WEST TEXAS ORTHOPEDICS – PATIENT INFORMATION

Date: _____ Dr. _____
How did you hear about us _____ Primary Care Dr. _____
Have you previously been seen by a WTO Dr? _____ Who? _____ When? _____

PATIENT INFORMATION
Last Name: _____ First Name: _____ M.I.: _____
Address:_____ City/State/Zip: _____
Home ph# _____Cell Ph# _____ Work Ph#_____
Consent to Call □Yes □No Email _____
DOB _____ Sex □Male □Female □Single □Married □Widowed □Divorced
SS# _____ Driver's License # _____ State _____
Employer/School: _____ Address: _____
Primary Language _____ Race_____ Ethnicity_____
Medical History Authority? □Yes □No

Guarantor info: Name _____ DOB _____ SS# _____
Address _____ Phone #_____ Relationship _____
Emergency Contact: Name_____ Address_____
Phone#_____ Relationship _____
□Insurance □Medicare □Medicare disability □Medicaid □Cash □Workers' Comp
□Auto ____ at fault ____ not at fault
Primary _____Ins Phone _____
Primary Policyholder's Name _____ DOB _____ SS# _____
ID# _____ Group# _____ Relationship to insured □Self □Spouse □Child □Other
Employer _____ Employer phone _____
Employer address_____
Secondary_____ Ins Phone _____
Secondary Policyholder's Name _____ DOB _____ SS# _____
ID# _____ Group# _____ Relationship to insured □Self □Spouse □Child □Other
Employer _____ Employer phone _____
Workers Comp Info: Employer _____ Date of Accident _____
Employer address_____ Workers Comp Claim #_____
Employer phone _____Employer Fax _____
Description of Accident and Injured Body Part _____
_____
Contact Name_____ Contact Phone#_____

Assignment of Benefits/Release of Medical Information: I authorize West Texas Orthopedics (WTO) to release any medical information that may be necessary to process my medical/surgical claims. I request that payment of my insurance benefits be made on my behalf to WTO for any service furnished to me. This assignment will remain in effect until revoked by me in writing.

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD & DRIVER'S LICENSE.

Disclosure of Interest: Drs. Dean, Nelson, Mallams, Hester and Power have ownership interest in the Texas Surgical Center (TSC), and as a result, may financially benefit from the referral of services to the TSC in the form of increased dividends or distributions. Please let us know if you have any concerns regarding the financial relationship between the doctors listed above and TSC. You do have the option of using an alternative healthcare facility.

Patient or Guarantor _____ Date _____
(rev 3/10/15)

WEST TEXAS ORTHOPEDICS – MEDICAL HISTORY

Last Name _____ First Name _____ MI _____
DOB_____ Age_____ SS# _____ Referred by _____
Describe your current problem/complaint (Specify LEFT or RIGHT body part)_____
_____
Describe how the injury occurred _____
_____
Date of injury or date problem began _____
Was this an on-the-job injury? ☐Yes ☐No Was your employer notified? ☐Yes ☐No
Is the injury/problem due to an auto accident? ☐Yes ☐No At fault? ☐Yes ☐No
Insurance / attorney? _____
Have you had prior treatment for this injury? ☐☐Yes ☐☐No By whom? _____
If yes, please describe treatment _____
Have you had any of the following diagnostic studies for this injury?

X-rays: ☐Yes ☐No Date: _____ Where? _____ Myelogram: ☐Yes ☐No Date: _____ Where? _____
MRI: ☐Yes ☐No Date: _____ Where? _____ Discogram: ☐Yes ☐No Date: _____ Where? _____
CAT Scan: ☐Yes ☐No Date: _____ Where? _____ EMG/NCV: ☐Yes ☐No Date: _____ Where? _____

Family Physician/Location:_____ Cardiologist: _____
Height _____ Weight _____ BMI (body mass index, if known) _____
Is there any possibility of you being pregnant? ☐Yes ☐No (If yes, please tell X-ray tech prior to any x-rays)
History of: ☐Endometriosis ☐Osteoporosis ☐Post-menopausal ☐Hormone Replacements

Pharmacy _____ Location _____
MEDICATION / DOSAGE / FREQUENCY (list additional meds on back)

Food allergies: _____

Medication Allergies **&** reactions:_____

IV contrast? ☐yes ☐no Topical Iodine? ☐yes ☐no

Have you ever had an allergy to Latex? ☐yes ☐no Allergy to metal? ☐yes ☐no Tape allergy? ☐yes ☐no Type_____

Past Medical /Family History	**NOTES: Please Indicate Self or Family Member (Father, Mother, Brother, Sister, Maternal or Paternal Grandfather, or Grandmother)**	**Past Medical /Family History**	**NOTES: Please Indicate Self or Family Member (Father, Mother, Brother, Sister, Maternal or Paternal Grandfather, or Grandmother)**
AIDS/HIV		High Cholesterol	
Anxiety/ Depression		Hypertension	
Arthritis		Kidney Disease	
Asthma		Liver Disease	
Atrial Fibrillation		Meniere's Disease	
Bleeding Disorder		Migraines	
Blood Transfusion		Nasal Polyps	
Respiratory		Orthotics	
Cancer		Osteoporosis	
Chronic ear infections		Pacemaker	
Coronary Artery Disease		Peripheral Vascular Disease	
Deep Vein Thrombosis		Pulmonary Embolism	
Dementia		Rheumatoid Arthritis	
Diabetes		Seizures/Epilepsy	
Difficulty Swallowing		Stroke	
Gout		Thyroid Problems	
Heart Atack or Heart Problems		Tuberculosis	
Hepatitis		Ulcers	
Hernia		Other	

PREVIOUS SURGERIES / HOSPITALIZATIONS / ILLNESSES (include date)

Other information you feel the doctor should know: _____

SOCIAL HISTORY

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed # of Children? _____

Do you currently smoke? ☐Yes ☐No _____ packs per day? Smokeless tobacco products (chew/dip)? ☐yes ☐no

Have you previously smoked? ☐<1 year ☐>5 years Tobacco-years of use _____

Do you drink alcohol? ☐No ☐Rarely ☐1-2 week times a week ☐Daily / how much? _____

Caffeine ____ cups/day coffee/tea ____oz/day soft drinks ____ /day

Do you use recreational drugs? ☐yes ☐no If yes, what? _____

Diet? Regular, Vegetarian, Diabetic, Gluten Free, Cardiac, other_____ General Stress Level? Low Medium High

Do you exercise? ☐Never ☐Rarely ☐Moderately ☐Daily Sporting Activities _____

Hand Dominance (please circle) RIGHT LEFT Is Blood Transfusion Acceptable in an Emergency? ☐yes ☐no

Are you currently employes? ☐yes ☐no Occupation _____ Do you live alone? ☐yes ☐no

Do you have difficulty dressing or bathing? ☐yes ☐no Do you have difficulty walking or climbing? ☐yes ☐no

Deaf or serious diffculty hearing? ☐yes☐no Blind or serious difficulty seeing? ☐yes☐no

History of mental or psychological problems? ☐yes ☐no Describe: _____

History of Methicillin-resistant staphylococcus (MRSA)? ☐yes ☐no

Do you have any non-healing wounds? ☐yes ☐no Do you have any body piercings? ☐yes ☐no Where?_____

Have you had steroids within the last six months? ☐yes ☐no

Have you ever had general anesthesia? ☐yes☐no Did you have any problems? ☐yes ☐no Describe _____

PATIENT PRESCRIPTION POLICY / CONTRACT

Pain medications (Narcotics) can be very useful, but have high potential for misuse and abuse and are, therefore, closely controlled by the local, state, and federal governments. Used properly, they are very effective in relieving pain symptoms. If used excessively, however, they can cause adverse effects such as vomiting, constipation, lethargy, or even death. To insure these medications are used properly, **I agree to the following conditions:**

1. I am responsible for my pain medications. If my prescription is lost, misplaced, stolen, or completely used before the refill date, I understand it will not be refilled.
2. I will not request nor accept pain medications from any other physician or individual while I am receiving such medication from my doctor at West Texas Orthopedics.
3. I agree to use one and only one pharmacy.
4. Refills: Please call your pharmacy regarding refills. All refill requests must be approved by the prescribing physician. Refills may take up to 24 hours for processing. ***Do not call after hours. The on-call doctor will not approve refills.***
5. For all NSAIDS (anti-inflammatory medications) lab work may be required every 6 months.
6. I understand that **if I violate any of the above conditions**, my prescriptions/refills will be canceled and my physician may terminate my treatment and care. If the violation involves obtaining controlled substances from another individual or physician, I may also be reported to my primary physician, local medical facilities, pharmacies or other local authorities.

I attest that the information given above in my medical history is true and correct to the best of my knowledge. I also agree to the terms and conditions outlined in the above prescription contract.

_____ _____

Patient Name (Print) Date

_____ _____

Patient or Legal Guardian Signature Physician signature

(rev 3/11/15)

Authorization Form For Release of Protected Health Information

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by patient, or an agent given medical power of attorney, your private health information and/or treatments will not be disclosed.

By signing this form, I authorize you to use and disclose the protected health information described below.

The health information you may release subject to this authorization is as follows:

☐ Medical ☐ Financial ☐ Other: _____

Release my protected health information to the following person(s)/entity:

Name: _____Relation _____ Phone: _____

Name: _____ Relation _____ Phone: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Privacy Officer West Texas Orthopedics Midland, TX 79703

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.**

_____ _____ _____

Signature of Patient Date of Birth Date

_____ _____

Signature of Personal Representative Relationship to patient (or other authority)

Financial Policy

Thank you for choosing West Texas Orthopedics as your healthcare provider. Our offices are committed to providing the best medical care through communication and understanding. Confirmation and updating of personal address and phone/cell numbers for contact will assure our ability to communicate with you. At any time you have questions or concerns requiring further information, whether it is medical or business, our staff is available to assist you.

The following information outlines our policies regarding the payment of your doctor's bill.

The cost of medical care is determined by the nature and complexity of the illness. There is no *"flat* rate" for examinations and treatment. You are given an **estimated** amount at time of visit before checkout. After reviewing the Physicians/Providers documentation for the visit additional services/procedures maybe added to the visit.

Out-Of-Network Insurance Patients will be expected to pay the Out-of – Network Co-Insurance and Deductibles at the time services are rendered. West Texas Orthopedics will file with your Insurance Company as a courtesy.

Contracted Insurance Patients at each visit, your current insurance card(s) will require presentation when *"signing in" at* the front desk. The Patient, or (in the case of minors) the accompanying Parent/Guardian, will be responsible for any co-pays, deductibles, or non-covered services at the time of the visit. The contracted allowable fees, of the specific contracted insurance, will be considered when payment is requested. Co-pays will not be billed since this is a requirement on your part by your insurance. If the insurance company is unable to process a claim due to inaccurate or missing information from you, you are responsible for the bill.

Non-Insured Patients will be expected to pay in full the estimated total at the time of service.

A statement of your unpaid balance plus additional services not covered by insurance will be sent to you for full payment within 30 days. To avoid collection procedures your account must be kept current.

Please sign to acknowledge you agree and understand policy:

Patient Name Print: _____

Patient or Legal Guardian: _____ Date:_____

Cancellation Policy/No Show Policy
For Doctor Appointments and Surgery

1. ***Cancellation/No Show for Doctor Appointment***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a Fifty dollar ($50) fee; this will not be covered by your insurance company. A patient who is a no-show more than three times is dismissed from the practice.

2. ***Scheduled Appointments***

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

_____	_____	___/___/___
PRINT NAME PATIENT	**SIGNATURE PATIENT/GUARDIAN**	**DATE**

PATIENT ACCOUNT# _____

OFFICE USE ONLY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **West Texas Orthopedics** to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. West Texas Orthopedics has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment. I voluntarily consent to receive medical and health care services provided by West Texas Orthopedics, employees and such associates, assistants, and other health care providers. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that West Texas Orthopedics may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.
Please mark if you agree to accept artificial messages by:

Phone Calls □ Yes □ No **Text Messages □ Yes□ No** **Emails □ Yes □ No**

How to contact our Privacy Officer: West Texas Orthopedics 4214 Andrews Hwy, Ste 208 Midland, TX 79703 or 10 Desta Dr. Ste. 100E Attention: Privacy Officer Telephone:(432) 686-0321 Facsimile: (432) 689-3029

Acknowledgement and Consent

I have reviewed the Notice of Privacy Practices for West Texas Orthopedics. West Texas Orthopedics is authorized to use and disclose health information about patient listed below for treatment, payment and healthcare operations purpose consistent with its Notice of Privacy Practice.

Print Name: _____

_____ _____
Signature of patient Date
(or patient's personal representative)

_____ _____
Name of Personal Representative Relationship to patient
(or other authority)

WEST TEXAS ORTHOPEDICS – LITIGATION POLICY

James Adams, MD; John Dean, MD; David Ferguson, MD; Daniel Nelson, MD;
David Mallams, MD; David Power, MD; Dawn Reeves, PA-C;
10 Desta Dr., Ste. 100-E, Midland, TX 79705; Phone 432-686-0321 / Fax 432-686-0664
4214 Andrews Hwy., Ste. 208, Midland, TX 79703; Phone 432-686-0321 / Fax 432-689-0859

John Dean, M.D. and R. Dawn Reeves, P.A.-C will not see any patient which could result in them or any of their employees being involved in any type of litigation. This includes testimony as a fact witness, testimony as an expert witness, written or oral deposition, or any type of contact whatsoever with an attorney.

If you have retained an attorney, or if you are considering attorney involvement in connection with the medical condition for which you wish to be treated, please understand that you will not be seen under any circumstances – **NO EXCEPTIONS.**

I have read and understand this "Litigation Policy."

_____
Signature

_____
Printed Name

_____
Date

(rev 12/2/14)

WEST TEXAS ORTHOPEDICS – WORKERS' COMPENSATION DISCLAIMER

(PLEASE READ CAREFULLY AND CHECK THE PROGRAM THAT APPLIES TO YOU)

NOT WORK-RELATED:

The injury/condition that I am seeking treatment for today is **NOT** work-related. I will **NOT** be filing a workers' compensation claim. I understand that failure to disclose this information truthfully will result in all charges becoming my responsibility. I understand that in the event I inform my personal health insurance company this injury/condition is work-related, my personal insurance company may not accept responsibility for the charges incurred; therefore, I will be responsible for payment in full.

_____ _____ _____

Print Patient Name Signature Date

WORK-RELATED:

The injury/condition that I am seeking treatment for today **IS** work-related and **I HAVE** filed a workers' compensation claim. I understand that the workers' compensation rules of the State of Texas are as follows:
(Please mark the appropriate box below)

☐ 1. **Workers' Compensation Under Texas Workers' Compensation Guideline**: Your first report of injury must be on file with the workers' compensation insurance company and the first office visit must be approved.

☐ 2. **Non-Subscriber**: Your employer has elected not to carry traditional Texas Workers' Compensation insurance, but does provide coverage for their employees.

☐ 3. **Occupational Workers' Compensation**: Patient must have approval of insurance company prior to initial visit. The insurance company will not offer open medical for life on compensable injury. Occupational policy is for a predetermined time frame and it is your responsibility to know that time frame. Any and all charges after that date will become your responsibility and payment is expected at time of service.

☐ 4. **Employers with no coverage**: Payment is due at the time of service.

a) Employers will need to sign a contract prior to your visit.
b) Payment is due in full at each visit.
c) Employers will need to sign a separate contract regarding any necessary or elective surgical procedures.

_____ _____ _____

Print Patient Name Signature Date

(rev 9/5/14)