ALPHA ORTHOPEDICS & SPORTS MEDICINE

Charles E. Toulson, MD
Jon C. Thompson, MD
Brian J. Snow, MD
Duncan L. McKellar, Jr., MD
Mark G. Hubert, MD

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 **YOU ARE REQUIRED TO INDICATE WHICH IS PRIMARY/SECONDARY**

(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 Alpha Orthopedics 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 Alpha Orthopedics 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 Alpha Orthopedics. 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 Alpha Orthopedics, 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):** _____

REV: 2020.04.28

Patient Name: _____ **DOB:** _____

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

Is your visit today related to an injury that occurred while at work? YES NO

Is your visit today related to an auto or motorcycle accident? YES NO

TELL US WHO WE CAN SHARE YOUR PRIVATE INFORMATION WITH:

Please complete the fields below and select the appropriate checkboxes based on your approval for each person you list.
If you do not list someone to pick up prescription on your behalf, they will NOT be allowed to pick them up.

_____ _____ _____
Emergency Contact Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Can Pick Up Prescriptions**

_____ _____ _____
Contact Name Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Can Pick Up Prescriptions**

_____ _____ _____
Contact Name Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Can Pick Up Prescriptions**

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 Alpha Orthopedics and Sports Medicine 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. Alpha Orthopedics and Sports Medicine will furnish you with a notice (by request only) which provides information about how Alpha Orthopedics and Sports Medicine 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 Alpha Orthopedics and Sports Medicine Notice of Health Information Practices.**

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

NOTICES TO PATIENTS

Physician's Assistant Certified/Nurse Practitioner Consent- This practice, its affiliates or business associates has on staff, or on-call Physician's Assistant-Certified or Nurse Practitioners collectively known as ("Non-Physician Practitioners") to assist in the delivery of orthopedic medical care. I acknowledge a Non-Physician Practitioners is not a physician. The state medical board licenses Non-Physician Practitioners, under the supervision of a physician, can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care and assist at surgery. "Supervision" does NOT require the constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. **Alpha Orthopedics & Sports Medicine**, its employees, affiliates, or designated business associate may bill your insurer or plan administrator fiduciary separately to obtain payment. A list of services may be provided that are within the scope of practice for Non-Physician Practitioners upon request. I acknowledge the above information and consent to the services of Non-Physician Practitioners for my health care needs. I understand that at any given time, I can request to see the physician instead of the Non-Physician Practitioners.

Patient Referral- To serve you with the highest care quality, sometimes it is necessary to have other care providers join our team to complete or continue your medical procedures or treatment. We would like to keep you informed about any referrals to care providers who may be in or out-of-network. Should this practice or my physician refer me to a physician or non-participating provider out of the preferred provider panel, this practice or physician will disclose to me that the referral is out of the preferred provider panel and any ownership interest. I understand this practice or my physician is not restricted from referring me to an out-of-network provider, and I may have more out-of-pocket costs from a non-participating provider.

DISCLOSURE OF PHYSICIAN OWNERSHIP - To better serve you, some of the physicians at Alpha Orthopedics & Sports Medicine 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 provides them with a voice in administration and in clinical 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 of our surgeons have an ownership or financial interest:

- Methodist McKinney Hospital, including Methodist McKinney Outpatient Surgery Center, Medical City McKinney Surgery Center, Baylor Scott & White Surgical Hospital Sherman, Eminent Medical Center, Texas Health Presbyterian Hospital Allen

As our patient, you always have the option of utilizing an alternate health care facility. Please ask one of our representatives for a list of alternate facilities. The physicians of Alpha Orthopedics & Sports Medicine welcome any questions regarding this aspect of their patient's care.

As many of our surgeons are renowned for their skill and outcomes, they are frequently sought out by medical device manufactures and other healthcare companies to participate in research, development and education initiatives. These organizations realize that physicians are important contributors to the ongoing advancements in healthcare. As such, these companies sometimes offer consulting, teaching and investment opportunities, which is a common industry practice. Some of these healthcare companies 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 treatment and care is made upon the physician's clinical judgement and what is in your best medical interest.

The following is a current list of healthcare-related organizations (individually a 'Company') with whom one or more of our surgeons have a consulting agreement or ownership interest:

- ZimmerBiomet, Stryker, Arctic Bracing, Physicians Integrated Network, Episode Solutions, DJO Surgical, Kyocera, Alpha Surgical Assist, LLC

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

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 to 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 may also 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 healthcare. You have the right to choose your health care provider. Therefore, you have the option to use a healthcare facility other than a Facility (previously defined) to whom I might refer you from time to time.
4. I will not be treating you differently if you choose to obtain healthcare at a facility other than a Facility and, if you desire, I will be happy to provide you information about alternative healthcare 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 or financial interest in a Facility or a Company and that this notice was provided to you prior to any referral of you to a Facility, a Company or another physician.

_____	_____	_____
Print Name	Signature	Date

Alpha Orthopedics & Sports Medicine – Office Policies

Appointments & Office Hours

- Our office hours are 8:00am to 12:00 pm and 1:30pm to 5:00pm Monday through Friday. The Lobby is closed between noon to 1:00 daily.
- For urgent matters after 5:00pm, please call our main phone number, 972-838-1635 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, AMEX, Discover and CareCredit.***
- 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.

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.**

Fees for Services

- Medical records requests are processed by a HIPAA-complaint third party vendor. We may ask for a $5 fee for your x-rays on disk.
- 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.)**
- Other fees: Returned check fee: $35.00, Notarized Forms (including Temporary Handicap Placards): $10.00

Medication Refill & Narcotics 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. Narcotic Prescriptions will only be written during normal business hours and we CANNOT accommodate walk-in requests. You will need to call our refill line and allow up to 48 business hours for us to obtain a signature. We will call when your prescription can be picked up. Beginning September 1, 2019, the Texas Legislature passed a bill limiting opioid prescriptions to 10 days. In addition, this practice verifies your prescription history against the Texas PMP database.

I have read and understand the Office Policies 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. MVA claims present many challenges for the medical providers resulting in difficulty or significant delays in receiving reimbursement. Insurance companies often refuse to pay or will take back payments already made for MVA-related cases.
Alpha Orthopedics and Sports Medicine 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 at time of each visit. We will provide you with receipts and the documentation you will need to submit for reimbursement. We regret that we are not able to confer with attorneys or defer payment obligations while a case settles.
****We will bill your commercial insurance (non-government) IF we are provided with all your attorney information to verify that we are part of the subrogation.** You will need to provide this information on an additional form that you can obtain from our Front Desk. Please note we are unable to bill government payors (Medicare, Tricare), including Medicare replacement plans or motor vehicle insurance for MVA claims.**

DECLINATION: I have read and fully understand this form and by my signature I am attesting that my current medical condition/injury <u>did not</u> happen as a result of an auto or motorcycle collision.

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

OR

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 Alpha Orthopedics and Sports Medicine terminating my patient-physician relationship.

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

_____
Patient Name (if patient is a minor)

Work-Related Injury?

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 **<u>first visit</u>**. 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 you 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 <u>did not</u> 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:	Drug Allergies:	Food Allergies:
○ None	○ None	○ None
○ Latex	○ _____	○ Peanuts
○ Adhesives	○ _____	○ Shellfish
○ Other:	○ _____	○ _____
○ _____	○ _____	○ _____

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?: