

PLEASE PRINT

PATIENT INFORMATION (The Person Seeing the Physician)

PATIENT'S NAME - Last, First, Middle Initial		Email Address		Age	Birthdate
ADDRESS - Number and Street			City	State	Zip
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> M - Married <input type="checkbox"/> S - Single <input type="checkbox"/> D - Divorced <input type="checkbox"/> W - Widow/Widower	Spouse's Name		Patient's Driver's License No.	
Occupation or Student	Patient's Social Security No.	Home Phone (include area code)		Business Phone (include area code)	
Employer Name	Employer Address	City	State	Zip	

IMPORTANT → DO YOU HAVE ANY ALLERGIES? NOT KNOWN NO YES What Kind?

Patient's Personal Physician or Primary Care Physician (PCP)	Referring Physician	Referred By
--	---------------------	-------------

Same as above

RESPONSIBLE PARTY INFORMATION (The Person Who Is Financially Responsible)

RESPONSIBLE PARTY NAME - Last, First, Middle Initial		Address - Number and Street			
City	State	Zip	Home Phone (include area code)		
Resp. Party Social Security No.	Driver's License No.	Employer	Business Phone (include area code)		

EMERGENCY CONTACT

NAME - Last, First, Middle Initial		Relationship	Address - Number and Street		
City	State	Zip	Home Phone (include area code)		

INSURANCE INFORMATION (Please Present Insurance Card to Receptionist)

Do NOT indicate your Worker's Compensation Insurance Carrier here. This must be verified by your employer prior to seeing the Physician.

Type: <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance Plan:	Subscriber's Name (The person who has the policy)	Subscriber's Social Security No.
Insurance Company Name	Insurance Co. Phone No. (include area code)	SUBSCRIBER DATE OF BIRTH
Insurance Company Address	Policy No.	Group No.
Employer, If Group Coverage		
Patient's Relationship to Subscriber: <input type="checkbox"/> S - Self <input type="checkbox"/> W - Wife <input type="checkbox"/> H - Husband <input type="checkbox"/> C - Child <input type="checkbox"/> O - Other	METHOD OF PAYMENT: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> DEBIT CARD <input type="checkbox"/> CREDIT CARD	

Please read before signing - Assignment of Benefits, Medical Release, and Statement of Financial Responsibility

I authorize Plano Orthopedic Sports Medicine & Spine Center, P.A. to release medical information and/or records that may be necessary to request reimbursement from (including but not limited to): insurance companies, HMO's, PPO's, Managed Care Contracting agencies, contracted Independent Physician Associations (IPA's), Texas Department of Insurance Division of Workers Compensation, if injury is work related, Third Party Review organizations contracted by an insurance company to review insurance claims, and/or insurance adjusters, to whom a claim has been submitted. I also give my authorization to have medical records mailed, delivered or FAXed to my Primary Care Physician (PCP), "Gatekeeper" or any other physician responsible for my medical care under a managed care contract (if applicable). I also give my authorization to have my medical record mailed, delivered or FAXed to a consulting physician who may review my medical treatment plan with my Plano Orthopedic Physician. I assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to the physician's Professional Associations of: Drs. Sutker, Barber, Smith, Lund, Troop, Courtney, Crates, Dauber, Carmody, Chaim, Montgomery et al. In the event that I receive a payment from my insurance carrier where my physician has filed the claim on my behalf, I will forward that payment to my physician to have it applied to my account. I understand that an insurance claim will be filed with my primary insurance carrier only (Plano Orthopedic will not file on "Secondary" insurance). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges (for non-work related injuries) whether or not paid by said insurance (less any mandated or contractual adjustments). I understand and agree that I am responsible for responding promptly to my insurance company if they request any additional information or accident report and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred. I understand that any overpayment on my account will be promptly refunded. If an account is established, I authorize Plano Orthopedic Sports Medicine & Spine Center, P.A., to obtain a credit report when necessary in regards to my account. Payments by insurance plans on my account must be made within 60 days of filing, and any co-pay or deductible amounts remaining are due by the responsible party and must be paid in full within 30 days after insurance has paid, or there may be a late fee assessed against my account of 1.5% each month on the unpaid balance. I understand that this form must be updated at least annually, may be updated at each visit, and that I will provide Plano Orthopedic with any changes of address or insurance coverage immediately. Failure to notify Plano Orthopedic of any insurance plan changes, could result in loss of insurance benefits and could make me liable for medical charges. Proof of identity is required (e.g., drivers license) for each patient and/or responsible party. I understand that I need to present my insurance card at each visit, and understand that I may be required by my insurance plan to pay my co-payment at each visit. My email address will be used to notify me of appointments or other medical related issues and will not be sold or delivered to any other entity.

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

SIGNED BY _____ (NAME PRINTED) RELATIONSHIP TO PATIENT IF MINOR: PARENT GUARDIAN

Plano Orthopedic Sports Medicine & Spine Center, P.A.

Universal Injury, Condition and/or Accident Statement

Patient Name _____
Full Name

Today's Date ____/____/____

Please complete the following statement. Most Insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury or condition and sign In BOX 4. We must have Box I "Date of Injury or Condition" completed to file your claim.

1 **Date of Injury or Condition:** _____ < (COMPLETE DATE ON OR ABOUT)
Month / Day / Year THIS DATE IS REQUIRED FOR INSURANCE FILING

→ *The following details are required IF this was an INJURY:*

Where did injury occur: _____
(e.g., Auto, home, parking lot, friend's house, etc.; if at work, complete Box 2)

How did injury occur (brief summary): _____

2 Was injury or condition work related? [] YES [] NO < (Required/Please Answer)
If YES then...

Name of Employer: _____ Phone _____

Employer contact or Supervisor: _____ Phone _____

Adjuster's Name (if known): _____ Phone _____

3 Is there a possible third party liability statement (e.g. Auto, Homeowners, Property): [] YES [] NO
If YES then...

Name of Employer: _____ Phone _____

Adjuster's Name (if known): _____ Phone _____

4 I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

Patient's Signature (or Responsible party if patient is a minor)

Date: _____

Plano Orthopedics & Sports Medicine Center

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.

Plano Orthopedics & Sports Medicine Center has adopted the following privacy policies.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of Plano Orthopedics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and Disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

SIGNATURE NEEDED ON THIRD PAGE

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your PHI.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your PHI.
4. The right to amend or submit corrections to your PHI.
5. The right to receive an accounting of how and to whom your PHI has been disclosed.
6. The right to receive a printed copy of this notice.

Plano Orthopedics Duties

We are required by law to maintain the privacy of your PHI and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you do so by sending a letter outlining your concerns.

Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed, and give my permission to Plano Orthopedics & Sports Medicine Center to use and disclose my health information in accordance with it.

Name of Patient

Signature of Patient

Date

Signature of Parent or Guardian

If you would like to indicate a child or spouse to *Discuss* medical information with our Doctors or Physician Assistant please indicate below.

Name

Relationship

Name

Relationship

Name

Relationship

This is not release of MEDICAL RECORDS.

There is a separate form you will need to fill out. Please ask for one if you would like to release your PHI to any other doctor or facility. You will be asked to fill one out if you request your records. The form is available on our website. www.posmc.com.

This authorization will expire in two (2) years from the above date unless written revocation is received.

Past Medical History

Plano Orthopedic Sports Medicine & Spine Center

NAME _____

DATE _____

REFERRING PHYSICIAN _____

You need to fill this form out completely.

AGE _____

SEX _____

HEIGHT _____

WEIGHT _____

1. **PAST MEDICAL HISTORY:** Please indicate by an "X" if any of the following apply to your past medical history.

___ Anemia

___ High Blood Pressure

___ Arthritis

___ HIV

___ Cancer

___ Pneumonia

___ Diabetes

___ Rheumatic Fever

___ Heart Problems

___ Tuberculosis

___ Hepatitis

___ Ulcers

Any Other Problems:

2. **SURGERY:** List every surgery you have ever undergone: What, When and Where

3. **MAJOR ACCIDENTS:** List any accident which required hospitalization, type of injury and date

4. **OTHER HOSPITALIZATIONS:** State reason and dates

5. **ALLERGIES TO MEDICATIONS:**

6. CURRENT MEDICATIONS:

7. ANY OTHER ALLERGIES:

8. SOCIAL HISTORY:

❖ Do you smoke?

YES _____ NO _____ If yes, how much/many per day? _____

❖ Do you drink alcohol?

YES _____ NO _____ If yes, how much and how often? _____

❖ Do you use illicit drugs?

YES _____ NO _____ If yes, what do you use and how often? _____

❖ Are you now or have recently been on any diet medication? *This includes prescription as well as over the counter diet medication.*

YES _____ NO _____ If yes, what medication? _____

Are you currently taking it? _____

❖ Are you now taking any herbal or health food medication/treatment other than vitamins?

YES _____ NO _____ If yes, what are you taking? _____

9. FAMILY MEDICAL HISTORY: Are there any diseases which tend to run in your family? Please list any known diseases.

10. REVIEW OF SYSTEMS: Please circle any problems or symptoms you have had or currently have.

- A. Skin rashes, pressure sores, boils, sores, or lumps under the skin
- B. Headaches, dizziness, fainting spells, convulsions or seizures
- C. Loss of vision, blurred vision, spots before your eyes, double vision, wear glasses
- D. Ringing in the ears, ear infections, drainage from the ears
- E. Bleeding from the nose, trouble breathing from the nose, sinus infection
- F. Need dental care, wear dentures, excessive bleeding from gums, sores in mouth, or sore tongue

- G. Trouble swallowing, frequent sore throats, hoarseness
- H. Shortness of breath, wheezing, “smoker’s cough”, asthma, pain in chest after exercise
- I. High blood pressure, anemia, unusual bleeding or bruising, heart attack, rheumatic fever, heart murmur
- J. Flushing or blushing spells, changes in your ability to tolerate hot or cold weather
- K. Severe acid indigestion, heartburn, ulcers, internal bleeding, jaundice, hepatitis, diarrhea, constipation, passage of blood or mucous from the stool
- L. Kidney or bladder infection, burning when urinating, passage of blood from the bladder, difficulty controlling your bladder or bowel, gallstones, kidney stones, bladder stones
- M. Aching joints, swelling or painful muscles or joints, morning stiffness in hands or feet, back trouble or back injury
- N. Burning or tingling sensation in lower extremities, body, everywhere

Please explain any of the above problems which apply to you.

Please sign below acknowledging that you have filled out this form to the best of your knowledge.

X _____
Patient or Guardian Signature

Date

**Plano Orthopedic
Sports Medicine & Spine Center**

5228 W. Plano Parkway
Plano, TX 75093
972.250.5700



PLANO
ORTHOPEdic
Sports Medicine & Spine Center, P.A.

Disclosure

Allan N. Sutker, M.D., P.A.
Sports Medicine
Arthroscopic Surgery of the
Knee and Shoulder
Orthopedic Surgery

F. Alan Barber, M.D., FACS, P.A.
Arthroscopic Surgery of the
Knee and Shoulder

Purcell Smith, III, M.D., P.A.
Surgery of the Hand, Wrist, Elbow
Orthopedic Surgery

Earl R. Lund, M.D., P.A.
Surgery of the Hand and
Upper Extremity
Arthroscopic Wrist Surgery

Randal L. Troop, M.D., P.A.
Sports Medicine
Arthroscopic Surgery of the
Knee and Shoulder
Orthopedic Surgery

Stephen P. Courtney, M.D., P.A.
Reconstructive Surgery of the
Neck and Back
Orthopedic Surgery

John M. Crates, M.D., P.A.
Orthopedic Surgery
Arthroscopic Surgery
Surgery of the Foot and Ankle

Kenneth S. Dauber, M.D., P.A.
Physical Medicine and
Rehabilitation

Cameron N. Carmody, M.D., P.A.
Reconstructive Surgery of the
Neck and Back
Orthopedic Surgery

Solomon H. Chaim, M.D., P.A.
Surgery of the Foot and Ankle
Orthopedic Surgery

William K. Montgomery, M.D., P.A.
Total Joint Replacement

.....
The Plano Orthopedic physician you are seeing may have a financial interest in the following facilities:

Baylor Medical Center at Frisco
5601 Warren Parkway
Frisco, TX 75034
(214) 407.5000

Surgery Center of Plano
1620 Coit Road
Plano, TX 75075
(972) 519.1100

**Texas Health
Center for Diagnostics & Surgery**
6020 West Parker Rd
Plano, TX 75093
(972) 403-2700

Preston Plaza Surgery Center
17950 Preston Rd, Ste 75
Dallas, TX 75252
(972) 267.5400

Plano Therapy Center
3405 Midway, Ste 500
Plano, TX 75093
(972) 473.0229

Allen Therapy Center
1223 W McDermott, Ste 50
Allen, TX 75013
(972) 359.1288

North Star MRI (Frisco)
8501 Wade Blvd., Ste 220
Frisco, TX 75034
(214) 618.3420

North Star MRI (Allen)
997 Raintree Circle, Ste 110
Allen, TX 75013
(972) 954.8001

North Star MRI (Plano)
3700 W 15th St Bldg D #200
Plano, TX 75075
(972) 758.9000

The facilities and our physicians are committed to providing clinical excellence in a safe and attractive environment for you and your family members. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality care for you.

Should you have any questions or concerns regarding this notice, please ask your physician or a member of his staff.

This verifies that I have read and understood the above statement.

Signature: _____ Date: _____

.....