible for any charges incurred whether in or out of network. Please notify the office of any changes in insurance coverage before services are rendered.
- If you do not have insurance, the office staff can provide you with a cost for services which is due in full, at time of service.
- Any account balance you may have must be paid in full prior to scheduling surgery.
- We reserve the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery.
- If you have multiple primary insurance policies, you are responsible for coordinating primary vs. secondary with your insurance companies. Failure to do so will result in claim denials and refusal to pay.

Auto Accidents/Worker's Compensation

- See next sections

Identity Verification

- If you would like us to bill your insurance carrier, you must present a valid insurance card AND identification prior to being seen at check-in **at every visit** or payment in full will be required.

Fees for Services

- Medical records: $25.00 for first 30 pages, $.25 each page thereafter. Please allow up to 15 business days.
- Disability, FMLA, employer-related or legal forms are $25.00, per occurrence. **(**Our physicians do NOT perform complete disability evaluations for military or worker's compensation reviews.)**

Medication Refill Policy

- All requests for prescriptions must be made 48 hours in advance. Please have your pharmacy request your refill. Medication refills are only addressed during office hours. Narcotic prescriptions must be picked up in person and cannot be mailed or called in. *By signing below, you are authorizing us to view your external Rx history.

I have read and understand the Office Policy and I agree to accept responsibility as described above. I also understand the Policy may be amended from time to time by the practice.

Printed Name	Signature	Date

Motor Vehicle Accident?

We value you as our patient and want to provide the best care for you. It is our policy that we do not bill private medical or motor vehicle insurance for Motor Vehicle Accident (MVA) claims. MVA claims present many challenges for the medical providers resulting in difficulty or significant delays in receiving reimbursement. It can sometimes take many years for our office to receive proper payment.
North Texas Orthopaedic & Spine does not recognize MVA or litigation claims, nor do we accept any letters of payment from any third party. You will be classified as a self-pay patient and you will be required to pay all medical expenses in full for every visit. We will provide you. We regret that we are not able to confer with attorneys or defer payment obligations while a case settles.

DECLINATION: I have read and fully understand this form and by my signature I am attesting that my current medical condition/injury did not happen due to a motor vehicle accident.

_____ _____
Patient Signature (parent/guardian if patient under 18) Date

I,_____(print name) have read and understand this Financial Policy. I understand and agree to this Financial Policy. I further understand and agree that my failure to follow this Financial Policy may result in North Texas Orthopaedic and Spine terminating my patient-physician relationship.

_____ _____
Patient's Signature (or Parent/Guardian Signature as applicable) **Date**

Work-Related Injury?

The patient is responsible for: Providing our office with accurate information about the reason for seeking care today. If you feel this visit is or may be covered by **Workers' Compensation** (did your injury occur on or near your office/jobsite or while working for your employer?) it is your responsibility to notify our office at your **first visit**. If you fail to notify our office at your first visit, *you will be responsible for paying for any related, previously billed charges and any further charges up to and if we obtain payment from the work comp insurance company.* If we receive payment from the workers' comp insurance company, we will issue the patient a refund for the claim(s) paid.

DECLINATION: I have read and fully understand this form and by my signature I am attesting that my current medical condition/injury did not happen while at work and/or while at my place of employment.

_____ _____
Patient Signature (parent/guardian if patient under 18) Date

OR

If you think your injury may be or is covered by your employer's workers' compensation policy, please fill out the below sections:

Employer:_____

Name of Supervisor/HR Director: _____

Supervisor/HR Phone:_____ Email:_____

What was the date of your accident? _____

Name of Worker's Comp Insurance Company_____

Accident claim #: _____

Adjuster name:_____ Contact info: _____

_____ _____
Patient signature (parent/guardian if patient under 18) Date

_____
Patient name (please print)

Patient Name:_____ **Today's Date:** _____

What are we seeing you for today? _____

Which side is affected? Right Left Both **Was this the result of an accident/injury?** No Yes

If yes, please describe <u>in detail</u> what happened:

_____

_____

Date pain started?_____ **The pain:** started suddenly progressively became worse

The pain is: constant intermittent **Does the pain move to other areas?** No Yes:

Have you had prior surgery at site of pain? No Yes **Type of surgery and when** _____

Severity of pain: Mild Moderate Severe *** **HEIGHT:**_____**WEIGHT:**_____***

Yes		Yes		Yes	
☐	Bruising	☐	Locking	☐	Tingling in Arms
☐	Cracking Sensation	☐	Night Pain	☐	Tingling in Legs
☐	Decreased Mobility	☐	Night Awakening	☐	Tenderness
☐	Difficult Sleeping	☐	Numbness	☐	Weakness
☐	Instability	☐	Popping	☐	Bleeding
☐	Limping	☐	Spasms	☐	Enlarged Bruise
☐	Redness	☐	Clicking	☐	Warmth
☐	Joint Pain	☐	Grating		
☐	Stiffness	☐	Swelling		

What Makes Symptoms Worse?

☐	**Nothing**	☐	**Movement**
☐	**Bending**	☐	**Pushing**
☐	**Climbing Stairs**	☐	**Sitting**
☐	**Standing**	☐	**Walking**
☐	**Lifting**	☐	**Descending Stairs**
☐	**Kneeling**	☐	**Other** _____

Relieved by

☐	**Nothing**	☐	**Injection**	☐	**Rest**
☐	**Brace/Splint**	☐	**Massage**	☐	**Stretching**
☐	**Elevation**	☐	**Pain/RX Meds**	☐	**Other**_____
☐	**Exercise**	☐	**Mobility**		
☐	**Heat**	☐	**OTC Medicines**		
☐	**Ice**	☐	**Physical Therapy**		

Types of Pain

☐	Aching	☐	Piercing
☐	Burning	☐	Sharp
☐	Dull	☐	Throbbing
☐	Stabbing	☐	Tearing
☐	Shooting	☐	Numbness
☐	Discomfort		
☐	Other _____		

ARE YOU CURRENTLY EXPERIENCING? (REVIEW OF SYSTEMS)

☐ Fever ☐ Significant Weight Change ☐ Vision Problems ☐ Cough/Cold Symptoms

☐ Shortness of Breath ☐ Chest Pain ☐ Heart Palpitations ☐ Diarrhea ☐ Constipation

☐ Urinary Incontinence ☐ Pain with Urination ☐ Joint Pain ☐ Chronic Headache

☐ Rash on Affected Limb

Patient Name:_____ **Today's Date:** _____

Surgical History:	Date:
Please list any treatment pertaining to today's complaint (injections, physical therapy, medications…) : Date:	

Medication:	Dosage:	Direction/How Taken:

Additional information please write on the back of this page.

Family History

Condition:	Family Member:	Comments:

Additional information please write on the back of this page.

Pharmacy:	***All fields required***	
Pharmacy Name:	Address:	Phone:

Environmental Allergies:

- ○ None
- ○ Latex
- ○ Adhesives
- ○ Other:
- ○ _____

Drug Allergies:

- ○ None
- ○ _____
- ○ _____
- ○ _____
- ○ _____

Food Allergies:

- ○ None
- ○ Peanuts
- ○ Shellfish
- ○ _____
- ○ _____

PAST MEDICAL HISTORY	***All Fields Required***
Name	**Date:**

Have you ever had or currently have any of the following (mark all that apply):

- ○ **AIDs/HIV**
- ○ **Tuberculosis**
- ○ **Hepatitis**
- ○ Alcoholism
- ○ Alzheimer
- ○ Anemia
- ○ Angina
- ○ Asthma
- ○ Atrial Fibrillation
- ○ Benign Prostatic Hypertrophy
- ○ Cancer
- ○ Congestive Heart Failure
- ○ COPD
- ○ Coronary Artery Disease
- ○ Crohn's Disease
- ○ Depression
- ○ Diabetes
- ○ Drug Abuse (illegal or Rx)
- ○ Deep Vein Thrombosis
- ○ Fibromyalgia
- ○ Gallbladder Disease
- ○ GERD
- ○ Gout
- ○ Heart Attack
- ○ High Cholesterol
- ○ Hypertension
- ○ Ulcerative Colitis
- ○ Juvenile Rheumatoid Arthritis
- ○ Kidney Disease
- ○ Liver Disease
- ○ Lyme Disease
- ○ Migraine Headaches
- ○ Multiple Sclerosis
- ○ Obesity
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Parkinson Disease
- ○ Peptic Ulcer Disease
- ○ Psoriasis
- ○ Peripheral Vascular Disease
- ○ Renal Disease
- ○ Rheumatoid Arthritis
- ○ Scoliosis
- ○ Seizure Disorder
- ○ Sleep Apnea
- ○ Stroke
- ○ Systemic Lupus Erythematous
- ○ Spinal Stenosis
- ○ Spondyloarthropathy
- ○ Traumatic Arthritis
- ○ Thyroid Disease
- ○ Valvular Disease

Social History	**Circle your responses**
Females – Any chance you may be pregnant? : Yes No	Do you live alone or with family?
Receiving Hospice Care?: Yes No	Are you in Skilled Nursing or an Inpatient Rehab Facility? Yes No
Activity Level: Low Moderate Active	
Current Smoker ☐ Former Smoker ☐ Non-Smoker ☐	If former how long ago did you quit?
If current how often?:	How many per day: / Interestead in Quiting? Yes No
Do you consume alcohol?: Yes No	How Often: / How Many Drinks?:
Have you ever used illegal drugs?: Yes No	Type: / Currently?
Have you been addicted to prescription medications?: Yes No	Type?:
Do you drink caffeinated beverages? Yes No	How many cups per day?: