

SOUTHWEST ORTHOPAEDIC GROUP[©]

PATIENT INFORMATION

For Office Use Only
Medical Chart Number: _____
Physician: _____

Instructions: All sections must be completed. If not applicable, please indicate as "N/A."

Was this injury sustained on the job? Yes No If so, has a claim been filed with your employer? Yes No

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Nickname _____ Male Female
 Date Of Birth ____/____/____ Age ____ Social Security # _____ - _____ - _____ Marital Status: Single Married Widowed Divorce
 Home Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____ e-mail _____
 Employer/School Name _____ Employed: Full Time Part Time Student: Full time Part time
 Employer/School Address _____ City _____ State _____ Zip _____ Phone (____) _____
 Driver's License # _____ State License Issued _____ Primary Care Physician or Family Physician's Name _____

EMERGENCY CONTACT

Primary Contact _____ Relationship _____ Phone (____) _____ - _____ Hm Wk Cell
 Secondary Contact _____ Relationship _____ Phone (____) _____ - _____ Hm Wk Cell

REFERRED BY

Doctor _____ Hospital/Clinic _____ Patient _____
 Family Member _____ HMO/PPO Directory _____ Employer _____
 Print Advertising _____ Internet _____ School _____
 Other _____

PRIMARY INSURANCE	SECONDARY INSURANCE
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(Please complete blanks with subscribers/primary insurance holders information)
 Subscribers Name _____
 Male Female Date Of Birth ____/____/____
 Social Security # _____ - _____ - _____
 Patient's Relationship to Subscriber _____
 Employer _____
 Employer's Address _____
 City _____ State _____ Zip _____
 Insurance Co Name _____
 Phone # (____) _____ - _____
 Claims Filing Address _____
 City _____ State _____ Zip _____
 Identification # _____ Group # _____

(Please complete blanks with subscribers/primary insurance holders information)
 Subscribers Name _____
 Male Female Date Of Birth ____/____/____
 Social Security # _____ - _____ - _____
 Patient's Relationship to Subscriber _____
 Employer _____
 Employer's Address _____
 City _____ State _____ Zip _____
 Insurance Co Name _____
 Phone # (____) _____ - _____
 Claims Filing Address _____
 City _____ State _____ Zip _____
 Identification # _____ Group # _____

GUARANTOR (if patient is a minor)

Last Name _____ First Name _____ M.I. _____ Male Female
 Date Of Birth ____/____/____ SS#: _____ - _____ - _____ Driver's License # _____ State License Issued _____
 Relationship to patient _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____
 Have you ever been treated by one of the physicians at Southwest Orthopaedic Group? No Yes
 If yes, which physician _____ Approximate date ____/____/____

CONSENT FOR TREATMENT: I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.
FINANCIAL RESPONSIBILITY: I acknowledge full financial responsibility for services rendered. I also understand that payment of charge incurred is due at time of services.
AUTHORIZATION TO RELEASE INFORMATION: I hereby understand and acknowledge I have been provided with a Notice of Privacy Practices. I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.
ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to Southwest Orthopaedic Group. I have read and dully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date _____ Signature (patient, parent, or guardian) _____ Relationship _____

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MEDICAL HISTORY

All sections must be completed. If not applicable, please indicate as "N/A".

Last Name _____ First Name _____ M.I. _____ Male Female
 Date Of Birth ____/____/____ Age _____

Primary Physician (provide first & last name) _____ Height _____ Weight _____ Temp _____

ILLNESSES (Check yes or no. Provide details to all yes answers)		DRUG ALLERGIES (check yes or no)		
<i>Yes</i>	<i>No</i>	<i>Details Medication</i>	<i>Yes</i>	<i>No</i>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems/Pacemaker/Chest Pain _____	If yes, provide details _____	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____		
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Lung Disease/Shortness of Breath _____		
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disorders _____		
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems _____		
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems/Stroke _____		
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots/Phlebitis _____		
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____		
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Bladder Infections _____		
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer/Bleeding _____		
<input type="checkbox"/>	<input type="checkbox"/>	Depression/Mental Illness _____		
<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Change _____		
<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Vision Change _____		
<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat, Mouth Problems _____		
<input type="checkbox"/>	<input type="checkbox"/>	Seizure _____		
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis _____		
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling _____		
<input type="checkbox"/>	<input type="checkbox"/>	Other Illness/Hospitalization _____		
<input type="checkbox"/>	<input type="checkbox"/>	Previous Bone or Joint Problems _____		
<input type="checkbox"/>	<input type="checkbox"/>	Other Sports Injury _____		

Yes No

PREVIOUS SURGERY (type and dates) _____

FAMILY HISTORY (illness, reactions to anesthesia) _____

RECENT TEST RESULTS (EKG, chest x-ray, blood or HIV tests, etc.) _____

RECENT ILLNESSES OR SYMPTOMS _____

SMOKE? (pack/day) _____

DRINK? (how often?) _____

WOMEN ONLY

Pregnant? _____

Birth Control (type) _____

Date Last Period Started _____

Normal? _____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person, except when you have authorized us to do so. I have read and answered completely and accurately.

SIGNATURE: _____ DATE: _____

<i>For Office Use only</i>					
	<i>Date</i>	<i>Initials</i>			
History Reviewed / Updated _____			Weight _____	Blood Pressure _____	Temp _____
History Reviewed / Updated _____			Weight _____	Blood Pressure _____	Temp _____
History Reviewed / Updated _____			Weight _____	Blood Pressure _____	Temp _____
History Reviewed / Updated _____			Weight _____	Blood Pressure _____	Temp _____

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INJURY INFORMATION

For Office Use Only

Medical Chart Number: _____

Physician: _____

Date _____

Last Name _____ First name _____ Date of Birth _____

1. WHAT IS YOUR INJURY:

- Shoulder ____ Right ____ Left
Are you right or left handed? ____ Right ____ Left
- Knee ____ Right ____ Left
- Other _____ (please specify area) ____ Right ____ Left

a) Date of injury _____

b) Was your injury triggered by (check all that apply)?

- Sport _____
- Daily Activity _____
- Other _____
- No specific trigger can be identified

c) How long of you been feeling pain? _____

2. SYMPTOMS

Shoulder (check all that apply)

Pain (check intensity): ____ Mild ____ Moderate ____ Severe

When does the pain occur? (e.g., activity, night, etc) _____

Swelling (check intensity): ____ Immediate (less than 4 hours) ____ Delayed ____ Recurring

Dislocation – Has this happened before? ____ Yes ____ No

Weakness

Is motion restricted? ____ Yes ____ No

Other _____

Knee (check all that apply)

Pain (check intensity): ____ Mild ____ Moderate ____ Severe

When does the pain occur? (e.g., activity, night, etc) _____

Swelling (check intensity): ____ Immediate (less than 4 hours) ____ Delayed ____ Recurring

Pop/snap in knee

Locking/unable to bend or straighten properly

Kneecap unstable

Difficulty with stairs

Difficulty entering or leaving car

Other _____

Other – please specify area _____ (check all that apply)

Pain (check intensity): ____ Mild ____ Moderate ____ Severe

When does the pain occur? (e.g., activity, night, etc) _____

Swelling (check intensity): ____ Immediate (less than 4 hours) ____ Delayed ____ Recurring

Unstable sensation / looseness

Popping or “catch” in joint

Other _____

3. TREATMENT (check all that apply and provide details)

None/Rest _____

Brace/Cast _____

Anti-inflammatory/Medications (for this injury - e.g. Aleve, Advil) _____

Injection _____

Rehabilitation/Therapy _____

Surgery _____

Return to Activity (& Date) _____

4. ACTIVITY

a) Primary sport _____

b) What level? (e.g., college, recreational) _____

c) Other sports _____

d) Runner? ____ miles x ____ days/week = ____ miles/week

e) How does injury affect your daily activities? _____

5. OCCUPATION

a) What is your profession? _____

b) What is your job description? _____

c) How has your injury affect your job? _____

SOUTHWEST ORTHOPAEDIC GROUP©
Payment Policy

Thank you for choosing Southwest Orthopaedic Group for your health care needs. We are committed to providing you with quality health care. The purpose of this payment policy is to advise you of your responsibility for services rendered. If you have any questions regarding this policy before signing please let us know. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at time of visit. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This agreement is part of your contract with your insurance company.
3. **Non-covered services.** Please be aware that some or all services you may receive may be non-covered services or not considered reasonable or necessary by insurer. You are responsible for payment of these services in full at each time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy an identification card (i.e. drivers license) and current valid proof of insurance. If you change coverage it is your responsibility to inform us of coverage changes. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission.** We will submit your claim and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please, be aware that if a balance remains unpaid, we may refer your account to a collections agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find a alternative medical care. During that 30-day period our physicians will only be able to treat you on an emergency basis only.
8. **Missed appointments.** Our policy is to charge for missed appointment not canceled within a reasonable amount of time (at least within 24 hours). These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

I have read and understand the payment policy and agree to abide by its guidelines. In additional, I hereby give Southwest Orthopaedic Group the authority to check my credit when making payment arrangements with Southwest Orthopaedic Group and/or it's contracted credit agency.

Print Patient Name

Signature of patient or responsible party if minor

Date

Southwest Orthopaedic Group

Notice of Privacy 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.

Our Promise To You, Our Patients

Your information is confidential.

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At Southwest Orthopaedic Group, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit Southwest Orthopaedic Group, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- Tool in educating health professionals,
- Source of data for medical research,
- Source of data for our planning and marketing, and
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

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

- Obtain a paper copy of this notice of privacy policies upon request,
- Inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law),
- Amend your health record as provided by 45 CFR 164.526,
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528,
- Request confidential communications of your health information as provided by 45 CFR 164.522(b), and
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522(a) (however, we are not required by law to agree to a requested restriction).

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment, And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken.

For More Information or To Report A Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer, Raehdi Zayed, at (512) 451-1969.

If you believe your privacy rights have been violated, you can either file a complaint with Raehdi Zayed, or with the Office for Civil Rights, U.S. Department of Health and Human Services (ORC). There will be no retaliation for filing a complaint with either our practice or the ORC. The address for the ORC is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment, And Health Operations

We will use your health information for treatment.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

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 operations.

For example:

Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes 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 healthcare and services we provide.

- Business Associates

There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a transcription service we use to transfer dictated patient care into the medical record. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

- 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 ensure the privacy of your health information.

- Funeral Directors

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

- 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 or transplant.

- Fundraising

We may contact you as part of a fund-raising effort.

- Food and Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs, or replacement.

- Workers Compensation

We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers 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.

- Appointment Reminders

We may contact you or a family member at the phone number you have provided to us as a reminder that you have an appointment.

- Marketing

we may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- Directory

Unless you notify us that you object, we will use your name, location in the facility, and general condition for our directory purposes. This information may be provided to members of your family and to other people who ask for you by name.

- Notification

We may use or disclose information to notify or assist in notifying a family member or personal representative (or other person responsible for your care) of your location and general condition.

- Communication With Family

Health professionals, using their best judgment, may disclose to a family member, other relative, or close personal friend (or any other person you identify) health information relevant to that person's involvement in your care or payment related to your care.

- Law Enforcement

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.