

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? <input type="checkbox"/> Yes <input type="checkbox"/> No | Former name, if applicable: | Social Security No: | Birth date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> 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: | | Phone: | | Fax: | |
| 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 | | | | | |
| <ul style="list-style-type: none"> 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.

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

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 in detail 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 |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Locking | <input type="checkbox"/> Tingling in Arms |
| <input type="checkbox"/> Cracking Sensation | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Tingling in Legs |
| <input type="checkbox"/> Decreased Mobility | <input type="checkbox"/> Night Awakening | <input type="checkbox"/> Tenderness |
| <input type="checkbox"/> Difficult Sleeping | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Instability | <input type="checkbox"/> Popping | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Limping | <input type="checkbox"/> Spasms | <input type="checkbox"/> Enlarged Bruise |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Clicking | <input type="checkbox"/> Warmth |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Grating | |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | |

| | |
|--|--|
| What Makes Symptoms Worse? | |
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Movement |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Pushing |
| <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Descending Stairs |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Other _____ |

| | | |
|---------------------------------------|---|--------------------------------------|
| Relieved by | | |
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Injection | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Massage | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Elevation | <input type="checkbox"/> Pain/RX Meds | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Mobility | |
| <input type="checkbox"/> Heat | <input type="checkbox"/> OTC Medicines | |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Physical Therapy | |

| | |
|--------------------------------------|------------------------------------|
| Types of Pain | |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Piercing |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Discomfort | |
| <input type="checkbox"/> Other _____ | |

| | | | | |
|---|--|---|--|---------------------------------------|
| ARE YOU CURRENTLY EXPERIENCING? (REVIEW OF SYSTEMS) | | | | |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Significant Weight Change | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Cough/Cold Symptoms | |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Chronic Headache | |
| | <input type="checkbox"/> 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:

| | | |
|---|--|--|
| <input type="radio"/> None <input type="radio"/> Latex <input type="radio"/> Adhesives <input type="radio"/> Other: <input type="radio"/> _____ | <input type="radio"/> None <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____ | <input type="radio"/> None <input type="radio"/> Peanuts <input type="radio"/> Shellfish <input type="radio"/> _____ <input type="radio"/> _____ |
|---|--|--|

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
- High Blood Pressure
- 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 Erythematosus
- Spinal Stenosis
- Spondyloarthropathy
- Traumatic Arthritis
- Thyroid Disease
- Valvular Disease

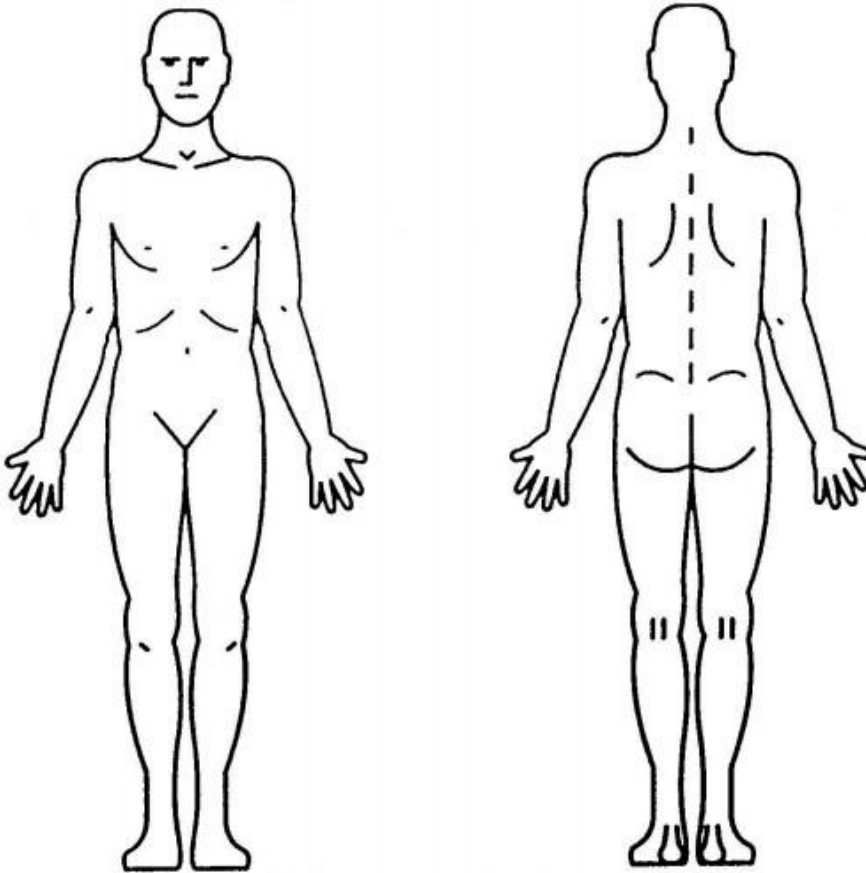
Social History**Circle your responses**

| | | | | | |
|--|--|--|----------|---|--|
| 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 <input type="checkbox"/> | | Former Smoker <input type="checkbox"/> | | Non-Smoker <input type="checkbox"/> | |
| If current how often?: | | How many per day: | | Interested in Quitting? 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?: | | | |

Name: _____ DOB: _____
 Today's Date: _____ Time: _____

On the diagrams below, mark the areas on your body where you feel the sensations described below using the appropriate symbol(s). Mark the areas of radiation, including all affected areas.

Aching Numbness Pins & Needles Burning Stabbing
 +++++ ===== 0000 xxxxx ////



Pain Intensity Scale

Circle the area on the scale below that best describes how you rate the intensity of the pain that you are experiencing:
 "0" being no pain and "10" being worst possible pain

| | | | | | | | | | |
|---------|---|---|---|----------|---|---|---|---|-------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No Pain | | | | Moderate | | | | | Worst |
| | | | | | | | | | |



Disclosure of Physician Ownership

Dear Patient:

Dr. Vudhi Slabisak, MD is the owner of NTOS, LLC and has ownership and/or investment interests in:

Legent Health:

Legent Hospital for Special Surgery, Plano, TX, Legent Outpatient Surgery Frisco Neuro

Vital, LLC

Vital Assistance, LLC

Callie Anesthesia, LLC & Clover Anesthesia, LLC P5

Performance Concepts, LLC

Dr. Bruce Markman has investment interests in Peak Health Surgicare Richardson

Dr. James Stanley has investment interests in Peak Health Surgicare Richardson

Services provided by these facilities may be out of network, and as a result you may receive an out of network bill. However, you have the right to choose the provider of your healthcare services and you have the option to choose the healthcare facility.

You will not be treated differently by Dr Slabisak, Dr. Markman, or Dr. Stanley if you choose to have services performed at a different facility.

I have read and acknowledged the Disclosure of Physician Ownership at NTOS.

Patient/ Legal Guardian Signature

Print Name

Date