



**WILLIAM K. MONTGOMERY, M.D.**

5228 W. Plano Parkway  
Plano, TX 75093  
972-250-5700  
972-250-5747 (fax)

Dear Patient,

The following forms need to be filled out before you come to your appointment. Filling out these forms completely and accurately will expedite the registration process. Thank you in advance for your time. We look forward to seeing you in the office.

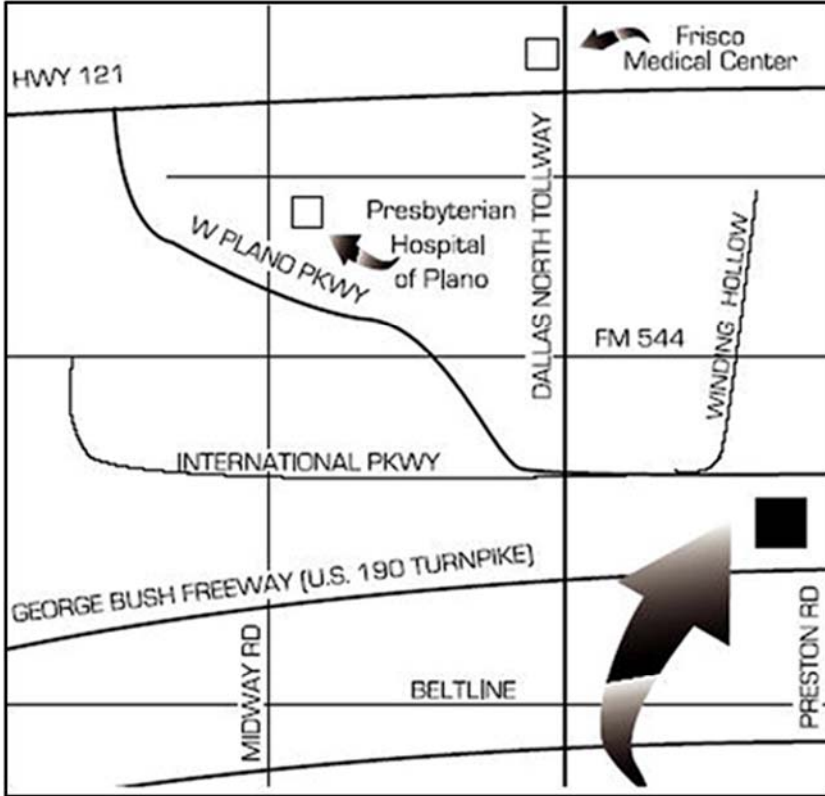
1. Patient Information Form (2 pages)
2. Authorization for Use and Disclosure of Protected Health Information (PHI)
3. Prior Medical History and Review of Systems (4 pages)
4. Patient Assessment and Treatment Outcomes (2 pages)
5. Regarding Insurance Correspondence
6. Medical Record Release Form
7. Universal Injury, Condition and/or Accident Statement

The staff of William K. Montgomery, M.D.



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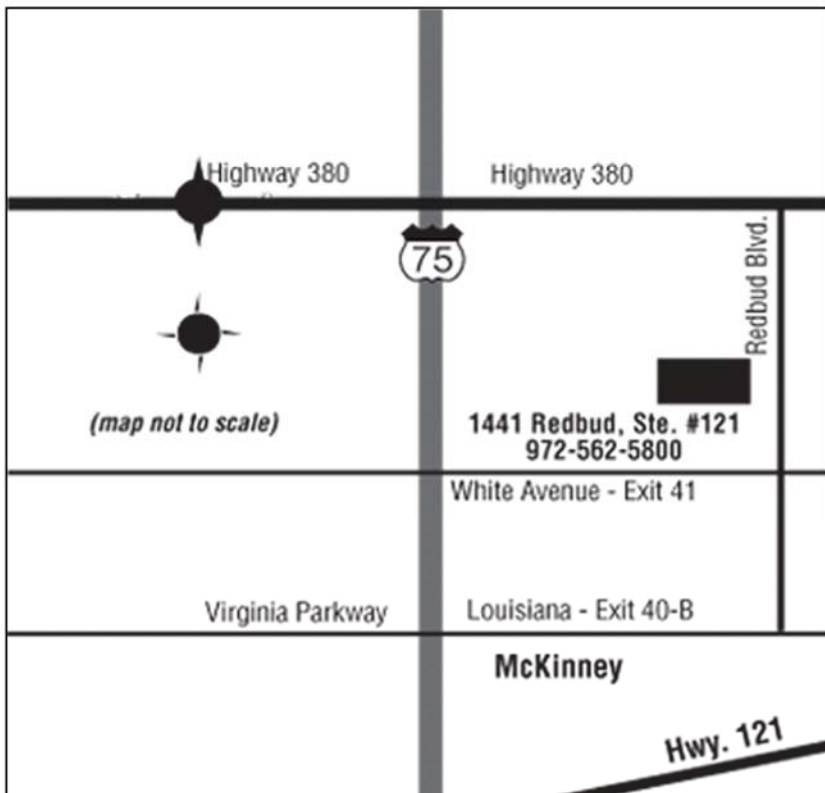


The Plano office is located at:

5228 W. Plano Parkway  
Plano, TX 75093  
972-250-5700  
Fax 972-250-5747

**Driving instructions:**

Exit the Dallas North Tollway onto Plano Parkway and turn east toward Preston. The office is located at the intersectin of Winding Hollow and Plano Parkway, across from Shepton High School.



The McKinney office is located at:

1441 Redbud, Ste. 121  
McKinney, TX 75069  
972-250-5700 (for scheduling)  
972-562-5800 (office)

**Driving instructions:**

Exit U.S. 75 (Central Expressway) onto White Street (Exit 41). Go east to Redbud Blvd. Go north to Heritage Medical Building and turn north into the parking lot.

# William K. Montgomery, M.D.

Date of visit: \_\_\_/\_\_\_/\_\_\_

Patient Name: \_\_\_\_\_

Male ( ) Female ( )      Date of Birth: \_\_\_/\_\_\_/\_\_\_      Age: \_\_\_\_\_

Height: \_\_\_\_\_      Weight: \_\_\_\_\_      BMI: \_\_\_\_\_

If you are having a problem, what is the main complaint you are having?

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Have you seen any other physician for this problem?

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## Physician's Notes:

Duration:

Meds/NSAIDS:

Injections:

Surgeries:

How did you hear about us? \_\_\_\_\_

If you were referred by another doctor, what is the name, phone #, and specialty?

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list any **DRUG ALLERGIES** you may have and the side effects of taking them:

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# PLANO ORTHOPEDIC SPORTS MEDICINE & SPINE CENTER

## UTILIZES

### CERTIFIED PHYSICIAN ASSISTANTS (PA-C)

### DURING YOUR PATIENT CARE

Plano Orthopedic & Sports Medicine Center has on staff Physician Assistants to assist in the delivery of orthopedic medical care. Plano Orthopedic & Sports Medicine Center has utilized Physician Assistants over the past 20 years working as an integral part of our Plano Orthopedic & Sports Medicine Center team.

Physician Assistants are medical professionals and have 4 to 7 years of postsecondary education. A graduate from an accredited PA program must pass the NCCPA-administered Physician Assistant National certifying Exam before becoming a PA-C; this certification is required for licensure in all states. In addition, a PA must earn and log 100 Continuing Medical Education hours and reregister his or her certificate with the NCCPA every 2 years. Every 6 years, a PA must also recertify by successfully completing the Physician Assistant National Recertifying Exam or Pathway II exam.

Physician Assistants are medical professionals and their scope of practice is spelled out in their PA-Physician practice agreement and they cannot practice in a manner other than prescribed by their supervising physician. The physician supervision, in most cases, need not be direct or on-site, and many Physician Assistants practice alone when their supervising physician is in surgery, out of the clinic and in some cases in satellite clinics. Physician Assistants work in hospitals, clinics and other types of healthcare facilities and exercise autonomy in medical decision making as determined by their supervising physician.

Physician Assistants working at Plano Orthopedic & Sports Medicine Center may provide the following services:

- ***Obtaining histories and performing physical exams***
- ***Order and/or perform diagnostic and therapeutic procedures***
- ***Formulate a working diagnosis***
- ***Develop and implement a treatment plan***
- ***Monitor the effectiveness of therapeutic interventions***
- ***Assist in surgery***
- ***Offer counseling and education***
- ***Supply sample medications and write prescriptions***
- ***Make appropriate referrals***

Please be aware Physician Assistants working at Plano Orthopedic & Sports Medicine Center do see and treat patients usually along with the physician. In certain circumstances, the PA may be available to see and treat you when the doctor is not immediately available. At any time you may request an appointment to see the Physician only.

# 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](http://www.posmc.com).**

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

**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
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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



**Have you ever had any of the following conditions? If you had the condition in the past, but are no longer troubled with it, mark "past". If it is a current problem, please mark "current". If you wish to make a note regarding a condition, please mark under "notes" and write in the notes space below. Please fill in the diagnosis date for conditions you have had.**

Diagnosis Date    Have you ever had:    Past    Current    Notes

**Metabolic**

Diabetes			
Hypoglycemia (Low blood sugar)			
Hyperthyroid			
Other metabolic problems			

**Head**

Head Injury			
Other head problems			

**Dental**

Abscesses			
Gingivitis			
Other dental problems			

**Neck**

Arthritis in your neck			
Pain in your neck			
Stiffness in your neck			
Thyroid trouble — goiter			
Other neck problems			

**Skin**

Boils			
Infections			
Psoriasis			
Ulcers			
Other skin problems			

**Eye**

Cataracts			
Cataract surgery			
Glasses/contacts			
Loss of vision			
Eye Pain			
Other eye problems			

**Nose / Throat**

Hearing loss			
Hearing Aid			
Ear Infection			
Ringing/buzzing			
Other ear problems			
Nose bleeds			
Hoarseness of throat			
Polyps in your nose			
Sinus trouble			
Trouble swallowing			
Other nose/throat problems			

**Notes:**

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Diagnosis Date    Have you ever had:    Past    Current    Notes

**Respiratory**

Asthma			
Bronchitis			
Chronic cough			
Coughing up blood			
Emphysema			
Pain in breathing			
Pneumonia			
Sinus infection			
Shortness of breath			
Wheezing			
Other respiratory problems			

**Neurological**

Headaches			
Fainting			
Seizures (epilepsy)			
Paralysis of arm			
Paralysis of leg			
Paralysis below waist			
Paralysis below neck			
Numbness in arm			
Numbness in leg			
Foot drop			
Stroke			
Other neurological problems			

**Cardiovascular**

High blood pressure			
Low blood pressure			
Chest pain			
Claudication/peripheral			
Congestive heart failure			
Cold fingers & toes			
Heart attack			
Heart disease			
Irregular heartbeat			
Leg cramps at night			
Leg cramps while walking			
Leg/ankle swelling			
Rheumatic fever			
Other cardiovascular problems			

**Blood**

Anemia			
Bleeding problems			
Hemophilia			
Prior Transfusions			
Pulmonary Embolism			
Other blood problems			

**Thrombophlebitis (blood clots)**

Diagnosed by:    ● X-ray    ● Scan    ● Dr.  
                           ● Don't know    ● Doppler    ● Other

If yes most recent, ● 6 mo    ● 1 yr    ● 2 yr  
                               ● 3 yr    ● 4 yr    ● 5 yr

Treatment:    ● None    ● Coumadin    ● Heparin  
                           ● Other

Hospitalized:    ● Yes    ● No



## Family and socio-economic information

### Have any of the following diseases occurred in your family?

- Arthritis
- Bleeding disorders
- Blood disorders
- Cancer
- Diabetes
- High Blood Pressure
- Heart Disease
- Kidney Failure
- Rheumatism
- Seizures
- Stroke

### Have any family members had a joint replacement?

- Yes
- No

### What is your marital status?

- Single - Never Married
- Separated
- Widowed
- Married
- Divorced
- Remarried

### What is your work status?

- Full Time
- Retired
- Partially Disabled
- Part Time
- Fully Disabled
- Unemployed

### Annual household income from all sources:

- < 10,000
- 10,000 to 20,000
- 20,000 to 40,000
- 40,000 to 60,000
- 60,000 to 100,000
- > 100,000

### Please list your occupation:

- Professional
- Light Labor
- Heavy Labor
- Management
- Student
- Salesperson
- Construction
- Cashier - Clerk
- Secretary - Clerical
- Assembly Line Engineer
- Engineer - Technical
- Teacher
- Homemaker
- Other

### Is the current problem related to a claim for worker's compensation?

- Yes
- No

### Is the current problem related to any current lawsuit?

- Yes
- No

### Is there the possibility of a claim against another party for legal liability related to the current problem?

- Yes
- No

### Notes:

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### Home Environment

- Yes  No Are you staying in a nursing home?
- Yes  No Do you live alone?
- Yes  No Can you perform routine household duties?
- Yes  No Can you prepare your own meals?
- Yes  No Are there stairs to enter your home?
- Yes  No Are there stairs inside your home?
- Yes  No Is there a bathroom on the first floor?
- Yes  No Is the bathroom able to be entered with a walker?
- Yes  No Is there a bedroom on the first floor or can one be created?

### Which assistive devices are available in your home?

- None
- Wheelchair
- Shower bench
- Tub rails
- Raised toilet seat
- Chair lift
- Hand rails - banisters

### Who is available to help you if you need surgery?

- Spouse
- Son
- No one
- Mother
- Brother
- Father
- Sister
- Daughter
- Friend

### What is the highest grade you completed in school?

- 8th or less
- Some High School
- High School grad / GED
- Some technical school
- Technical school grad
- Some College
- College grad
- Some post-grad
- Post-grad or professional degree

### How many natural/adopted children are still at home?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- Other \_\_\_\_\_

### Religious preference:

- None
- Jehovah's Witness
- Catholic
- Jewish
- Muslim
- Other
- Christian Non-denominational
- Buddhist
- Hindu
- Mormon
- Protestant

### Notes:

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**WILLIAM K. MONTGOMERY, M.D. P.A.**  
**PATIENT ASSESSMENT AND TREATMENT OUTCOMES**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

<p><b>1) How much pain do you have in your hip or knee?</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:40%;">HIP</th> <th style="width:40%;">KNEE</th> </tr> </thead> <tbody> <tr> <td></td> <td>R L No Pain</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Slight, occasional, no compromise in activity</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Mild, no effect on ordinary activity, pain after stairs or unusual activity, use aspirin</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Mild or occasional, walking and stairs</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Moderate, tolerable, limit activities, use of prescription drugs</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Marked, serious limitations, continual</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Severe or totally disabled</td> <td>R L</td> </tr> </tbody> </table>		HIP	KNEE		R L No Pain	R L		R L Slight, occasional, no compromise in activity	R L		R L Mild, no effect on ordinary activity, pain after stairs or unusual activity, use aspirin	R L		R L Mild or occasional, walking and stairs	R L		R L Moderate, tolerable, limit activities, use of prescription drugs	R L		R L Marked, serious limitations, continual	R L		R L Severe or totally disabled	R L	<p><b>2) When does your hip or knee pain bother you?</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:40%;">HIP</th> <th style="width:40%;">KNEE</th> </tr> </thead> <tbody> <tr> <td></td> <td>R L Pain with first steps which goes away</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Pain only after long walks</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Pain with all walking activity</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Pain at all times</td> <td>R L</td> </tr> </tbody> </table> <p>Comments: _____</p>		HIP	KNEE		R L Pain with first steps which goes away	R L		R L Pain only after long walks	R L		R L Pain with all walking activity	R L		R L Pain at all times	R L
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<p><b>5) How much does your hip or knee limit your ability to do sports or physical recreation?</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:40%;">HIP</th> <th style="width:40%;">KNEE</th> </tr> </thead> <tbody> <tr> <td></td> <td>R L No limitations</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Slightly limits me</td> <td>R</td> </tr> <tr> <td></td> <td>R L Moderately limits me</td> <td>R</td> </tr> <tr> <td></td> <td>R L Greatly limits me</td> <td>R</td> </tr> <tr> <td></td> <td>R L Totally limits me</td> <td>R</td> </tr> <tr> <td></td> <td>{ } Cannot do sports</td> <td></td> </tr> </tbody> </table>		HIP	KNEE		R L No limitations	R L		R L Slightly limits me	R		R L Moderately limits me	R		R L Greatly limits me	R		R L Totally limits me	R		{ } Cannot do sports		<p><b>6) How much does your hip or knee limit your ability to work?</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:40%;">HIP</th> <th style="width:40%;">KNEE</th> </tr> </thead> <tbody> <tr> <td></td> <td>R L No limitations</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Slightly limits me</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Moderately limits me</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Greatly limits me</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Totally limits me</td> <td>R L</td> </tr> <tr> <td></td> <td>{ } Not working for other reasons</td> <td></td> </tr> </tbody> </table>		HIP	KNEE		R L No limitations	R L		R L Slightly limits me	R L		R L Moderately limits me	R L		R L Greatly limits me	R L		R L Totally limits me	R L		{ } Not working for other reasons	
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<p><b>7) During the past four weeks, how often has your hip or your knee interfered with your ability to get together with friends or relatives?</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:40%;">HIP</th> <th style="width:40%;">KNEE</th> </tr> </thead> <tbody> <tr> <td></td> <td>R L All or the time</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Most of the time</td> <td>R L</td> </tr> <tr> <td></td> <td>R L A good bit of the time</td> <td>R L</td> </tr> <tr> <td></td> <td>R L Some of the time</td> <td>R L</td> </tr> <tr> <td></td> <td>R L A little bit of the time</td> <td>R L</td> </tr> <tr> <td></td> <td>R L None of the time</td> <td>R L</td> </tr> </tbody> </table>		HIP	KNEE		R L All or the time	R L		R L Most of the time	R L		R L A good bit of the time	R L		R L Some of the time	R L		R L A little bit of the time	R L		R L None of the time	R L	<p><b>8) Work capacity for the past three months:</b></p> <table style="width:100%; border-collapse: collapse;"> <tbody> <tr> <td style="width:10%;">{ }</td> <td style="width:40%;">0%</td> </tr> <tr> <td>{ }</td> <td>25%</td> </tr> <tr> <td>{ }</td> <td>50%</td> </tr> <tr> <td>{ }</td> <td>75%</td> </tr> <tr> <td>{ }</td> <td>100%</td> </tr> </tbody> </table>	{ }	0%	{ }	25%	{ }	50%	{ }	75%	{ }	100%
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**9) What is your highest possible level of activity (ABLE) What level of activity are you routinely doing (ROUTINELY do)?**  
(select one answer for each column)

	ABLE	ROUTINELY DO
{ }	Bedridden or confined to a wheelchair, need assisted care	{ }
{ }	Sedentary - minimum capacity for walking or other activity, low level activities of daily living (stairs, carrying, lifting, stooping)	{ }
{ }	Semi-sedentary - white collar job, bench work, light housekeeping, indoor activities of daily living (stairs, carrying, lifting, stooping)	{ }
{ }	Outdoor activities of daily living	{ }
{ }	Moderate manual labor, low stress sports, (golf, swimming, biking, hiking)	{ }
{ }	Heavy manual labor, high stress sports (racquet sports, basket, baseball, skiing, tennis, running)	{ }

<p><b>10) What kind of support do you need when walking?</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">{ } { } { }</td> <td style="border: none;">Unable to walk Wheelchair No support needed</td> <td style="width: 30%; border: none;"><b>In which hand do you use cane or crutch?</b></td> <td style="border: none;">R L R L</td> </tr> </table> <p><b>If walking with support</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">{ } { } { } { } { }</td> <td style="border: none;">1 cane, only - long (30 min.) walks 1 cane, full-time 1 crutch 2 canes 2 crutches or walker</td> <td style="width: 30%; border: none;"><b>Which joint(s) is aid used for?</b></td> <td style="border: none;">HIP KNEE R R L L</td> </tr> </table>	{ } { } { }	Unable to walk Wheelchair No support needed	<b>In which hand do you use cane or crutch?</b>	R L R L	{ } { } { } { } { }	1 cane, only - long (30 min.) walks 1 cane, full-time 1 crutch 2 canes 2 crutches or walker	<b>Which joint(s) is aid used for?</b>	HIP KNEE R R L L	<p><b>11) How far are you able to walk?</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><b>Without support</b></td> <td style="width: 50%; border: none;"><b>using support</b></td> </tr> <tr> <td style="border: none;">{ } { } { } { } { } { } { } { }</td> <td style="border: none;">{ } { } { } { } { } { } { } { }</td> </tr> <tr> <td style="border: none;">Unlimited 1 mile or greater 6-10 blocks or &gt; 1/2 to &lt; 1 mile 1-5 blocks or 1/4 to 1/2 mile 1 block Less than 1 block Indoors only Between bed and a chair</td> <td style="border: none;"></td> </tr> </table>	<b>Without support</b>	<b>using support</b>	{ } { } { } { } { } { } { } { }	{ } { } { } { } { } { } { } { }	Unlimited 1 mile or greater 6-10 blocks or > 1/2 to < 1 mile 1-5 blocks or 1/4 to 1/2 mile 1 block Less than 1 block Indoors only Between bed and a chair				
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**WILLIAM K. MONTGOMERY, M.D.**

5228 W. Plano Parkway  
Plano, TX 75093  
972-250-5700  
972-250-5747 (fax)

**REGARDING INSURANCE CORRESPONDENCE**

Changes in the insurance industry, particularly “managed care” including PPOs, HMOs, and others, have led to an unacceptable volume of phone and mail correspondence, notes, letters, and other requirements that have no direct impact on patient care but require an increased overhead of office personnel and expense.

Effective immediately, our office will correspond *once* at no charge with your primary carrier for charges incurred directly resulting from a specific visit or procedure performed by us. **ANY OTHER CORRESPONDENCE** required by your insurance company or your work is YOUR RESPONSIBILITY and will incur an additional \$20.00 charge for Preparation and Handling, including the doctors’ or staff person’s time. This fee will be payable in advance, at the time the forms are presented. These will include but are not limited to:

- Disability forms, family medical leave forms
- Letters for “medical necessity” of prescriptions or diagnostic tests
- Coordination of more than two insurance carriers
- Protracted precertification procedures requiring multiple phone calls or letters
- Other correspondence requiring extended staff time, letters, calls, etc.

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

**Plano Orthopedic and Sports Medicine Center**

Authorization for Disclosure of Confidential Information

**(Medical Record Release)**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

**I authorize Plano Orthopedic and Sports Medicine Center to release my  
medical records to:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Please fax the medical release to 972-250-5749**



**Universal Condition, Injury and/ or Accident Statement**

*ALL boxes must be answered before seeing the Physician*

Patient Name \_\_\_\_\_

Today's Date \_\_\_/\_\_\_/\_\_\_

Please complete the following statements. Most Insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. We must have Box 1 "Date of Injury or Condition" completed to file your claim.

1

**Date of Injury:** \_\_\_/\_\_\_/\_\_\_ **OR check**  **if Condition** < (COMPLETE DATE ON OR ABOUT)  
*This date is required for insurance filing*

If an auto injury, you must provide the letter of subrogation from your private insurance. See Box 3 below.

Where were you when your injury or pain occurred? (If at work, see Box 2) \_\_\_\_\_  
i.e., auto, home, parking lot, friend's house, etc.

2

**If the injury happened during work and you have not filed a report with your employer, please file your first report of injury with your employer. Your appointment will be rescheduled for a later date and time.**

*For work related injuries, it is important to follow all the rules in the workers' compensation system. If you do not follow these rules, you may be held responsible for payment of medical bills.*

How did injury or pain occur, what were you doing? (brief summary) \_\_\_\_\_

Did the injury occur during work hours? [ ] YES [ ] NO

If YES, you should have reported your injury to your employer and have been approved to file a work related injury.

Employer's Name \_\_\_\_\_

Contact (name of Human Resources or Risk Manager) \_\_\_\_\_

Workers Compensation Insurance Company, Phone #, Claim #, Adjuster \_\_\_\_\_

3

Is there a possible third party liability statement (your injury occurs somewhere other than home or work such as auto, homeowners, property): [ ] YES [ ] NO

If YES, a letter of subrogation must be provided before seeing the doctor. Your health insurance will deny the claim if the letter is not obtained. Your auto or home owner's insurance company can help you with the subrogation forms.

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