Release of Information

The purpose of this form is to alert our office as to those family members and/or friends who may be scheduling or canceling appointments on your behalf and/or will need to have access to your medical information.

Please note: Our office will automatically release information to your listed primary care physician upon request.

To Parents of Minor Children: Please fill out this form if there are stepparents, grandparents or friends who will take part in your child's care.

I, _____ (patient/guardian), give my permissions for the following people to have access to any and/or all of my personal medical information. I understand that I will not be notified if any of the following persons make an inquiry regarding my medical condition(s) or history.

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

_____ _____
Patient Signature Date

If you do not wish for us to disclose your health information to anyone, please sign and date below.

_____ _____
Patient Signature Date

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provisions of healthcare services, Dr. David Y. Liao Orthopedic Center creates and maintains health records and other information describing among other things, my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have a right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices, and prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must: agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

Patients Name (Printed) Date

_____ _____

Patients Signature (Guardian if Minor) Social Security Number

Patient Information

Name: _____ DOB: _____ Age: _____

SSN: _____ Male____ Female _____ Marital Status: S M D W

Mailing Address: _____ Apt No: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Work Address: _____

Spouse Name: _____ DOB: _____ SSN: _____

Spouse Employer: _____ Phone: _____

If Patient is a Minor or Student

Mother's Name: _____ DOB: _____ SSN: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Father's Name: _____ DOB: _____ SSN: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Emergency Contact (Not Living with you)

Name: _____ Relationship: _____

Address: _____ Phone: _____

Who is your Primary Care Physician? _____ Phone: _____

Pharmacy Name: _____ City: _____
All prescriptions will be electronically submitted to your listed pharmacy

What are you being seen for today?

Please be as detailed as possible so that we may assist you with your problem/injury.

Patient Name: _____ DOB: _____

What problem(s) are you being seen for today? _____

_____

What caused the problem? _____

_____

_____

_____

When did the problem/injury happen? _____

Where did the problem/injury happen? _____

Is this do to a Motor Vehicle Accident?	YES	NO
Is this a Work Related Injury? (Please be aware: that if this a work related injury, we will not be able to bill any type of commercial insurance)	YES	NO
Have you had any prior diagnostic testing (X-Rays, MRI, etc…) associated with this particular problem/Injury?	YES	NO

If yes, where: _____

Have you had any prior treatment or surgeries associated with this particular problem/injury?	YES	NO

If yes, who treated you? _____

When and where were you treated? _____

Name of Physician /Facility /Friend who referred you to us: _____

Signature: _____ Date: _____

Assignment of Benefits

I hereby instruct and direct _____ Insurance Company to pay, by check, made out and mailed to:

Dr. David Y. Liao, D.O.
P.O. Box 835
Terrell, Texas 75160

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make the check out to me and mail to the above address.

I understand that I am responsible for any amounts not covered by my Insurance Company.

I understand that any unpaid amounts over 90 (ninety) days will be submitted for collections and an 18% interest fee will be applied. _____ (Please Initial)

I hereby authorize Dr. David Y. Liao, D.O. to furnish information to the Insurance Carriers on my behalf.

A copy of this authorization shall be as valid as the original.

Patient/Guardian Signature: _____ Date: _____

Attention All Medicare Patients

1. Are you currently residing in any type of Nursing Home, Skilled Nursing, or Assisted Living Facility? YES NO

2. Have you been a resident of any type of Nursing Home, Skilled Nursing, or Assisted Living Facility in the past two months? YES NO

3. If you answered Yes to either of the above questions, please provide the name and address of the Facility and the dates you resided there:

   _____

   _____

Patient/Guardian Signature: _____ Date: _____

(Please note: Our office may need to contact the Nursing Facility in which you reside or have resided, in order to properly care for your needs, due to Medicare's regulations with Consolidated Billing. Your appointment may have to be rescheduled until this information has been obtained.)

Symptoms

Patient Name: _____ Date: _____

If you were injured, was it:

_____ At Home
_____ At Work
_____ Auto Accident

Other: _____

Did your pain come on:

_____ Suddenly _____ Gradually

Is the Pain:

_____ Constant _____ On and Off

Are you able to:

Work	Yes	No
Sleep Normally	Yes	No
Do Daily Activities	Yes	No
Care for Yourself	Yes	No
Function Normally	Yes	No

Approximate Height: _____

Approximate Weight: _____

Have you ever had this problem before _____ When _____
Who treated you: _____

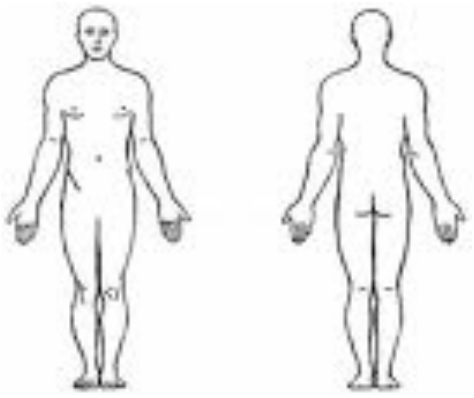
Women Only: Are you able to have children _____ If no, why _____
When was your last menstrual cycle _____Was it normal _____

ARE YOU NOW OR COULD YOU BE PREGNANT YES NO

Using the diagram below: Circle the area(s) of pain and tell us on a scale of 1-10 (1 being the least amount of pain and 10 being the worst), how you rate your pain in each area.

Area 1- Pain is (1-10) _____ Area 2- Pain is (1-10) _____ Area 3- Pain is (1-10) _____

In the figures at the right, please mark your areas of pain or discomfort using these symbols:
+++ Burning //// Stabbing ….. Pins & Needles xxx No Feeling



When or What Activities make the pain worse? _____
What makes the pain better? _____

History

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO
IF YES, WHAT: _____

ARE YOU CURRENTLY TAKING ANY TYPE OF BLOOD THINNING MEDICATION, INCLUDING ASPIRIN? _____ IF YES, WHAT: _____

Current Medications

(Prescription and Over the Counter)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Hospitalizations and Surgeries

Please list all surgeries and periods of Hospitalization (Give Dates)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please mark any conditions that you now have or have recovered from in the past:

___ Severe Headaches
___ Hypertension
___ Stroke
___ Epilepsy
___ Fatigue
___ Dizziness/Fainting
___ Anxiety
___ Shortness of Breath
___ Asthma
___ Chest Pain/Angina
___ Heart Palpitations
___ Heart Murmur
___ Arrhythmia
___ Congenital Heart
___ Rheumatic Fever
___ Anemia
___ Hyperlipidemia
___ Scarlet Fever
___ Allergies/Hay Fever
___ Liver Disease
___ Renal Disease
___ Endocrine Disease
___ Urinary/Genital Dys.
___ Digestive Problems
___ Sexual Dysfunction
___ Ovarian Cysts.
___ HIV/AIDS
___ Diabetes
___ Gout
___ Arthritis
___ Bone Pain
___ Claudication
___ Ulcer
___ Venereal Disease
___ Mental Illness
___ Alcohol/Drug Problem

Family History: Has anyone in your immediate family (Mother, Father, Grandparents, Siblings, etc…) had:

Condition	Who	Condition	Who
Heart Disease	_____	Epilepsy	_____
Hypertension	_____	Glaucoma	_____
Stroke	_____	Bleeding Disorders	_____
Cancer	_____	Kidney Disease	_____
Diabetes	_____	Thyroid Disease	_____

Habits:

Do you now or have you ever smoked? _____ Packs/Day _____ Stopped _____
Do you use alcohol? _____ How Often _____ Amount _____
Coffee or Caffeine? _____ How Often _____ Amount _____
Recreational Drugs? _____ What _____ How Often _____

Narcotics Agreement

The purpose of this contract is to maintain a safe, controlled treatment plan. Controlled substances such as narcotics, tranquilizers and barbiturates are useful but have a high potential for misuse, they are intended to relieve pain (it is unlikely that any medication will take away pain completely) specifically to improve function and/or ability to work. Because my physician may prescribe these medications I agree to the following conditions:

I understand that the possible complications of chronic narcotic therapy include but are not limited to:

- Chemical dependence (addiction)
- Constipation (which could be severe enough to require medical treatment)
- Difficulty urinating
- Drowsiness
- Nausea
- Itching
- Slowed respiration
- Reduced sexual function

If I take more medication than prescribed a dangerous situation could result, such as coma, organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms which can be very uncomfortable or dangerous. If I become pregnant, there are known and unknown risks to the unborn child. I am obligated to let my doctors know if I am pregnant or become pregnant.

The terms of this contract include the following:

Only one pharmacy will be used for filling narcotic prescriptions,

The pharmacy you have selected is: _____

City: _____ Telephone: _____

1. If it is found that I received a prescription for narcotic medications from a source other than Dr David Liao, I will be discharged from Dr. David Y. Liao, D.O. Orthopedic Center, LLC and any prescriptions for narcotic medication will be discontinued.

2. I agree to take the medication exactly as prescribed by Dr. David Liao. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without prior approval from Dr David Liao or a staff member.

3. I agree that Dr David Liao will NOT replace any lost, stolen, or inaccessible narcotic medications or narcotic prescriptions for any reason.

4. I must keep all regular follow up appointments as recommended. Failure to comply may cause discontinuation of narcotic prescriptions and possible discharge from Dr David Y. Liao, D.O. Orthopedic Center, LLC.

5. I agree to comply with random urine, blood, saliva or breath testing to document the proper use of medications.

6. I will not drive a motor vehicle or operate heavy machinery while impaired.

7. I understand that driving a motor vehicle may not be allowed while taking controlled substances and it is my responsibility to know and comply with state laws.

8. I have been given information about the use of narcotic medications and possible risks of side effects including development of tolerance, dependence, addiction, and withdrawal problems due to the medications and I agree to undergo narcotic administration.

9. I agree to NOT hoard medication or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescriptions and possible discharge from Dr. David Y. Liao, D.O. Orthopedic Center, LLC.

10. I agree to the following:

    a) That I am NOT currently abusing illicit or prescription drugs and that I am not undergoing treatment for substance dependence or abuse.
    b) That I have never been involved in the sale, illegal possession or transport of any drugs.
    c) For Women: That I am not pregnant and that I will inform the physician immediately should I become pregnant.

This form has been fully explained to me. I have read it or have had it read to me, and I understand and agree to the terms of this contract. By signing below I understand I am also authorizing Dr David Liao Orthopaedic Center, LLC, David Y. Liao, D.O. and staff to obtain and review my prescription history (this will help insure any medication given will not counteract with any current medication and to obtain current medications and dosages). If any part of this contract as outlined above is broken I understand that it will result in the immediate discharge from Dr. David Y. Liao, D.O. Orthopedic Center, LLC, and discontinuation of narcotic prescriptions.

_____ _____

Patient Signature **Date**

_____ _____

Physician / Witness Signature Date