



**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**

<p>I wish to be contacted in the following manner: (check all that apply)</p> <p><input type="checkbox"/> Cell</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Work</p> <p><input type="checkbox"/> Email</p>	<p>OK To leave a message with Detailed information?</p> <p><input type="checkbox"/> Cell</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Work</p> <p><input type="checkbox"/> Email</p> <p>(see email request form)</p>	<p>Leave message with call back number only</p> <p><input type="checkbox"/> Cell</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Work</p> <p><input type="checkbox"/> Email</p>
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**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: \_\_\_\_\_

## 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**

- Acid Reflux
- A.D.H.D./A.D.D.
- Alzheimer's Disease
- Anemia
- Asthma
- Bipolar Disorder
- Bleeding Disorder
- Blood Clots
- Cancer \_\_\_\_\_
- Cholesterol
- Concussion

**Denies Past Medical History**

- 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

## 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***
- |                                                  |                                        |                                               |                                           |
|--------------------------------------------------|----------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Ankle Surgery           | <input type="checkbox"/> Foot Surgery  | <input type="checkbox"/> Lung Surgery         | <input type="checkbox"/> Stomach Surgery  |
| <input type="checkbox"/> Arm Surgery             | <input type="checkbox"/> Hand Surgery  | <input type="checkbox"/> Neck Surgery         | <input type="checkbox"/> Thyroid Surgery  |
| <input type="checkbox"/> Back Surgery            | <input type="checkbox"/> Head Surgery  | <input type="checkbox"/> Neuro Surgery        | <input type="checkbox"/> Urology Surgery  |
| <input type="checkbox"/> Breast Surgery          | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Other _____          | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Colon Surgery           | <input type="checkbox"/> Hip Surgery   | <input type="checkbox"/> Reproductive Surgery | <input type="checkbox"/> Wrist Surgery    |
| <input type="checkbox"/> Ear/Nose/Throat Surgery | <input type="checkbox"/> Knee Surgery  | <input type="checkbox"/> Shoulder Surgery     |                                           |
| <input type="checkbox"/> Elbow Surgery           | <input type="checkbox"/> Leg Surgery   | <input type="checkbox"/> Skin Surgery         |                                           |

- Family History**       ***Denies any Family Medical History***
- |                                          |                                         |                                                   |                                                 |
|------------------------------------------|-----------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Kidney Problems          | <input type="checkbox"/> Respiratory Conditions |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Gout           | <input type="checkbox"/> Mental Illness           | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Musculoskeletal Diseases | <input type="checkbox"/> Thyroid                |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> 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):**

- |                                                                                                                                                                                          |                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> ER/Urgent Care (please indicate which hospital/urgent care) _____                                                                                               | <input type="checkbox"/> Family/Friend _____                                             |
| <input type="checkbox"/> Primary Care Doctor <input type="checkbox"/> Other Physician Referral _____                                                                                     | <input type="checkbox"/> Other POSM Doctor _____                                         |
| <input type="checkbox"/> POSM website <input type="checkbox"/> ZocDoc <input type="checkbox"/> Google <input type="checkbox"/> Bing <input type="checkbox"/> Other Website _____         |                                                                                          |
| <input type="checkbox"/> Social Media <input type="checkbox"/> Facebook <input type="checkbox"/> Instagram <input type="checkbox"/> Twitter                                              |                                                                                          |
| <input type="checkbox"/> Magazine <input type="checkbox"/> Southlake Style <input type="checkbox"/> Living Magazine <input type="checkbox"/> Other Magazine/Publication _____            |                                                                                          |
| <input type="checkbox"/> Community Event _____                                                                                                                                           | <input type="checkbox"/> Sporting Event _____ <input type="checkbox"/> Other Event _____ |
| <input type="checkbox"/> Southlake Chamber of Commerce <input type="checkbox"/> Irving Chamber <input type="checkbox"/> Irving Hispanic Chamber <input type="checkbox"/> Coppell Chamber |                                                                                          |
| <input type="checkbox"/> Insurance Carrier Recommended <input type="checkbox"/> Saw the Building <input type="checkbox"/> Workers' Compensation                                          |                                                                                          |

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**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

**Gastrointestinal:**

- Abdominal Pain
- Constipation
- Jaundice
- Diarrhea
- Nausea/Vomiting
- Ulcers

**Musculoskeletal:**

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

**Eyes:**

- Blurred Vision
- Double Vision

**Genitourinary:**

- Urine Hesitancy
- Incontinence
- Urinary retention
- Hematuria

**Endocrine:**

- Excessive Thirst
- Tired
- Too Cold/Hot

**HENT:**

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

**Integumentary:**

- Boils
- Itching
- Redness
- Skin Rash

**Psychiatric:**

- Depression
- Difficulty Sleeping
- Anxiety

**Cardiovascular:**

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

**Neurologic:**

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

**Hema-Lymph:**

- Anemia
- Blood Clotting
- Swollen glands
- Easy Bruising

**Allergic/Immunologic:**

- Drug Allergies
- Hay Fever

**Respiratory:**

- Shortness of Breath
- Wheezing
- Cough

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### 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

## **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.

## 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:**

- 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.
- 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.
- 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



## **Notice of Privacy Practices**

### **Your Information. Your Rights. Our Responsibilities.**

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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/](http://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](http://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](http://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.**

## INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

### AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3<sup>rd</sup> Edition: Developed by the Texas Pain Society, April2008 ([www.texaspain.org](http://www.texaspain.org))

NAME OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

**THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.**

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

- To the best of my knowledge **I am NOT pregnant.**
- If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.
- **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.**

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment

plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

**PAIN MANAGEMENT AGREEMENT:**

**I UNDERSTAND AND AGREE TO THE FOLLOWING:**

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

**My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:**

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician.**
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible.** Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

- 1) I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
- 2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
- 3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
- 4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Physician Signature (or Appropriately Authorized Assistant)

\_\_\_\_\_  
Name and contact information for pharmacy