SPINECARE CONSULTANTS

Accurate Diagnosis • Accurate Treatment

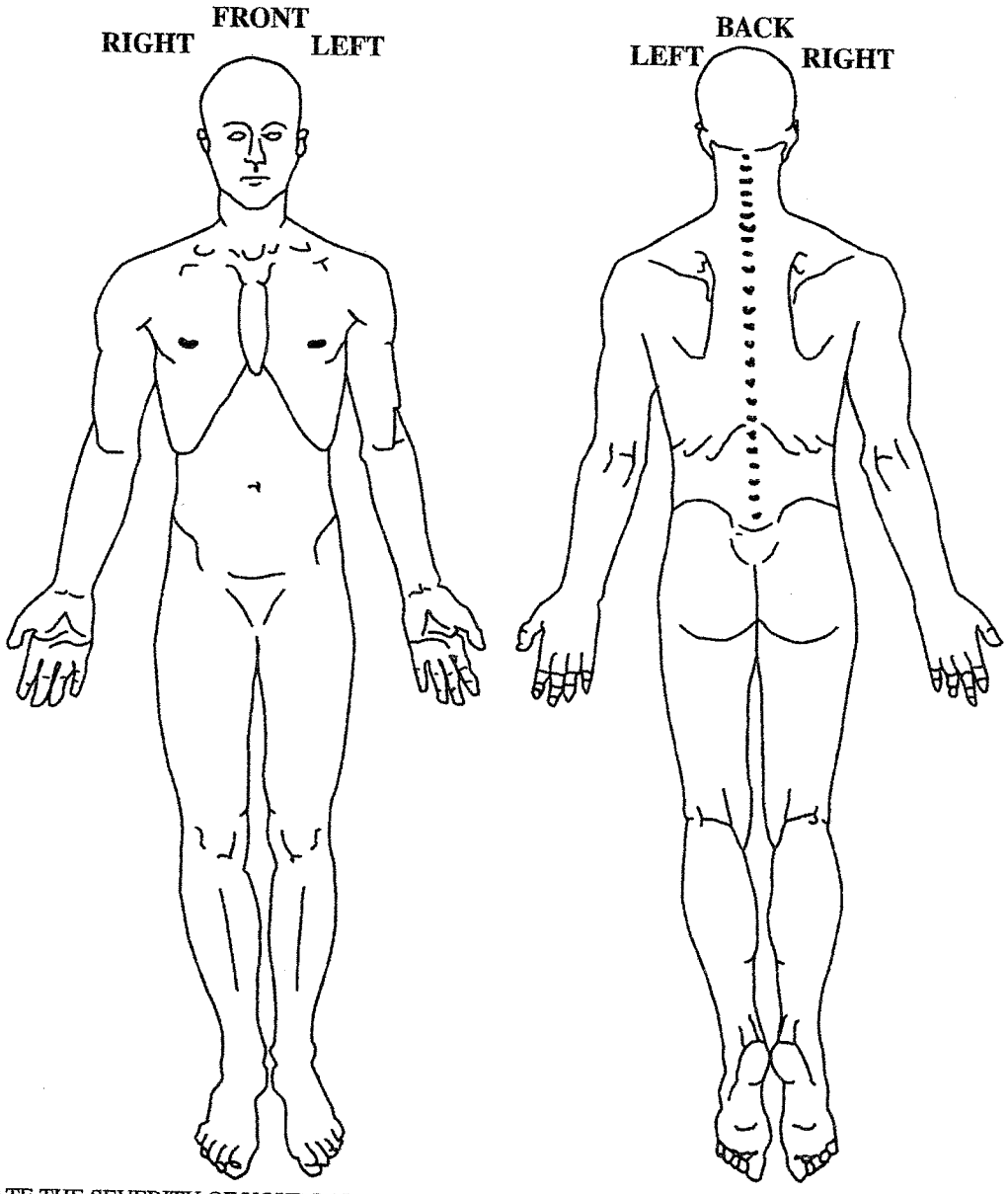
Doctor, McCann & Arthur, L.L.P.

relief starts here...

PAIN ILLUSTRATION

Mark the areas on your body where you feel the described sensations.
Use appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness = = = = = Pins & Needles ooooo Burning xxxxx
Stabbing ///// Chronic Ache zzzzz



ESTIMATE THE SEVERITY OF YOUR PAIN (CHOOSE ONE NUMBER)

0 No Pain 1 Mild Pain 2-3 Moderate Pain 4-5 Moderate to Severe Pain

6-7 Severe Pain 8-9 Intensely Severe Pain 10 Most Severe Pain

PATIENT PLEASE INITIAL _____ Date _____

SPINECARE CONSULTANTS

Accurate Diagnosis • Accurate Treatment

Doctor, McCann & Arthur, L.L.P.

relief starts here...

Initial Medical Questionnaire - CONFIDENTIAL

PAST MEDICAL HISTORY: - Do you suffer from any of the following?

	YES	NO		YES	NO
Chronic Headaches	☐	☐	Urine / Stool Leakage (Incontinence)	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐
Heart Rhythm Disorders	☐	☐	Strokes	☐	☐
Heart Attacks	☐	☐	Muscular Dystrophy	☐	☐
Other Heart Disease	☐	☐	Recent Infections	☐	☐
Diabetes	☐	☐	Reactions to Anesthesia	☐	☐
Thyroid Problems	☐	☐	Sickle Cell Anemia	☐	☐
Asthma	☐	☐	Hemophilia / Easy Bleeding	☐	☐
Emphysema / COPD	☐	☐	Recent Weight Loss	☐	☐
Other Lung Disease	☐	☐	Depression	☐	☐
Heartburn or Ulcers	☐	☐	Suicidal Thoughts	☐	☐
Hepatitis	☐	☐	Cancer	☐	☐
Pancreatitis	☐	☐	Type: _____		
Kidney Stones	☐	☐	Other: _____		

PAST SURGICAL HISTORY:

	YES	NO		YES	NO
Spine (Neck or Back)	☐	☐	Tubal Ligation	☐	☐
Tonsillectomy	☐	☐	Bladder / Kidney	☐	☐
Appendectomy	☐	☐	Bowel / Colon / Ulcer	☐	☐
Gallbladder	☐	☐	Shoulder / Knee / Hip / Joint	☐	☐
Lung	☐	☐	Other: _____		
Heart	☐	☐	_____		
Hysterectomy	☐	☐			

FAMILY HISTORY: - Do your parents, brothers, sisters, etc., suffer from any of the following?

	YES	NO		YES	NO
Heart Disease	☐	☐	Migraines	☐	☐
Hemophilia / Bleeding Disorder	☐	☐	Anesthetic Reactions	☐	☐
Sickle Cell Anemia	☐	☐	Muscular Disorders	☐	☐
Cancer	☐	☐	Other: _____		

SOCIAL HISTORY: - Do you, or have you ever used the following?

	YES	NO		YES	NO
Smoking / Tobacco	☐	☐	Cocaine	☐	☐
Alcohol	☐	☐	Other Street Drugs: _____		
Marijuana	☐	☐	Other: _____		

Work:	☐ Employed	☐ Unemployed	☐ Retired	☐ Homemaker	☐ Disabled
Marital Status:	☐ Married	☐ Separated	☐ Divorced	☐ Single	☐ Widowed
Lawsuits Pending:	☐ Yes	☐ No	☐ Settled		

MEDICATIONS:

ALLERGIES: _____ IODINE: ☐ Yes ☐ No

ALL CURRENT MEDICATION YOU ARE TAKING (NAME, SIZE AND FREQUENCY)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Name (sign please): _____ **Date:** _____

SPINECARE CONSULTANTS
Accurate Diagnosis • Accurate Treatment

Doctor, McCann & Arthur, L.L.P.

relief starts here...

CURRENT SYMPTOM CHECKLIST

Please review the following and check any that currently apply. If this is a follow-up visit, please check only the **new** symptoms that have occurred since you were last seen.

Head & Neck
- ☐ Headahces
- ☐ Visual changes
- ☐ Eye pain or light sensitivity
- ☐ Ringing in the ears
- ☐ Ear pain or drainage
- ☐ Loss of smell or taste
- ☐ Sinus pain or nasal drainage
- ☐ Throat pain or infection

Chest:
- ☐ Painful breathing
- ☐ Shortness of breath
- ☐ Productive cough or infection

Cardiovascular:
- ☐ Chest Pain
- ☐ Irregular heart rhythm
- ☐ Fainting or light-headedness
- ☐ Swelling of the feet or hands
- ☐ Temperature or color change in hands or feet

Abdomen:
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Diarrhea
- ☐ Black/tarry stools
- ☐ Rectal bleeding
- ☐ Constipation

Urological:
- ☐ Painful urination
- ☐ Bloody urine
- ☐ Loss of bowel or bladder control
- ☐ Inability to void
- ☐ Loss of sexual ability

Musculoskeletal:
- ☐ Painful or swollen joints
- ☐ Muscle twitching
- ☐ Recent fractures
- ☐ Spine pain
- ☐ Muscle pain

Neurological:
- ☐ Seizure activity
- ☐ Confusion
- ☐ Numbness or tingling
- ☐ Balance or coordination loss
- ☐ Isolated weakness
- ☐ Paralysis
- ☐ Altered speaking ability
- ☐ Memory loss

Infection:
- ☐ Chronic Headaches
- ☐ Skin breakdown
- ☐ Unhealed wounds
- ☐ Drainage of pus
- ☐ Urinary or abdominal infections
- ☐ Dental infections or abscesses

Psychiatric:
- ☐ Depression
- ☐ Suicidal thoughts or intent
- ☐ Fatigue
- ☐ Loss of interest in pleasurable activities
- ☐ Abnormal anger or violent activities
- ☐ Hallucinations - visual or auditory
- ☐ Excessive daytime drowsiness

Endocrine:
- ☐ Cold or heat intolerance
- ☐ Excessive appetite or thirst
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Urinary frequency
- ☐ Abnormal hair growth or loss

Hematological/Oncology:
- ☐ Easy bleeding or bruising
- ☐ Notable or changing masses or lumps
- ☐ Multicolored or changing moles or markings
- ☐ Excessive weight loss without reason

Allergy/Immunology:
- ☐ Rashes
- ☐ Scaling
- ☐ Itching
- ☐ Wheezing

Skin:
- ☐ Skin discoloration
- ☐ Skin lesions

OB/GYN:
- ☐ Change in cycle
- ☐ Excessive bleeding during cycle
- ☐ Missed cycles
- ☐ Vaginal discharge

☐ **I have had no new symptom changes since my last evaluation.**

Signature: _____ Date: _____

Printed Name: _____

SPINECARE CONSULTANTS
Accurate Diagnosis • Accurate Treatment

Doctor, McCann & Arthur, L.L.P.

relief starts here...

PAIN MEDICATION AGREEMENT

I WILL NOT

I will ***not*** see any other "Pain Management" type physician for my pain management while under the care of this group. All my medication from this clinic cannot be obtained from any other source. In the event of an acute case (dental work or surgical procedure), I must notify my physician in advance.

I will ***not*** use alcohol or illegal controlled substances (cocaine, marijuana, etc.). I have been made aware of the dangerous side effects of narcotic and tranquilizer use alone or in combination with other substances. Thus, I absolve the physicians and staff of any willful negligence.

I will ***not*** share, sell or trade my medication(s) or prescription(s) with anyone.

I will ***not*** attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctors unless approved by my physician in advance.

I WILL

I will provide the physician and staff with all my medical records pertaining to my past pain treatment. I understand that failure to provide such information gives the clinic the right to refuse to treat me.

I will be responsible for my pain medicine, keeping it safe from loss or theft. Lost medications will NOT be replaced. Stolen medication will not be considered for refill until a police report is filed and sent to the doctors' attention.

I will use my medicines at the rate they are prescribed. If I use my medicines at a greater rate, it will result in my being without medication for a period of time. Physicians will NOT authorize any early refills under any circumstance.

I will use only one pharmacy to fill all my prescriptions. I agree to use _____

Pharmacy, located at _____.

telephone number: _____ for filling prescriptions for all my pain medications.

I will agree that no refills will be available during evenings or weekends.

I will agree to authorize the doctor and the pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse or sale etc. of my pain medications. I agree to waive any applicable privilege or the right to privacy or confidentiality with respect to these authorizations.

I will submit to a blood or urine test if requested by my doctor.

I understand all the policies above and my signature below states my agreement to comply. I am aware that if I breach this agreement, then *Doctor, McCann & Arthur, L.L.P.* holds the absolute right to discharge me as a patient.

Signature: _____ **Date:** _____

SPINECARE CONSULTANTS
Accurate Diagnosis • Accurate Treatment

Doctor, McCann & Arthur, L.L.P.

relief starts here...

OBTAIN MEDICAL DOCUMENTATION

Patient's Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

DOCUMENTATION INCLUDED

This document allows *Doctor, McCann & Arthur, L.L.P.* to obtain your (or your dependent's) medical records from other healthcare providers who have treated or are treating you (or your dependent minor).

This authorization applies to any and all of my (or my dependent's - if guardian of minor) medical records including, but not limited to, progress notes, laboratory reports, radiological / nuclear medicine reports, history and physical examinations, consultation reports, electrophysiological studies and any other medical documentation pertaining to my (or my dependent's) care.

_____ (Initials)

I understand that my express consent is required to release any of my health care information pertaining to testing, diagnosis, and/or treatment for AIDS (HIV), sexually transmitted diseases, psychiatric / psychological / mental health disorders, drug or alcohol abuse. I hereby authorize the person(s) below to release to *Doctor, McCann & Arthur, L.L.P.*, or their representatives, all information pertaining to such diagnoses.

Exclusions: _____ ☐ **None** _____ (Patient's Initials)

By signing below, I agree to all the terms and conditions of this document and certify that I have read and understand the above information and its implications. This authorization is valid indefinitely or until I revoke it in writing. I have made any and all exclusions specially known as noted in writing above. A Photostat copy of this authorization is valid as the original.

_____ Date: _____
(Patient/Guardian/Guarantor Signature)

_____ Date: _____
(Witness Signature)

FOR OFFICE USE ONLY

This document shall authorize the person(s) or entity listed below to release to *Doctor, McCann & Arthur, L.L.P.* any and all of the above patient's records as per the above release.

Name: _____

REASON FOR REQUEST:

☐ Coordination of treatment ☐ Obtain information regarding previous treatment(s)

☐ Other: _____

Provider: ☐ Dr. McCann ☐ Dr. Doctor

Fax or send information to: 7505 S. Main St., # 150, Houston, TX 77030 **Fax:** (713) 790-1525
Questions, please call: (713) 790-1500 **Phone:** (713) 790-1500

Provider: ☐ Dr. Arthur

Fax or send information to: 18955 Memorial N., Ste. 420, Humble, TX 77338 **Fax:** (281) 540-0080
Questions, please call: (281) 540-7246 **Phone:** (281) 540-7246

MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Date of Birth: _____ / _____ / _____ **Social Security #:** _____ - _____ - _____

I, _____, patient of _____ (Fondren Physician), am authorizing **Fondren Orthopedic Group L.L.P.** to use and / or disclose my health information as identified below to:

Name of Provider: _____
Address: _____
_____
Phone Number: _____
Fax Number: _____

For the following purpose(s): **[describe each purpose; if requested by the patient, you may state "at patient's request"]**

_____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and / or records, if such information and / or records exist:

_____ All records from _____ (date) to _____ (date)
_____ Initial Exam records
_____ All Office records
_____ All Hospital records
_____ Radiology Images
_____ Laboratory / Pathology reports
_____ Billing / Financial statements

_____ (Initials) **I DO** (_____) or **I DO NOT** (_____) consent to the release of information relating to psychiatric or psychological testing, alcohol and / or drug abuse diagnosis, prognosis and treatment and / or **HIV (AIDS)** testing and / or results.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I also understand that revocation will not apply to information that has already been released as specified by this authorization.

This consent shall become invalid **180 days** from the date signed unless a different expiration date, event or condition is specified. Specify: _____

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
2. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization for this disclosure.
3. I have the right to receive a copy of this authorization.
4. A copy or facsimile (fax) of this authorization **is** as valid as the original.

_____
Signature of Individual or Individual's Legal Representative

_____
Date

_____
Print Name or Print Name of Legal Representative

_____
Relationship to Individual

Mail to: Fondren Orthopedic Group LLP
Medical Records Department
601 Rockmead
Kingwood, TX 77339

or

Fax to: 281-312-3859

Phone: 281-312-3818

Oswestry Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking *ONE* box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the *ONE* spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (i.e. washing, dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (for example: on a table)
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ a mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours of sleep
- ☐ Because of pain I have less than 4 hours of sleep
- ☐ Because of pain I have less than 2 hours of sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. sports)
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Traveling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to receive treatment

Printed Name_____ Date: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO MEDICAL PROVIDERS

PRIVATE – GROUP – HEALTH INSURANCE AUTHORIZATION OF BENEFITS

Patient: _____ **DOB:** _____

Address: _____ **City/State/Zip** _____

Policyholder: _____

Employer: _____ **Group #:** _____

Social Security #: _____ **Policy #:** _____

I hereby authorize and instruct that _____ Insurance Company pay authorized insurance benefits, on my behalf, by check made out and mailed to:

Capitol Medical Management Group, L.L.P.
P. O. Box 4897
Houston, Texas 77210-4897

If my current policy prohibits direct payment to medical provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

_____

c/o Capitol Medical Management Group, L.L.P.
P. O. Box 4897
Houston, Texas 77210-4897

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. *This is a direct assignment of my rights and benefits under this policy.* This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment amount. A photocopy of this Agreement shall be considered as effective and valid as the original.

Signed and dated at the above named practice this _____ day of _____, 2018

Signature of Policyholder _____

_____

Signature of Claimant, if other than Policyholder _____

Capitol Medical Management Group

relief starts here...

RELEASE OF MEDICAL DOCUMENTATION

Patient's Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

DOCUMENTATION INCLUDED

This document allows ***Capitol Medical Management Group*** to release your medical records to other healthcare providers who have treated or are treating you (or your dependent minor) or payors who request these records as allowed by law.

This authorization applies to any and all of my (or my dependent's - if guardian of minor) medical records including, but not limited to, progress notes, laboratory reports, radiological / nuclear medicine reports, history and physical examinations, consultation reports, electrophysiological studies and any other medical documentation pertaining to my (or my dependent's) care.

_____ (Initials)

I understand that my express consent is required to release any of my health care information pertaining to testing, diagnosis, and/or treatment for AIDS (HIV), sexually transmitted diseases, psychiatric / psychological / mental health disorders, drug or alcohol abuse. I hereby authorize ***Capitol Medical Management Group*** to release all information pertaining to such diagnoses.

Exclusions: _____ ☐ None _____ (Patient's Initials)

By signing below, I agree to all the terms and conditions of this document and certify that I have read and understand the above information and its implications. I have made any and all exclusions specially known to *Capitol Medical Management Group* as noted in writing above. This authorization is valid indefinitely or until I revoke it in writing. A Photostat copy of this authorization is valid as the original.

_____ Date: _____
(Patient/Guardian/Guarantor Signature)

_____ Date: _____
(Witness Signature)

☐ ADDITIONAL RELEASE TO:

This document shall authorize *'Capitol Medical Management Group'*, to release any and all of my medical records as understood above to:

Name: _____

Address: _____

REASON FOR RELEASE:

☐ Coordination of treatment
☐ Disability application
☐ Provide information regarding previous treatment(s)
☐ Provide information for legal matters

☐ Other: _____

_____ Date: _____
(Patient/Guardian/Guarantor Signature)

_____ Date: _____
(Witness Signature)

Account Number: _____

THE INFORMATION PROVIDED IN THIS FORM IS CRITICALLY IMPORTANT AND IT IS ESSENTIAL THAT YOU READ THIS DOCUMENT VERY CAREFULLY

Fondren Orthopedic Group L.L.P. relies solely upon the information you provide to us in this statement and in the other documents you will complete in order to collect payment from your Insurance Company. If this information is inaccurate, Fondren Orthopedic Group L.L.P., will be unable to process your eligibility to receive insurance benefits from your Insurance Company, which may inhibit and hamper the processing of your claim.

Furthermore, if the information you present is inaccurate, Fondren Orthopedic Group L.L.P., may not be able to collect payment from your Insurance Company and will need to make other payment arrangements with the person requesting the services provided by Fondren Orthopedic Group L.L.P. *Providing false information on the requested forms is not a good solution and will only result in serious legal consequences in the future.*

This document is to be completed by the insured person named below.

If you do not have private medical insurance, Medicaid or Medicare coverage, please inform us of that fact so we can attempt to make alternative arrangements for your medical care.

Patient Name: _____ (Person seeking medical care)

Insured's Name: _____ (Person completing this form)

Insured's
Employer Name: _____

Insured's
Social Security #: _____

Insurance
Company: _____

Policy Number: _____

Group Number: _____

CERTIFICATIONS REGARDING ELIGIBILTY FOR MEDICAL BENEFITS

Please write your initials beside each statement indicating that you are making the certification stated therein. By writing your initials beside each statement, you are acknowledging that you understand each of these statements and that to the best of your knowledge each of these statements is true and correct. Finally, by writing your initials beside each statement you are agreeing to take any and all action necessary by the statement made therein. If you are unable to make these certifications, please inform Fondren Orthopedic Group L.L.P., of that fact immediately.

_____ I hereby certify that the Insurance Company named above is my current medical insurance provider and that I or my family member is currently entitled to receive any and all medical benefits provided under this policy.

_____ I hereby certify that I am currently employed by the Employer named above and that I have not been terminated nor have I resigned my position with my current Employer.

Account Number: _____

_____ I hereby certify that in the event I am terminated or resign my position with Employer prior to any Fondren Orthopedic Group L.L.P., physician or employee providing any service to Patient, I will inform Fondren Orthopedic Group L.L.P., of the change in my employment status prior to receiving any additional services from any Fondren Orthopedic Group L.L.P. physician or employee.

_____ I hereby certify that in the event there is any lapse in the medical benefits provided by the Insurance Company prior to or during the course of treatment by any Fondren Orthopedic Group L.L.P. physician or employee, I will inform Fondren Orthopedic Group L.L.P. of any lapse in the medical benefits provided by the Insurance Company prior to receiving any additional services from any Fondren Orthopedic Group L.L.P. physician or employee.

_____ If applicable, I hereby certify that my son or daughter is currently enrolled as a full time student (however that is defined by said institution) at _____ and that my son or daughter is not for any reason prohibited from receiving benefits under the Insured's policy.

_____ I hereby bind myself to pay Fondren Orthopedic Group L.L.P. on demand no more than the sum, which shall become due to Fondren Orthopedic Group L.L.P. whenever the Insurance Company shall fail to pay the same for any of the following reasons:

(1) The medical benefits provided by Insurance Company were terminated because the Insured was not employed by Employer at the time Patient sought the services of any Fondren Orthopedic Group L.L.P. physician or employee and was therefore ineligible to receive benefits;

(2) Any statement or representation made by the Insured regarding the existence of medical benefits provided by Insurance Company which are later discovered to be false or otherwise inaccurate and prevents Fondren Orthopedic Group L.L.P. from collecting payment from the Insurance Company;

(3) Any statement or representation made by the Insured regarding the Employer or the Patient (other than medical information), which is later discovered to false or otherwise inaccurate and prevents Fondren Orthopedic Group L.L.P. from collecting payment from the Insurance Company; and

(4) Any other statement or representation made by the Insured, which is later discovered to false or otherwise inaccurate and prevents Fondren Orthopedic Group L.L.P. from collecting payment from the Insurance Company.

I certify that the information I have provided herein is true and correct to the best of may knowledge and I give permission for Fondren Orthopedic Group L.L.P. to make any necessary inquires to verify the statements made herein. I agree to the obligations contained herein and in the other documents accompanying this certification and I hereby acknowledge and understand the purposes for which this information is needed.

By: _____ Signature

_____ Printed Name

_____ Street Address

_____ City, State and Zip

Fondren Orthopedic Group L.L.P.

Patient Name: _____ Clinic ID#: _____

Insurance Company: _____ SS#: _____

Provider Number: 066 Statement Group: _____

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and/or treatment.

I understand this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

MEDICARE – PATIENT'S CERTIFICATION: I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS' COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE coverage.

I have **Medicare Part B** coverage: ☐ Yes ☐ No

If yes, the type of coverage:

☐ Traditional Medicare OR ☐ Medicare Replacement Policy (HMO)

Medicare is my primary or secondary coverage: [-]

I have **Medicaid** coverage: ☐ Yes ☐ No

If yes, the type of coverage is:

☐ Traditional Medicaid OR ☐ Medicaid HMO Policy ☐ Chips Program

Medicaid is my primary or secondary coverage: [-]

I am seeing the doctor for a work-related injury: ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the Fondren Orthopedic Group, L.L.P. of the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.

☐ Payment is required today for all copays, deductibles, or co-insurance amounts that may be due by the patient.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all personal balances incurred as a result of services rendered to me during the course of my medical treatment.

Signature of Insured/Guardian Date

Witness Date

Patient Name: _____ Doctor's Name: _____

Date of birth: _____

Purpose of visit: _____

Due to: ☐ **Illness**

Date of onset: _____

Due to: ☐ **Injury**

Date of injury: _____

Where injury occurred: _____

Have you seen a doctor for this illness or injury?

☐ **Yes** . . . . if yes:

☐ **No**

Approximate date:: _____

Doctor's name: _____

Address: _____

Phone number: _____

Was this related to an automobile accident?

☐ **Yes** . . . . if yes:

☐ **No**

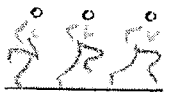
Insurance Company: _____

Agent name: _____

Address: _____

Phone number: _____

Patient's Signature: _____ Date: _____



Fondren Orthopedic Group L.L.P.
7401 S. Main Street
Houston, TX77030-4509
713-799-2300

Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.**, your medical provider, to : (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

Patient's Name _____ Fondren Account Number _____

Patient's Signature _____ Date _____

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

Legal Representative's Name _____

Legal Representative's Signature _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

FONDREN ORTHOPEDIC GROUP L.L.P.

I, _____, acknowledge and agree that I have reviewed a copy of **Fondren Orthopedic Group's Notice of Privacy Practices**.

_____ _____

Patient Signature Date

_____ _____

Signature of Patient's Legal Representative (if applicable) Date

_____ _____

Print Name of Legal Representative Relationship to patient

Clinic Use Only:

Fondren Orthopedic Group, LLP made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]:**

_____

_____

_____

_____ _____

Signature of Employee Date

_____ _____

Print Name of Employee Title

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP), and other doctors/specialists) with whom we may share your information:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What is the best phone number for us to contact you?
Phone Number: _____

What is this number (Home, Work, Cell, Other)? _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such message to include details (such as diagnosis and medication information) at this number?** _____

What other ways may we contact you? Please list any that are acceptable ways to reach you.
Home Phone Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Work Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Cell Phone Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Other: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print name of Patient or Legal Representative Relationship to Patient

2