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: ____________________________________

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

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 (circle type: heat, ice, massage, chiropractic manipulation, ultrasound, traction, exercise)

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

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

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***

____

____

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 ZocDoc 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

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

Signature: ____**Date:** ______________________________

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Patient History Questionnaire
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

HENT:
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Ear Infection
- ☐ Nasal Congestion
- ☐ Nose Bleeding
- ☐ Headaches
- ☐ Sinus Pain

Cardiovascular:
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Hypertension
- ☐ Palpitations
- ☐ Varicosities
- ☐ Rapid Heart Rate
- ☐ Irregular Heart Beat

Respiratory:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough

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

Genitourinary:
- ☐ Urine Hesitancy
- ☐ Incontinence
- ☐ Urinary retention
- ☐ Hematuria

Integumentary:
- ☐ Boils
- ☐ Itching
- ☐ Redness
- ☐ Skin Rash

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

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Swelling
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Ankle Instability
- ☐ Limitation of Motion
- ☐ Muscle Cramps
- ☐ Muscle Pain

Endocrine:
- ☐ Excessive Thirst
- ☐ Tired
- ☐ Too Cold/Hot

Psychiatric:
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Anxiety

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**: _________________________

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

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 **$350.00** for New Patients and **$200.00** 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 $35.00 charge. Failure to notify us 48 hours before cancelling a surgery may result in a $100.00 charge. 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

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Important Information About Provider/Patient Email

As a patient of a Precision Orthopedics & Sports Medicine (POSM), you have the right to request we communicate with you by electronic mail (email). It is also your right to be informed in sufficient detail about the risks of communicating via email with your health care provider or office, and how POSM will use and disclose provider/patient email.

PLEASE READ THIS INFORMATION CAREFULLY
Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition. If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you – and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and/or your PDA have inherent privacy risks – especially when your email access is provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the post office.

Email messages may be inadvertently missed. To minimize this risk, POSM or any of the DBA's will require that you respond appropriately to a test email message before we will allow health information about you to be communicated with you via email. You can also help minimize this risk by using only the email address that you are provided at the successful conclusion of the testing period to communicate with POSM.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. In order to forward or to process and respond to your email, individuals at POSM other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider. Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Patient Request for Email Communications

Communications over the Internet and/or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way. Nevertheless, you may request that we communicate with you via email. To do so, you must complete this form and return it to Precision Orthopedics & Sports Medicine (POSM).

Please be advised that:

1. **This Request applies only to the health care provider within Precision Orthopedics and Sports Medicine.** If you would like to request to communicate via email with another health care provider or office, you must complete a separate Request for that office.
2. POSM will not communicate health information that is specially protected under state and federal law (*e.g.*, HIV/AIDS information, substance abuse treatment records information, mental health information) via email even if we agree to communicate with you via email.
3. Your Request will not be effective until you receive and respond appropriately to a test email message from POSM.

Please provide the following information:

Patient Name: ____ Date of Birth: _______________

Phone number: ___________________________ Email Address: ____

Please select the question you want to use (by checking the one of the boxes below) for your test email and provide your answer.

- The last four digits of my Social Security #: ________________________________
- My mother's maiden name: ________________________________
- My middle name: ________________________________
- The street number of my residence: ________________________________

Please initial each blank and sign below:

- ❒ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.
- ❒ I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL form, and I have read and understand it.
- ❒ I understand and acknowledge that communications over the Internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.
- ❒ I understand that all email communications in which I engage may be forwarded to other providers, including providers not associated with POSM, for purposes of providing treatment to me.
- ❒ I agree to hold POSM and individuals associated with it harmless from any and all claims and liabilities arising from or related to this Request to communicate via email.
- ❒ **I choose to waive the option for any email communications.**

____ __________________________

Patient Signature Date

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Notice of Privacy Practices
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. **Effective Date of this Notice 1-1-2018.**

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, it must be made in writing, and mailed to Precision Orthopedics & Sports Medicine, Attn: Administration, 2120 N. MacArthur Blvd., Suite 100, Irving, TX 75061.

You will not be penalized for filing a complaint.

PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Spine Patients History Form Addendum

Last Name ____________________**First Name** ____________________**Date of Birth**_____________

Do you have numbness? ☐yes ☐no
if *yes*, where is the numbness located?____

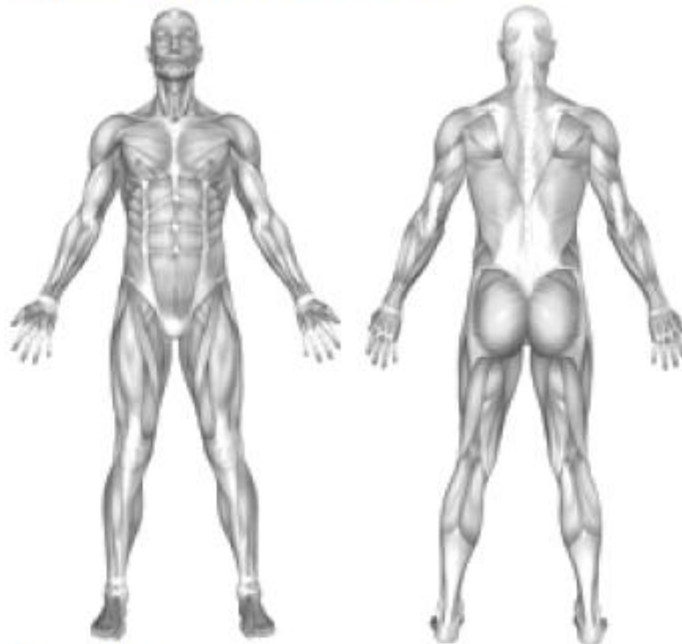
Do you have weakness of any body parts? ☐yes ☐no
if *yes*, where is the weakness located? ____

Do you have normal control of bowel and bladder? ☐yes ☐no
if *no*, what is the problem? ____

Do you have erection problems or sexual dysfunction? ☐yes ☐no
if *yes*, what is the type of problem? ____

Do you use: ☐cane ☐wheelchair ☐crutches ☐braces

Draw on the figures below where
the pain or symptoms are located:



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

Signature:______________________________________**Date:** ______________________________