PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Registration Form

Patient's Information

Last Name:________________________________First Name: _______________________________Middle Initial:_________

Date of Birth:______________________________ Primary Contact Number: Cell Home Work

Cell Phone: ________________________ Home Phone:______________________ Work Phone:_______________________

Email address: ____

Emergency Contact

Full Name:____Relationship:______________________________

Primary Contact Number:__________________________________ Cell Home Work

Alternate Contact Number:_______________________________ Cell Home Work

Contact Preferences

I wish to be contacted in the following manner: (check all that apply) Cell Home Work Email	OK To leave a message with Detailed information? Cell Home Work Email (see email request form)	Leave message with call back number only Cell Home Work Email

Automated Appointment Reminders

Precision Orthopedics has adopted an outside appointment reminder system of which will send you appointment confirmation requests via email 5 days prior, preferred phone two days prior, and a text one day prior to your appointment with limited information for the purpose of notifying you of your appointment time and the provider to which you will be seeing. I authorize my healthcare provider to disclose to this third party service limited Protected Health Information regarding my upcoming appointments. I consent to receiving these messages via email, phone and and/or text (text message rates will apply).

Disclosure of Medical Information

I hereby give permission to Precision Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following individuals (relatives or close personal friends):

Full Name: ____ Relationship: ___________________________

Full Name: ____ Relationship: ___________________________

Full Name: ____ Relationship: ___________________________

I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical conditions

Notice of Privacy Practices

_______ I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
(Initials)

Facsimile Authorization for Coordination of Care

I, the undersigned, authorize POSM to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary **coordination of care** for the patient listed below. **Medical records requests require separate form and authorization from this Facsimile Authorization**. I may revoke this authorization by giving POSM five (5) days written notice. This revocation may be by facsimile transmission; however, a **written copy of the revocation must be mailed to POSM as well.**

Signature:____Date: ___________________________________

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Patient Name: ______________________________

Patient Consent for Treatment

I, knowing that I have a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care to such diagnostic, medical, and/or office based surgical treatment under the general and specific instruction of POSM's physicians and/or any other licensed healthcare service provider, assistants and/or designee as is necessary in their judgment. I also acknowledge that no guarantees have been made to me as to the results of the treatments or examination and that the possible risks, benefits, and complications of the said procedure have been discussed with me by the service provider.

Prescription Refill Policy

Prescriptions will only be written and refilled from Monday through Friday 8:00 am to 4:30 PM. **No prescriptions will be written or called in after these hours or on holidays and weekends**. Therefore, it is your responsibility to closely monitor your supply of medications. We recommend that you make your prescription requests at least 48 hours prior to running out of your prescriptions.

Financial Disclosure Notice to Beneficiary

This is a notice informing you that some and/or all physicians of Precision Orthopedics & Sports Medicine could have an ownership interest in these entities. Your physician's ownership interest means that your physicians may benefit from choosing to perform surgical procedures at one of the following facilities: Baylor Las Colinas, Methodist Southlake, Blue Star Surgery Center, and Pine Creek Medical Center. Because of this, your physician hereby advises you that you have the right to choose to be treated at a different facility, should you desire, and he will make such arrangements, if possible. These facilities are separate legal entities from Precision Orthopedics and Sports Medicine. You will receive a separate billing from each entity.

Financial Agreement

We are dedicated to providing the best possible care to you and regard your understanding of our financial policies an essential element of your care and treatment. This financial policy is intended to clarify these issues.

- Please present your insurance card and photo ID at each appointment. You must provide your most current billing address, all available telephone numbers, email address and any important contact information. If this information changes. it is your responsibility to contact us with your updated information. Your insurance policy is a contract between you and your insurance company. If you did not follow your insurance plan's terms, including obtaining the necessary referral authorizations, they may not pay for all or part of your care, and you may not qualify for any managed care discounts. If your insurance company does not pay within 60 days of the date of service, you may be expected to pay for the balance in full.
- Self-pay patients: There is a minimum deposit of **$375.00** for New Patients and **$250.00** for follow-up patients due upfront for all private pay patients for professional services to include office visit, X-ray, and injections if indicated; durable medical equipment and/or special services will be billed separately. All deposits must be cash or credit card only – no checks accepted. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency. Payment is due at the time the service is rendered unless other arrangements have been made in advance. We accept cash, checks, VISA, MasterCard, Discover and AMEX.
- Some durable medical equipment and/or supplies may not be covered by your insurance requiring payment at time of service.
- We charge for certain forms such as Disability and FMLA forms, as well as medical records.
- Responsibilities for payments for patients who are minor children, whose parents are divorced, rest with the parent who seeks the treatment (This parent is the guarantor.) Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of POSM.
- We bill participating insurance companies as a courtesy to you. If your insurance company requires your social security number to file a claim, you will be required to provide it or pay for services at time of service. **We require that payment of deductibles, co-pays, surgery deposits, non-covered items and co-insurance be paid at the time of service. You are financially responsible for services not covered by your insurance company.**
- We do not bill third party insurance companies such as Auto or Liability Insurance; payment is expected in full at time of service. We will provide you with the necessary paperwork and forms to you to submit your claim to your insurance carrier.
- For ERISA, Out-Of-Network and Self-Funded plans, and Workers Compensation I hereby assign and convey directly to Precision Orthopedics & Sports Medicine, as my designated authorized representative, all insurance reimbursement for services rendered by POSM regardless of its network participation status. I authorize POSM and its billing representatives to negotiate, discuss, appeal and in any other way communicate with my insurance company in determining the final payment for services I received. POSM and its billing representative has full authorization to accept or reject any proposed reimbursement proposal, act in whatever way necessary to accomplish the final adjudication of any and all claims, and the results of that determination is binding.
- If you have a balance after we receive payment from the insurance company, we will mail you a statement to the billing address you provide. Payment in full is due upon receipt. Patients with an outstanding balance 60 days or more overdue must make a payment arrangement prior to scheduling appointments.
- Appointment cancellations within 24 hours of the scheduled time may result in a $50.00 charge. Failure to notify us 48 hours before canceling a surgery may result in a $250.00 charge. Rescheduled surgery will result in a $250.00 deposit that will be added to the surgery amount if surgery is proceeded with, however, if the rescheduled surgery is canceled that deposit will be forfeited. Returned checks for any reason will result in a $35.00 charge.

I/we assign to POSM, and Health care providers, and authorized direct payment to Facility(s) all insurance benefits or Medicare benefits which may be entitled. This assignment includes, but is not limited to, major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injured caused by a third party.

I / we agree to pay Facility(s) for any and all charges not paid pursuant to this assignment. I have read and POSM Patient Consent, Prescription refill, and Financial Policy and agree to abide by its guidelines.

______________________________ ______________________________

Signature of Patient/Parent/Legal Representative Date

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Patient Health History Form

(Please acknowledge each section; simply put "N/A" if it does not apply)

Last Name ________________________________**First Name** ________________________**Date of Birth**________________

Primary Care Physician (full name): ___________________________ **Do you want a report sent to your PCP?** yes no

Who referred you to us (full name)?____

Pharmacy: Name________________________________ City________________ Phone #___________________________

Chief Complaint: What is the main reason for your visit today? Describe problem in detail. (What Hurts)

____

____

____

Side: Left Right Both

How long have you had pain? _____Weeks _____ Months _____Years **Date of Injury:**_____________________

What is your pain quality? Dull Sharp Achy Burning

Where is your pain? Anterior (Front) Posterior (back) Lateral (Outside) Medial (inside)

When is pain the worst? Morning Evening After Strenuous Activity At Night (interferes with sleep)

Pain Level: 1 2 3 4 5 6 7 8 9 10

What actions/activities make the problem worse? Walking Standing Running Bending Lifting Reaching Overhead Activity Driving Sitting Other:__________________________________

What actions/activities make the problem better? Resting Ice Heat Elevation Pain Meds Activity Other_________

Are there any other associated signs or symptoms? Weakness Numbness/Tingling Radiating Pain Instability

Have you had any diagnostic studies or treatments for this problem? If so, when and where?

X-ray MRI EMG CT Ultrasound

Physical Therapy

Injections Bracing Surgery: ____

Other____

Are there any specific treatment options that brought you to us? (i.e. Stem Cell, Visco-supplementation, PRP, PT/OT, etc)

____

____

Past Medical History

Denies Past Medical History

Acid Reflux
A.D.H.D./A.D.D.
Alzheimer's Disease
Anemia
Asthma
Bipolar Disorder
Bleeding Disorder
Blood Clots
Cancer_____________
Cholesterol
Concussion
Congestive Heart Failure
Crohn's Disease
Diabetes – Type ____
Digestive Problems
Emphysema
Gout
Grave's Disease
Heart Attack
Heart Problems
Hepatitis
Herpes Zoster
High Blood Pressure
HIV or AIDS
I.B.S.
Kidney Problems
Leukemia
Liver Problems
Lung Problems
Lupus
Mental Illness
Morbid Obesity
Neoplasm, Benign
Neoplasm, Malignant
Other____________
Pneumonia
Schizophrenia
Seizures
Sleep Apnea
Stomach Ulcer
Stroke
Thyroid Disorder
Tuberculosis

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Patient Health History Form

(Please acknowledge each section; simply put "N/A" if it does not apply)

Past Orthopedic Medical History ***Denies Past Orthopedic Medical History***

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____

Previous Surgical History: ***Denies any Past Surgeries***

Ankle Surgery	Foot Surgery	Lung Surgery	Stomach Surgery
Arm Surgery	Hand Surgery	Neck Surgery	Thyroid Surgery
Back Surgery	Head Surgery	Neuro Surgery	Urology Surgery
Breast Surgery	Heart Surgery	Other_____________	Vascular Surgery
Colon Surgery	Hip Surgery	Reproductive Surgery	Wrist Surgery
Ear/Nose/Throat Surgery	Knee Surgery	Shoulder Surgery	
Elbow Surgery	Leg Surgery	Skin Surgery	

Family History ***Denies any Family Medical History***

Alcoholism	Cancer__________________	Kidney Problems	Respiratory Conditions
Anemia	Diabetes	Leukemia	Seizures
Arthritis	Gout	Mental Illness	Stroke
Asthma	Heart Problems	Musculoskeletal Diseases	Thyroid
Blood Disorders	Hypertension	Other___________________	

List all medications you are taking including vitamins or herbal supplements: ***None*** ***See Attached Listing***

____

____

____

____

List all known drug allergies: ____

Marital Status: Married Separated Divorced Single Widowed Common Law Marriage Domestic Partner

Work Status: Occupation______________________________ Disabled Retired Unemployed Student Homemaker

Are you Pregnant? yes no
Work related? yes no Date of Injury:_________________Occupation: __________________________
Sports related? yes no Date of Injury:_________________
Motor Vehicle Accident related? yes no Date of Accident:_______________

Do you drink alcohol? No Alcohol Yes, daily (___drinks per day) Yes, socially (___drinks per week)
Do you use tobacco? Never Currently (____ pack(s) per day) Formerly
Drug overuse/abuse: Never Currently In the Past

How Did You Hear About Us (please select all that apply):

ER/Urgent Care (please indicate which hospital/urgent care)______________________ Family/Friend______________________
Primary Care Doctor Other Physician Referral_____________________ Other POSM Doctor_______________________
POSM website Google Bing Other Website_____________________________
Social Media Facebook Instagram Twitter
Magazine Southlake Style Living Magazine Other Magazine/Publication___________________
Community Event___________________ Sporting Event___________________ Other Event ___________________
Southlake Chamber of Commerce Irving Chamber Irving Hispanic Chamber Coppell Chamber
Insurance Carrier Recommended Saw the Building Workers' Compensation

Are you interested in learning more about Advance Directives or a Living Will?

By signing below I am verifying that the information provided above is complete and accurate.

Signature: ____**Date:** ______________________________________

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REVIEW OF SYSTEMS

Last Name ______________________________ **First Name** ______________________ **Date of Birth** ______________

Please check any symptoms that you are currently experiencing.

Denies any current review of system symptoms

Constitutional:
- Chills
- Fever
- Headache
- Weight Gain
- Weight Loss
- Fatigue
- Body Aches
- Night Sweats

Eyes:
- Blurred Vision
- Double Vision

Throat:
- Sore Throat
- Difficulty Swallowing

Ears
- Ear Infection
- Nasal Congestion
- Hearing impaired

Nose:
- Nasal Congestion
- Nose Bleeding
- Sinus pain

Respiratory:
- Shortness of Breath
- Wheezing
- Cough

Gastrointestinal:
- Abdominal Pain
- Constipation
- Jaundice
- Diarrhea
- Nausea/Vomiting
- Ulcers
- Laxative use

Genitourinary:
- Urine Hesitancy
- Incontinence
- Urinary retention
- Blood in urine

Neurologic:
- Blackouts
- Dizziness
- Tingling/Numbness
- Seizures
- Tremors
- Sciatica
- Muscular Weakness

Skin:
- Boils
- Itching
- Redness
- Skin Rash

Psychiatric:
- Depression
- Difficulty Sleeping
- Anxiety

Musculoskeletal:
- Back Pain
- Joint Swelling
- Joint Pain
- Neck Pain
- Ankle Instability
- Restricted motion
- Muscle Cramps
- Joint Stiffness
- Muscle Pain

Endocrine:
- Excessive Thirst
- Fatigue
- Cold intolerance
- Heat intolerance

Cardiovascular:
- Chest Pain
- Heart Murmur
- High blood pressure
- Palpitations
- Varicos veins
- Rapid Heart Rate
- Irregular Heart Beat
- Heart Attack
- Rheumatic fever

Hema-Lymph:
- Anemia
- Blood Clotting
- Swollen glands
- Easy Bruising

Allergic/Immunologic:
- Drug Allergies
- Hay Fever

By signing below I am verifying that the information provided above is complete and accurate.

Signature:____ **Date:** ______________________