

Orthopedic Associates of Dallas

Today's Date: _____

FOR OFFICE USE ONLY

Acct # _____

Patient Information

Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Email Address	
Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Social Security #	Drivers License #
Occupation	Employer	Employer Address		
Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Spouse's Name	Race (check one) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other		
If Student, Indicate School	If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required):			
Emergency Contact (not living at same address)			Emergency Contact Phone # ()	
How did you hear about the physician you are seeing today? <input type="checkbox"/> Physician Referral (5) Who? _____ <input type="checkbox"/> Other Professional (6) <input type="checkbox"/> Existing Patient (10) <input type="checkbox"/> Family (8) <input type="checkbox"/> Friend (1) <input type="checkbox"/> Word of Mouth (9) <input type="checkbox"/> Baylor Hospital (19) <input type="checkbox"/> Health Plan/Insurance Company (17) <input type="checkbox"/> Emergency Room (7) <input type="checkbox"/> Direct Mail (18) <input type="checkbox"/> 1-800-4-BAYLOR Referral Line (3) <input type="checkbox"/> Website/Internet (13) <input type="checkbox"/> Walk-In (4) <input type="checkbox"/> Newspaper Advertisement (15) <input type="checkbox"/> Radio/TV (16) <input type="checkbox"/> Event (11) <input type="checkbox"/> Location (14) <input type="checkbox"/> Yellow Pages (2) <input type="checkbox"/> Unknown (20)				

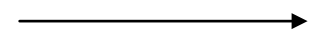
Responsible Party

Guarantor Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Drivers License #	
Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #	Patient Relationship to Guarantor
Employer	Employer Address			

Insurance Information

Name of Primary Insurance Company		Phone # ()	Name of Secondary Insurance Company		Phone # ()
1. Mailing Address			2. Mailing Address		
City		State	Zip	City	
State		Zip	State		Zip
Policy Number	Group Number	Effective Dates of Policy From: To:		Policy Number	Group Number
Effective Dates of Policy From: To:		Effective Dates of Policy From: To:			
Policy Holder (if other than patient)		Date of Birth		Policy Holder (if other than patient)	
Date of Birth		Relationship to Patient		Date of Birth	
Relationship to Patient		Social Security #		Relationship to Patient	
Social Security #		Relationship to Patient		Social Security #	
Relationship to Patient		Policy Holder's Employer		Work Phone #	
Policy Holder's Employer		Work Phone # ()		Policy Holder's Employer	
Work Phone # ()		Employer Address		Work Phone # ()	
Employer Address			Employer Address		
City		State	Zip	City	
State		Zip	State		Zip

(COMPLETE BACK OF FORM)



Orthopedic Associates of Dallas

FOR OFFICE USE ONLY Acct # _____

Patient Name: _____

Accident / Workers Comp

Insurance Company	Phone # ()
Mailing Address	
City	State Zip
Effective Dates of Policy From:	Date of Accident / Onset
To:	Due To: (circle one) Auto accident Work injury / illness Other
Agent / Adjuster / Case Manager	
If Workers Comp: Claim #	TWCC Claim #

Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:
I consent for _____ to authorize evaluation and treatment for my child named
(Name(s): First & Last)
herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Signature of Patient, Parent, or Legal Guardian **Date**

Patient Name: _____

PAST MEDICAL HISTORY:

2) Please check the ones that apply.

- | | | | |
|------------------------------------|--|--|---|
| AIDS/HIV <input type="checkbox"/> | Bleeding Problems <input type="checkbox"/> | COPD <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Migraines <input type="checkbox"/> | Emphysema/Asthma <input type="checkbox"/> | Hepatitis A,B,C <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Anemia <input type="checkbox"/> | Fibromyalgia <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> | Stomach Prob.(Ulcers,Reflux) <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Heart Problems <input type="checkbox"/> | Nerve Probs <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Kidney Problems <input type="checkbox"/> | Pneumonia <input type="checkbox"/> | Blood Clots (DVT,PE) <input type="checkbox"/> |
| Epilepsy <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Psychiatric Disorders <input type="checkbox"/> | Rheumatoid Arthritis <input type="checkbox"/> |
| Gout <input type="checkbox"/> | Muscle Diseases <input type="checkbox"/> | Depression/Anxiety <input type="checkbox"/> | |
| Cancer <input type="checkbox"/> | | | |
- Type:** Breast Prostate Lung Thyroid Myeloma Other _____

Other: _____

PAST SURGICAL HISTORY:

3) Please list any previous surgeries and the dates: _____

SOCIAL HISTORY

- * Do you use tobacco? Y N Packs per day _____ Smokeless varieties _____
- Alcohol use? Y N How often? Daily ___/week
- Marital History: M S D W How many people live with you? _____
- Are you currently working? Y N Retired
- Occupation: _____ Student
- Employer: _____ If not working, how long have you been off work? _____

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

- * Any direct relative with the same Orthopedic condition you are being seen for today? Y N _____
- Diabetes Y N _____ High Blood Pressure Y N _____ Heart Disease Y N _____
- Blood Clots Y N Arthritis Y N _____ Cancer Y N If yes, Type: _____

REVIEW OF SYSTEMS: Do you currently have any of the following medical symptoms? Please check those that apply.

- | | | | |
|-------------------------------------|---|--|---|
| Chest Pain <input type="checkbox"/> | Constipation <input type="checkbox"/> | Abnormal Bleeding <input type="checkbox"/> | Abnormal Menstrual Cycle <input type="checkbox"/> |
| Cough <input type="checkbox"/> | Cold Hands/Feet <input type="checkbox"/> | Growth Disturbance <input type="checkbox"/> | Incontinence of Bowel <input type="checkbox"/> |
| Depression <input type="checkbox"/> | Loss of Appetite <input type="checkbox"/> | Runny Nose <input type="checkbox"/> | Incontinence of Urine <input type="checkbox"/> |
| Ear Pain <input type="checkbox"/> | Muscle Weakness <input type="checkbox"/> | Numbness of feet <input type="checkbox"/> | Sleep Disturbance <input type="checkbox"/> |
| Fainting <input type="checkbox"/> | Impotence <input type="checkbox"/> | Numbness of Hands <input type="checkbox"/> | Sputum Production <input type="checkbox"/> |
| Fever <input type="checkbox"/> | Balance Problems <input type="checkbox"/> | Shortness of Breath <input type="checkbox"/> | Visual Disturbance <input type="checkbox"/> |
| Mania <input type="checkbox"/> | Seizures <input type="checkbox"/> | Sore Throat <input type="checkbox"/> | Swelling in the legs <input type="checkbox"/> |
| Skin Rash <input type="checkbox"/> | Skin Ulcers <input type="checkbox"/> | Wheezing <input type="checkbox"/> | Unexplained Weight Loss <input type="checkbox"/> |
| Vomiting <input type="checkbox"/> | Stomach Pain <input type="checkbox"/> | Weight Gain <input type="checkbox"/> | Other _____ |

Are you independent in normal daily activities? Yes/No Has this changed recently Yes/No

Current Medications: _____

Medication Allergies: Y N If yes, please list: _____

Have you ever had a reaction to anesthesia? Y N

Patient Signature: _____ Date ___/___/___ Reviewed by MD _____ Date ___/___/___

Reviewed by MD _____ Date ___/___/___ Reviewed by MD _____ Date ___/___/___

Orthopaedic Follow-up Survey

Date: _____ Chart # _____ Patient Name: _____

Provider: _____ Date of Surgery (if postop) : _____ Follow-up problem(s) _____

1.) How long has it been since your last visit? _____ Days Weeks Months

PERTINENT INFORMATION REQUIRED:

Changes to Medical History:

Please list any NEW Medications : (E4)

Allergies (New):

★ 2.) Since your last visit are you: Better Worse Same

a. On a scale of 0-100%, how much better are you now? _____ %

★ b. How severe is your pain now? Mild Moderate Severe Extremely Severe

★ c. What has been done for you since your last visit? (Use check box below)

Treatment	Has this helped?
<input type="checkbox"/> Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Brace/ Cast	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Injection	<input type="checkbox"/> Y <input type="checkbox"/> N

INTERVAL HISTORY: Since your last visit, have you:

(E3) 3.) Felt any **new** Numbness Tingling Swelling Weakness [No]

(ROS)
(MS)

(E4) 4.) Developed **new** Nausea, vomiting, blood in stool [No] (ROS)

(E5) 6.) Started or stopped smoking? Y N

(2-9)
(SHx)
(+ 14 ROS + VS)

Patient Signature: _____

M.D. _____

Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby give permission to *Orthopedic Associates of Dallas* to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
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 condition(s).

How to Contact

What is your preferred method of communication with the clinic?

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of communication, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

First Method of Communication

Please tell us your preferred method of communication by checking the appropriate box and providing your contact information below.

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Pager | <input type="checkbox"/> Durable Power of Attorney |
| <input type="checkbox"/> Work Phone | <input type="checkbox"/> Fax | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Letter | |
| <input type="checkbox"/> E-mail | <input type="checkbox"/> Nursing Home | |

Please print clearly:

Patient Name: _____ Patient Identifier #: _____

If above method of communication is by phone, please check the appropriate box:

- OK to leave a message with detailed information.
 Leave a message with call-back number only.

Second Method of Communication

Please tell us an alternative method of communication by checking the appropriate box and providing your contact information below. We will use the alternative method of communication if we cannot reach you using your preferred method of communication.

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Pager | <input type="checkbox"/> Durable Power of Attorney |
| <input type="checkbox"/> Work Phone | <input type="checkbox"/> Fax | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Letter | |
| <input type="checkbox"/> E-mail | <input type="checkbox"/> Nursing Home | |

Please print clearly:

If the above method of communication is by phone, please check the appropriate box:

- OK to leave a message with detailed information.
 Leave a message with call-back number only.

In-Clinic Communication Only

I request that communication regarding my medical condition(s) to occur **only** when I am in the clinic. Please print and hand me information when I am in the clinic. Do not call, mail, or otherwise communicate with me regarding my medical condition(s).

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require my specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal Representative

Date

Name of Legal Representative

Relationship to Patient

HEALTHTEXAS PROVIDER NETWORK NOTICE OF HEALTH INFORMATION PRACTICES

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.

Understanding Your Health Record/ Information

This notice describes the practices of HealthTexas Provider Network (“HTPN”) and that of its physicians¹ with respect to your protected health information created while you are a patient at HTPN. HTPN physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, HTPN physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at HTPN. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at HTPN.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of HTPN, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction, unless the request relates to a restriction on

¹ Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System’s subsidiary, community or affiliated medical centers.

disclosures to your health insurer regarding health care items or services for which you have paid out-of-pocket and in-full.;

- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Compliance Officer at HealthTexas Provider Network, 8080 North Central Expressway, Suite 1700, LB 83, Dallas, TX, 75206.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;

- Subject to certain exceptions under the law, provide notice of any unauthorized acquisition, access, use or disclosure of your protected health information to the extent it was not otherwise secured;

- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;

- Abide by the terms of this notice;

- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;

- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you upon your request at HTPN. The revised notice will also be posted at HTPN offices and on the Baylor Health Care System web page at www.baylorhealth.edu;

- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category

will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment.

For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at HTPN. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at HTPN.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, business associates are also required to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative,

or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fundraising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Baylor Health Care System Office of HIPAA Compliance at 1-866-245-0815.

If you believe your privacy rights have been violated, you can file a complaint with the Baylor Health Care System Office of HIPAA Compliance at 866-245-0815 or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: MAY 20, 2010
VERSION: 3

Patient Name: _____ Patient Identifier: _____



**ACKNOWLEDGMENT OF THE RECEIPT OF
HEALTHTEXAS PROVIDER NETWORK'S (HTPN) NOTICE OF HEALTH INFORMATION
PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians¹ may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's *Notice of Health Information Practices*.**

(Signature of Patient or Legal Representative)

(Date)

May 20, 2010
(Effective Date of Notice)

¹Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

Name: _____
Last First

DOB: _____
mm/dd/yr



HealthTexas Provider Network is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. **The purpose of collecting this information is to ensure that all patients receive high-quality care.**

We would like for you to provide us with your race and ethnic background. We will only use this information to **review the treatment patients receive and make sure everyone gets the highest quality of care.**

First, do you consider yourself Hispanic/Latino? *Of the following choices, please choose the one that best describes your ethnicity.*

- Yes No Decline

Which category best describes your race? *Of the following choices, please choose the one that best describes your race. Race definitions can be found at the bottom of this page.*

- American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
 Black or African American Multiracial
 White Decline
 Asian (includes Pakistan or Indian origins)

What language do you feel most comfortable speaking with your doctor or nurse? *Of the following choices please choose the one that best fits you.*

- English Tagalog Do not know
 Spanish Hindi Decline
 Vietnamese Italian Other (*please provide*): _____
 Chinese Korean Sign Language or other Auxiliary Aid
or Service

Do you require any assistive devices for a hearing impairment?

- Yes No Decline

Do you require assistive devices for vision impairment?

- Yes No Decline

Race Definitions: **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **Multiracial:** A person having more than one or a combination of the above origins