Patient Profile

Name:____ Date of Birth:_______________________

Address:____

(Street) (City) (State) (Zip)

Home#: (   )______________________ Work#: (   ) ___________________

Email:______________________________________ Preferred Contact Method: email/cell/work/home

Marital Status: _________________________ Sex: Male/Female SS#: _________________________

How did you hear about us? ____

Referring Physician: ____ Phone # (   ): _______________________

Primary Care Physician: ____ Phone # (   ): _________________________

Language: ____________________________ Race: ________________ Ethnicity: Latino/Not Latino/Decline

Next of Kin/Emergency Contact & Phone #: ____

Occupation: ______________________________ Employer: _____________________________________

If you are being seen for an injury, please indicate if it is the following: [] Work injury claim [] School injury claim

INSURANCE INFORMATION: (If you have Medicare and a secondary plan, please inform the receptionist)

Insurance Carrier: ____ Member ID#: ________________________

Name of Insured: ___________________________________ Relationship to Insured: Self/Spouse/ Child/Other

Insured's Date of Birth: ________________________ Insured's SS# ________________________

I authorize Orthopedic Specialists to release medical information that may be necessary to request reimbursement by my insurance company to whom I have submitted claims. I understand I am responsible for all medical fees during my treatment with Orthopedic Specialists. If surgery is required I assign all medical and or surgical benefits to include major medical benefits to which I am entitled to Orthopedic Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of assignment is to be considered as valid as an original. I understand that this office does not accept returns or issue refunds for any durable medical equipment. I understand that all refunds for my account must be requested by myself or my guarantor, and may take up to 90 days to process. I have reviewed this office's Notice of Privacy Practices, which explains how medical information will be used and disclosed. This includes the knowledge that all communications via email are not secure, and any information I send/receive is also not secure.

In the event I should need surgery, I understand Dr. Cook, Noack, and Grantham are in partnership with a group of surgeons and Texas Health Resources in the ownership of Texas Institute for Surgery.

By signing below, I acknowledge that I have read the above information.

Signature:____ Date:_________________________

Orthopedic Specialists
8440 Walnut Hill Ln., Ste 110
Dallas, TX 75231

Financial Policy

Thank you for choosing our office as your health care providers. We are committed to providing excellent health care services. As part of our professional relationship, it is necessary that you have an understanding of our financial policy.

ALL PARENTS/PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING ANY TREATMENT.

You understand and accept that it is your responsibility to:

Provide us with your current active insurance at every visit. Failure to do this may prevent this office from filing your claims to meet insurance timely filing deadlines, and you will be financially responsible for any services denied. Failure to do this may prevent this office from filing your claims to meet insurance timely filing deadlines, and you will be financially responsible for any services denied.

Provide us with your current billing and contact information. You may call us at any time to update this information. Know and understand your contractual insurance benefits including if we are participating providers for your insurance plan.

Copays, deductibles, and coinsurances are due at the time of services rendered.

All fees collected at the time of service are estimates based on your plan benefits verified through your insurance, and you may receive additional charges or a credit after insurance has processed all claims.

You will receive a statement (to the billing address you provide) notifying you of any balance due on your account. If you have any questions, it is your responsibility to contact our billing department within 30 days of receipt of your statement.

Refunds can only be issued after your insurance has processed all outstanding claims, and may take up to 90 days to process.

Failure to keep your account balance current may require us to cancel your appointment.

You will be charged a **$25 Returned Check Fee** for any checks that the bank returns unpaid for any reason as well as any credit card chargebacks.

You may be charged a **NO SHOW Fee of $35** if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

WE ACCEPT CASH, CHECK, MASTERCARD, VISA, AND DISCOVER.

By signing this form, you acknowledge you have read, understand, and accept this policy.

Guarantor Signature: ____ Date: _________________________

HIPAA AUTHORIZATION

I, ____ give permission to all my health care providers and payers to release and release my protected health information described below to:

Name(s):	Relationship:
____	_________________________________
____	_________________________________
____	_________________________________

Health information to be released (check all that apply):

[] My complete medical records (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions) OR

[] My complete medical records, as noted above, with the exception of the following information:

(Check as applicable):

[] Mental health records

[] Communicable diseases (including HIV and AIDS)

[] Alcohol / drug abuse treatment

[] Other (please specify) ____

This medical information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes or related reasons.

This authorization will be effective until

(Check one):

[] All past, present and future periods OR [] Date or event: ______________________________

unless I revoke it. (NOTE: You can revoke this authorization in writing at any time by notifying your healthcare providers, preferably in writing.)

Name of the person granting this authorization: ____

Signature of the person granting this authorization: Date:

____ ________________________

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General Patient Consent for Care Form

General Consent to Care:
I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, including injections, as ordered by a provider, while such medical care and treatment is provided through Orthopedic Specialists (Drs. Cook, Noack, & Grantham) on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.
I agree and acknowledge that Orthopedic Specialists is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Orthopedic Specialists facilities.

Telemedicine:
I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

To the Patient:
You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent
I hereby give my consent to treatment below to receive medical care and/or treatment from the providers of Orthopedic Specialists.

Name: ____ Date of birth ________________
Signature of Patient__________________________________ Date________________________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.
_____________________________________ [ ] Patient under 18 years of age

Signature of Patient or Legal Guardian: _____________________________________
Date: __________________

Printed Name of Patient or Legal Guardian: ____
Relationship to Patient: _____________________________________

This consent to medical treatment will expire 12 months from the date signed until revoked in writing

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Patient Questionnaire

PATIENT NAME:____ DATE: __________________

Please describe the problem you are here for today: [] Left [] Right [] Shoulder [] Elbow [] Wrist [] Knee [] Other (Please explain below)

____

How long have you had the problem? _______________________________ Date of injury (if applicable): __________

If it is an injury, how did the injury happen and where did it occur: ____

Is this a work related injury? _______ Yes _____NO

Please check mark the type of symptoms you have: (check all that apply)

[] Sharp [] Aching [] Stabbing [] Dull [] Cramping [] Throbbing [] Pins & Needles [] Numbness [] Constant [] Intermittent

On a scale of 1-10, how severe is the pain? No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

What makes it worse ____

What makes it better ____

Do you walk with an assistive device? [] Cane [] Crutches [] Walker

What physician(s) have you seen for this problem? ____

Did you bring: []X-rays [] MRI []CT []Bone Scan [] None

MEDICAL HISTORY: Please check any health issues that apply to you: [] No medical problems

[] AIDS/HIV
[] Alcoholism
[] Alzheimer's
[] Anemia
[] Rheumatoid Arthritis
[] Asthma
[] Blood clot, leg
[] Blood clot, lung
[] Stroke

[] Cancer, breast
[] Cancer, colon
[] Cancer, lung
[] Cancer, prostate
[] COPD
[] Depression
[] Diabetes, I or II
[] Drug abuse
[] Sleep apnea

[] Gout
[] Heart attack
[] High blood pressure
[] Hepatitis
[] Kidney problems
[] Arthritis
[] Seizures
[] Bleeding ulcers
[] Use of blood thinners

[] Childhood diseases
[] Liver problems
[] Bleeding problems
[] History of infections
[] Neuromuscular disorder (Parkinson's, etc)
[] Other heart problems

Please describe any other health problems you have not checked in the above list:______________________________
____
____

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Patient Questionnaire

PATIENT NAME:____ **DATE:** ____________________

SURGICAL HISTORY: Please list any surgeries you have had in the past

____

____

Have you ever had general anesthesia? [] Yes [] No If yes, any problems? [] Yes [] No

CURRENT MEDICATIONS: Please list prescription and over the counter medications

Name of medication:	Dosage:	How often do you take it:
______________________________	__________________	______________________
______________________________	__________________	______________________
______________________________	__________________	______________________
______________________________	__________________	______________________
______________________________	__________________	______________________
______________________________	__________________	______________________
______________________________	__________________	______________________
______________________________	__________________	______________________

ALLERGIES: ____

____

FAMILY MEDICAL HISTORY: Please check any of the following family medical problems (immediate family)

[] Heart problems
[] Asthma/emphysema
[] Bleeding problems
[] Drug abuse
[] Psychiatric problems
[] Alcoholism
[] Stroke
[] Anesthesia problems
[] Tuberculosis

SOCIAL HISTORY: [] Employed [] Student [] Disabled [] Retired

Do you smoke: [] Yes [] No If yes, how many per day? __________ if no, have you smoked in the past regularly? _______
Shoe size: ______

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Fall Risk Assessment

Complete if you are 65 years of age or older

Please circle **YES** or **NO** for each statement below:

YES (3) NO I have fallen more than once in the past year.

YES (2) NO I have fallen once in the past year.

YES (2) NO I use or have been advised to use a can or walker to get around safely.

YES (1) NO I sometimes feel unsteady or lose my balance when walking.

YES (1) NO I sometimes steady myself by holding onto furniture or walls.

YES (1) NO I need to push myself up from out of a chair with my hands.

YES (1) NO I sometimes have trouble stepping up onto a curb.

YES (1) NO I frequently have to rush to the toilet.

YES (1) NO I have lost some feeling in both of my feet.

YES (1) NO The medication I take sometimes makes me feel light headed or sleepy.

YES (1) NO I take medicine to help me sleep or improve my mood.

YES (1) NO I often feel sad or depressed.

________ Total Add up the number of points from your circled answers.

If you scored 4 or more points, you may be at risk for falling. Please discuss ways that may help prevent future falls with your physician.

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