PLEASE COMPLETE THIS FORM TO EXPLAIN THE NATURE OF YOUR VISIT.

PATIENT NAME:

_____

WHAT BODY PART ARE YOU BEING TREATED FOR?

_____

Please circle one: Right Left

DID YOU INJURE YOURSELF AT WORK? Please circle one: YES NO

FIRST DATE THAT YOU NOTICED THE PROBLEM?

_____

HOW DID THIS PROBLEM OCCUR?

_____

_____

WHERE DID THIS PROBLEM OCCUR? Please circle one:

HOME WORK OTHER

IF YOU CIRCLED OTHER, PLEASE EXPLAIN:

_____

_____

SIGNATURE: _____ DATE: _____

William C. Burns, II, M.D., P.A.

Patient's Name_____ Date_____

Social History:

Do you drink alcohol? Yes / No If yes, how many drinks a week?_____
Do you smoke cigarettes? Yes / No If yes, how many packs a day? _____
How long have you smoked? _____
Do you have a history of recreational drug use? Yes / No
If yes, which drugs? _____
Are you pregnant? Yes / No Date of your last menstrual cycle:_____
Method of birth control, if any: _____

Medical History:

Please circle any of the following that apply to you:

Alcohol abuse	Heart problems	Cancer
Drug abuse	Irregular heart beat	Diabetes
Childhood diseases	Heart murmur	Thyroid problems
Psychiatric problems	Rheumatic fever	Gallbladder problems
Depression	Palpitations	Liver disease
Nervous breakdown	High blood pressure	Hepatitis
Chronic fatigue	Shortness of breath	Colitis
Seizures	Asthma	Stomach ulcers
Epilepsy	Chronic bronchitis	Peptic ulcers
Anemia	Chronic lung disease	Arthritis
Bleeding problems	Emphysema	Ankle swelling
Blood clots / Phlebitis	Tuberculosis	Broken bones
Blood transfusions	Chronic sinus problems	Joint pain
Lupus	Chronic fever	Leg length difference
Eye disease	Chronic skin problems	Rheumatoid Arthritis
Kidney infection	Schleroderma	Scoliosis
Kidney Stones		

Please list any prescription and over-the-counter medications that you are currently taking: _____

_____

Please list any medications that you are allergic to: _____

_____

Please list any previous surgeries that have been performed on you: _____

_____

William C. Burns, II, M.D., P.A.

Patient's Name_____ Date_____

CURRENT SYMPTOMS:

Where do you have pain? (circle)

NECK	SHOULDER	ELBOW	WRIST	HAND	THIGH
BACK	BUTTOCK	KNEE	CALF	ANKLE	FOOT

Describe your pain: (circle)

Constant VS Intermittent (comes & goes)

Improving VS Getting worse

Does the pain awaken you at night?

Yes / No

Do you have: (circle)

Numbness: Yes / No

Where? _____

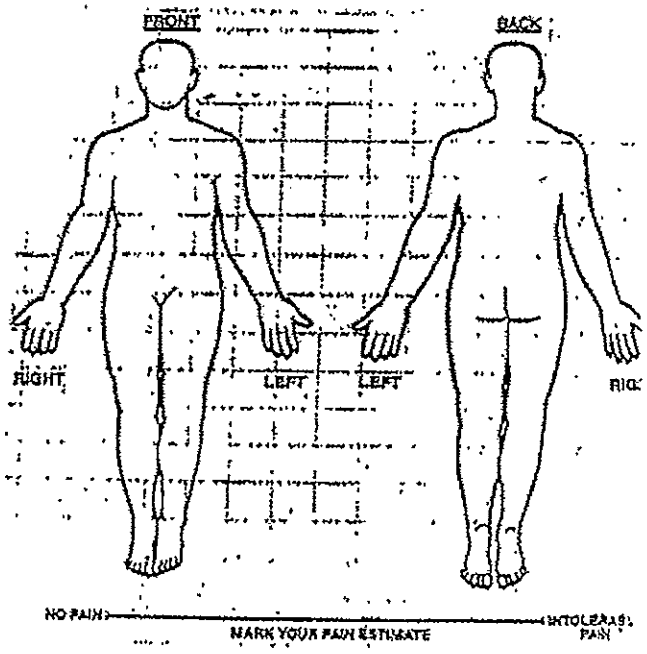
Weakness: Yes / No

Where? _____

Bladder Changes? Yes / No

Bowel Changes? Yes / No

Please indicate the location of your pain on the diagram ⇒



Have you had any Physical Therapy? Yes / No If so, when? _____

Where? _____ For how long?_____

Have you had any tests to diagnose this injury? (circle)

X-rays MRI CT EMG Bone Scan Myelogram

Did you bring of the above items with you? Yes / No

Where were they done? _____

Did another doctor refer you here? Yes / No

Referring Doctor's name: _____

William C. Burns II, M.D.

Patient's Name:_____ Age:_____ Birthdate:_____
(First / Middle Initial / Last)

Please Circle: Married Single Student Other Gender: Female Male

Patient or Parent's: SS#:_____ DL#:_____

Address:_____ City/State/Zip:_____

Primary Contact: Cell #: _____ ☐ patient ☐ mom ☐ dad ☐ spouse ☐ child

Secondary Contact: Home #:_____ Work #:_____

Patient's Occupation:_____ Patient's Employer:_____

Spouse's Name:_____ Spouse's Work #:_____

Name of nearest relative not living with you:_____ Phone #:_____

Name of referring physician, if any:_____ Phone#:_____

Name of Pharmacy: _____ Phone #:_____

If patient is under 18 years old or lives with parents, please complete: Student staus: Full-time OR Part-time

Father's Name:_____ Mother's Name:_____

Father's Birthdate:_____ Mother's Birthdate:_____

Father's SS#:_____ Mother's SS#:_____

Father's Employer:_____ Mother's Employer:_____

Employer's Address:_____ Employer's Address:_____

City/State/Zip:_____ City/State/Zip:_____

Work#:_____ Work#:_____

HOW DO YOU PLAN TO PAY FOR TODAY'S VISIT? CHECK CASH CREDIT CARD

What type of insurance plan do you have? Please circle one of the following:

HMO PPO EPO POS INDEMNITY MEDICARE WORKMAN'S COMP PRIVATE PAY

Name of PRIMARY INSURANCE:_____ ID#/Policy#_____

Name of Insured:_____ Insured Birthdate:_____

Please provide us with a copy of your insurance card Insured SSN: _____

Do you have SECONDARY INSURANCE? YES OR NO Name of Company: _____

I authorize William C. Burns, II, M.D. to release medical information that may be necessary to receive reimbursement from insurance companies to whom I have submitted a claim. I assign all medical and/surgical benefits, to include major medical benefits to which I am entitled, to William C. Burns, II, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that any overpayment on my account will be refunded.

Patient or Responsible Party's Signature:_____ Date:_____

(Revised 1/18/12)

William C. Burns II, M.D.
Craig Ranch Orthopaedics and Sports Medicine
5575 Warren Pkwy
Building 1, Suite 212
Frisco, TX 75034

Acknowledgement of Receipt of Notice of Privacy Practices

Name:_____

I have been provided this office's *Notice of Privacy Practices*, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

William C. Burns II, M.D., P.A. Financial Policy

The following financial policies are effective 3/1/2010, and apply to all services rendered on or after 3/1/2010. Please feel free to ask for clarification if necessary.

We asked for your insurance information when we scheduled your first appointment, and we made every effort to verify your coverage and benefits. While we do our best to verify that our doctors are contracted and in-network with your insurance plan, it is ultimately your responsibility to ensure that this is the case. We call your insurance company and ask for specific benefits for procedures that are common in our orthopaedic office. Based upon the information provided to us by your insurance company, we will expect payment according to the benefits quoted. Upon check-in, we will collect payment of the full amount of your co-payment. After you see the doctor, we will collect payment of any deductible and co-insurance amounts based on the services rendered. We will then file your insurance claim with your insurance company for that visit. When they process your claim, they will mail both you and us an Explanation of Benefits (EOB). When we receive the EOB, we will adjust any contracted discounts off of your account for that visit. We will post any payments received from the insurance company to your account for that visit. If there is a remaining balance due on your account for that visit, we will send you a statement in the mail or collect the balance due at your next visit. Payment for any outstanding balance is due and payable upon receipt. In the event payment is not received within 30 days of the date we received notice from your insurance, a one-time administrative fee in the amount of 10% of the past due amount shall be assessed. We do not extend credit to our customers and the administrative fee(s), related fees, charges and assessments are not interest, a credit service charge or a finance charge. The administrative fee is intended to be a reasonable advance estimate of our costs which result from patient's late payments and nonpayments. Further, all amounts past due are subject to interest thereon at the rate of one and one-half percent (1 ½%) per month, or the maximum rate allowed by law, whichever is less. In addition, in the event the past due balance is turned over for collection, the patient will be responsible for all costs, including but not limited to attorney's fees, costs of court and other out-of-pocket expenses. Any outstanding balances from prior visits must be paid before your next appointment. If you are unable to pay your portion of your medical bill, please reschedule your appointment or ask to speak to our billing representative to make prior payment arrangements.

Many insurance plans have a requirement that patients must provide additional information to them before they will pay your claim. If that happens, the full balance due on your visit becomes your responsibility to pay. Once an insurance company pends a claim, there is nothing that our office can do to get the claim paid; it is completely up to the patient to contact their insurance company, provide the needed information, and ensure that the insurance company pays the claim within 30 days. Additionally, if your insurance plan, group number or policy number changes, you must notify us at the time of service. Failure to provide us with current valid insurance information will result in the entire balance becoming your responsibility. This is because health care providers only have a certain amount of time in which to file your insurance claim; this timely-filing deadline varies from insurance company to insurance company.

It is important to remember that your insurance policy is a contract between you and the insurance company. We will do everything possible to assist you in getting your claim paid; however, all charges incurred for your medical care are your sole financial responsibility. Medical insurance is like a "credit card with discounts": by having insurance coverage and fulfilling all of your insurance plan policy provisions, you are not required to pay our full charges prior to service.

Your co-payment is due at check-in, prior to seeing the doctor. Any balances due from previous visits must be paid at check-in, prior to seeing the doctor. Any deductibles and co-insurance portions must be paid at check-out for services rendered at that visit. Payment for any outstanding balance is payable upon receipt, and is past due and subject to interest and collection costs as set forth herein after we receive notice that insurance has processed the claim. If you are unable to pay your portions at the time of service, we ask that you reschedule your appointment or make prior financial arrangements with our billing representative.

I,_____, do hereby affirm that I have read and understand the above financial policies. I understand that I am financially responsible for all medical fees incurred during my treatment with Dr. William C. Burns II, M.D. regardless of insurance coverage or benefits.

_____ _____ _____

(Print Patient name) (Signature of Patient/Guarantor) (Date) (3/1/10)

William C. Burns II, M.D., P.A.

Welcome! Please read the following office policies, and let us know if you have questions.

1. Please sign in at the front desk at each visit. Please complete any paperwork in its entirety.
2. We will collect your co-payment at check-in, prior to seeing the doctor.
3. **You will be expected to pay any previous balances prior to seeing the doctor.**
4. **You will be expected to pay any deductibles and co-insurance portions at the time of services at check-out.**
5. Please bring your driver's license and insurance card with you to all visits, as we must periodically verify your insurance coverage. We must have a copy of your current insurance card. If you do not have a valid insurance card, the visit must be paid for at the time of service.
6. Please inform our office 24 hours prior to your appointment if your insurance has changed. If your insurance plan changes and you fail to notify us at the time of service, you may be responsible for the entire balance due.
7. We ask that you please contact our office with any address, telephone or insurance changes.
8. We ask that you please schedule separate appointments for each injury or illness.
9. We ask that you please call to cancel or reschedule your appointment 24 hours prior to your appointment. FAILURE TO DO SO WILL RESULT IN A CHARGE OF $25.00 TO YOUR ACCOUNT, WHICH MUST BE PAID AT THE TIME OF YOUR NEXT APPTOINMENT.
10. As a courtesy to all of our patients, you may be asked to reschedule your appointment if you are more than 20 minutes late.
11. Please turn off cell phones when you are in the exam room.
12. If surgery becomes necessary, there may be a surgery deposit required depending upon your insurance coverage.
13. Your insurance company may require additional information from you in order to process your claim, such as: accident or injury details, other insurance coverage information or student status. If your insurance company pends your claim or does not pay your claim for any reason within 45 days after the date of service, the entire balance due becomes your responsibility and is past due and subject to a one-time administrative fee in the amount of 10% of the past due amount and to interest thereon at the rate of one and one-half percent (1 ½%) per month, or the maximum rate allowed by law, whichever is less.
14. After your insurance carrier has paid their portion, there may be an amount not covered and a balance due. The balance is due within 30 days after we receive notice of processing from your insurance company. In the event payment is not received within 30 days of the date we received notice from your insurance, a one-time administrative fee in the amount of 10% of the past due amount shall be assessed.
15. All past due balances are subject to interest thereon at the rate of one and one-half percent (1 ½%) per month, or the maximum rate allowed by law, whichever is less.
16. If your insurance mistakenly sends you our payment, please forward the check to us immediately. Failure to do so may result in your account being turned over to a collection agency or small claims court.
17. If your insurance plan requires you to have a referral, you must verify that a valid referral is on file with our office prior to your appointment.
18. If you need a prescription refilled, please contact your pharmacist, who will then contact our office. PAIN MEDICATION WILL NOT BE REFILLED ON WEEKENDS.
19. WE DO NOT BILL AUTO INSURANCE OR THIRD PARTY LIABILITY INSURANCE. Payment will be expected at the time of service.
20. Many insurance plans classify procedures such as fracture care, cast and splint applications, durable medical equipment and injections in the same category as minor surgery. Therefore, these claims may be processed using surgical benefits, and may require additional payment from you for deductible and/or co-insurance. We have no control over how your insurance covers and applies benefits for these services.
21. There is a $30.00 returned check fee. In the event of a returned check, please contact the billing department immediately.
22. In the event that a past due balance is turned over for collection, the patient will be responsible for all costs, including but not limited to attorney's fees, costs of court and other out-of-pocket expenses.
23. There is a charge for any forms that our office must complete, or any letters that we must write.

I,_____, do hereby affirm that I have read and understand the above office and policies. **I understand that I am financially responsible for all medical fees incurred during my treatment with Dr. William C. Burns II, M.D. regardless of insurance coverage or benefits, as well as any administrative fees and interest accrued on past due balances.**

_____ _____ _____

(Print Patient Name) (Signature of Patient/Guarantor) (Date) (3/1/10)

William C. Burns II, M.D., P.A.

Notice of Financial Interest

By law, we are required to inform you that Dr. Burns does have a financial interest in the following area health care facilities, and will benefit financially from services provided at these facilities:

PEAK McKinney
Warren Medical Imaging
Texas Health Surgery Center Craig Ranch

This does not in any way affect decisions made by Dr. Burns regarding your care.

Upon request, we will be happy to provide you with alternative facility options. You have the choice to obtain medical services at facilities other than those listed above. You will not be treated differently should you decide to obtain medical services elsewhere.

Should you have any concerns regarding this disclosure, please contact our office manager at (469)854-8392.

I have received and read this notice.

(Print Patient Name)	(Signature of Patient or Guardian)	(Date)

William C. Burns II, M.D.
Craig Ranch Orthopaedics and Sports Medicine
5575 Warren Pkwy
Building 1, Suite 212
Frisco, TX 75034

Patient Name: _____ Date of Birth: _____

Permission to Release Medical Records

I hereby give permission to Craig Ranch Orthopaedics and Sports Medicine to disclose and discuss any information related to my medical records to the following:

_____

Name Relationship to patient

_____

Name Relationship to patient

_____

Name Relationship to patient

( ) I do **NOT** wish to give permission to release any medical information.

Patient Signature: _____ Date: _____