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 Other

If you circled other, please explain:

____

Signature: ______________________________________ **Date:** ________________

William C. Burns, II, M.D.

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 week? ______________

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:

High Blood Pressure	Rheumatoid Arthritis	Hepatitis A	Arthritis
Heart Disease	Scoliosis	Hepatitis B	Ankle Swelling
Angina (Chest Pain)	Stroke	Hepatitis C	Fracture
Irregular Heartbeats	Seizures	Bowel Disorder	Joint Pain
Heart Attack ________	Epilepsy	Bladder Disorder	Joint Replacement
Rheumatic Fever	Asthma	Kidney Infection	Leg Length Difference
High Cholesterol	lung Disease	Kidney Stones	Cancer
Heart Problems	Pneumonia	Gallbladder Problems	HIV / AIDS
Heart Murmur	Ephysema	Liver Disease	Thyroid Disease
Palpitations	Tuberculosis	Colitis	Nervous Breakdown
Anemia	Chronic Bronchitis	Stomach/Peptic Ulcer	Ulcers
Sickle Cell	Shortness of Breath	Chronic Fatigue	Diabetes
Bleeding Disorders	Sleep Apnea	Lupus	Reflux
hemophilia	Depression	Eye Disease	Jaundice
Bleeding Problems	Bipolar Disorder	Chronic Sinus Problems	Drug Abuse
Blood Clots / Phlebitis	Anxiety/Panic Attacks	Chronic Fever	Schleroderma
Blood Transfusions	Alcohol Abuse	Chronic Skin Problems	

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.

Patient Name:____ **Date:**______________

Current symptoms:

NECK SHOULDER ELBOW WRIST HAND THIGH

BACK BUTTOCK KNEE CALF ANKLE FOOT

Describe your pain: (circle)

Constant VS Intermittent (comes and goes)

Improving VS Getting worse

Does this pain awaken you at night? Yes No

Do you have?: (circle)

Numbness? Yes No If yes, where?:_______________

Weakness? Yes No If yes, where?________________

Bladder or bowel changes? Yes No

Have you had any physical therapy? Yes No If so, when? __________________________

Where?________________________________ **For how long?**___________________________

Have you had any imaging done? (circle)

X-rays MRI CT EMG Bone Scan

Where were they done?____

Dr. William C. Burns, II, M.D.

Patient Name: ____ DOB:________________
First Middle Initial Last

Patient or Parent's SS# ____________________________ Gender: Female Male

Address:_____________________________________ City/State/Zip:_____________________

Cell Phone #:_________________________ Secondary #: ______________________________

Patient's Occupation:____________________ Patient's Employer:_______________________

Name of Primary Care Physician:_______________________ Phone #:___________________

Name of Pharmacy:______________________ Phone #:______________________________

If patient is under 18 years old or lives with parents, please complete:

Father's Name: ________________________ Mother's Name: ________________________

Father's DOB: _________________________ Mother's DOB: __________________________

Father's SS#: __________________________ Mother's SS#: ___________________________

Father's Employer: _____________________ Mother's Employer: ______________________

Contact #: _____________________________ Contact #: _____________________________

Name of Primary Insurance: _____________________ ID #: ___________________________

Name of Insured: _________________________________ DOB:________________________

Do you have a secondary insurance?: Yes No Insurance:___________________________

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 over payment on my account will be refunded.

Patient or Responsible Party's Signature: __________________________ Date:_____________

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

Acknowledgment 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.

Patient or Responsible Party's Signature____________________________

Date:_______________

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

The following financial policies are effective 01/01/2018, and apply to all services rendered on or after 01/01/2018. Please feel free to ask for clarification if necessary.

We ask for your insurance information when we schedule your first appointment, and we made every effort to verify your coverage and benefits. While we do our best to verify that our doctor is in-network with your insurance plan, it is ultimately your responsibility 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 benefits quoted. After you see the doctor we will collect any co-payment, 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. Payments for any outstanding balance is due and payable upon receipt.

Many insurance plans have a requirement that patients must provide additional information to them before they will pay your claim. 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. 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 you 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 you claim paid; however, all charges incurred for your medical care are your sole financial responsibility.

Any co-pay, deductibles, co-insurance and balance due must be paid at check out for services rendered at that visit. If you are unable to pay your portions at the time of your service, we ask that you reschedule your appointment or make prior financial arrangements with our billing representative.

I, (please print name) ______________________________, 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 William C. Burns, II, M.D. regardless of insurance coverage benefits.

Signature:____________________________________ Date: ________________________

William C. Burns, II, M.D.

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

1. Please complete any paperwork in it's entirety.
2. You will be expected to pay any co-pay, deductibles and co-insurance portions at the time of services at check out.
3. Please bring your drivers license and insurance card with you to your visit.
4. We ask that you please contact our office with any address, telephone or insurance changes.
5. Please inform our office 24 hours prior to your appointment in your insurance has changed. If your insurance plan has changed and you fail to notify us at the time of service, you may be responsible for the entire balance due.
6. We ask that you please schedule separate appointments for each injury.
7. As a courtesy to all of our patients, you may be asked to reschedule your appointment if you are more than 20 minutes late.
8. Please turn off cell phones when you are in the exam room.
9. If surgery becomes necessary, there may be a surgery deposit required depending upon your insurance coverage.
10. Your insurance company may require additional information from you in order to process your claim, such as; accident or injury details, other insurance coverage or student status. After your insurance carrier has paid their portion, there may be an amount not covered and balance due.
11. 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.
12. If your insurance plan requires a referral, you must verify that a valid referral is on file with our office prior to your appointment.
13. We do not see auto accidents.
14. Many insurance plans classify procedures such as fracture care, cast and splint application, 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.
15. There is a $30.00 returned check fee. In the event of a returned check, please contact the billing department immediately.
16. 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 fee's, costs of court and other out-of-pocket expenses.
17. There is a charge for any forms that our office must complete or any letters we must write.
18. If this is a work injury you must contact your employer regarding worker's compensation.

I, (please print name) ______________________________, 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 William C. Burns, II, M.D. regardless of insurance coverage benefits.

Signature:____________________________________ Date: ______________________

William C. Burns, II, M.D.

Notice of Financial Interest

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

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 services at facilities other than which is 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.

Signature:_________________________________ Date:_______________

William C. Burns, II, M.D.
Craig Ranch Orthopaedics and Sports Medicine
5575 Warren Parkway
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.

Signature:______________________________________ Date:_____________________