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

NEW PATIENT REGISTRATION FORM

Legal Name: _____ _____ _____ _____
Last First Middle Preferred

Home Address: _____ _____ _____
Street Apt# City/ST/Zip

Phone(s): Home: _____ Cell: _____ Work: _____

Email: _____ DOB: _____ Age: _____ DL#: _____

Gender: M or F Marital Status: Single Married Divorced Widow SS#_____

Employer Name: _____ Employer Address: _____ _____
Street City/ST/Zip

Employer Phone#: _____Occupation: _____

How did you hear about us? _____

Primary Care Doctor: _____ Doctor Phone#: _____

PRIMARY INSURANCE INFORMATION: (*FILL IN INSURANCE INFORMATION BELOW OR CHECK BOX IF COPY OF CARD WAS PROVIDED*)

Name of Primary Policy Holder: _____ Relationship to Patient: _____
As It Appears On Card

DOB: _____ Insurance Company: _____ Insurance Phone#: _____

Policy ID#: _____ Group#: _____ SS#: _____

MEDICARE SUPPLEMENTAL INSURANCE INFORMATION:

Name of Primary Policy Holder: _____ Policy ID/Group#:_____
As It Appears On Card

RESPONSIBLE PARTY INFORMATION: (*CHECK IF SAME AS ABOVE*)

Name: _____ Address: _____

DOB: _____SS#:_____Phone#:_____Relationship to Patient: _____

EMERGENCY CONTACT/LEGAL GUARDIAN:

Name: _____ Phone#: _____Relationship to Patient: _____

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS: I hereby authorize the above-named agency to release my treatment information requested by attorneys, physicians, insurance companies, employers, healthcare providers or any other entity which may be concerned with the payment of charges incurred for the treatment of services of Plano Orthopedic Sports Medicine & Spine Center, P.A., and hereby authorize payment directly to Plano Orthopedic Sports Medicine & Spine Center, P.A. for services rendered. I accept responsibility for payment of any charges not paid for or accepted by my insurance. This authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient or Legal Guardian **Date**

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

POSMC POLICIES & CONSENT TO TREAT

(PLEASE INITIAL ALL SECTIONS, SIGN & DATE FORM)

_____FINANCIAL RESPONSIBILITY AGREEMENT:

Initials

I agree to assign insurance benefits to Plano Orthopedic Sports Medicine & Spine Center, P.A. We bill all insurance companies that we are contracted with as "network" providers as a courtesy to our patients.

I acknowledge full financial responsibility for services rendered by Plano Orthopedic Sports Medicine & Spine Center, P.A. and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to Plano Orthopedic Sports Medicine & Spine Center, P.A.

_____CONSENT OF TREATMENT:

Initials

I authorize Plano Orthopedics Sports Medicine & Spine Center, P.A. Physicians and the Physician's Assistants to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care. I have read and understand the above clinic polices and I further acknowledge that I accept the terms outlined in each of the above policies.

_____PHYSICIAN ASSISTANT CONSENT

Initials

This facility has on staff Certified Physician Assistants (PA-C) to assist in the delivery of orthopedic medical care. I acknowledge a Physician Assistant is not a physician. A PA-C is licensed by the state medical board and under the supervision of a physician can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does NOT require constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. A list of services may be provided that are within the scope of practice for a PA-C upon request. I hereby acknowledge the above information and consent to the services of a Certified Physician Assistant for my health care needs. I understand that at any given time I can request to see the Physician instead of the PA-C.

_____MEDICATION POLICY CONSENT:

Initials

I authorize Plano Orthopedics Sports Medicine & Spine Center, P.A. Physicians and the Physician's Assistants to obtain a medication history and/or list of current medications via my pharmacy for medical records.

_____DISCLOSURE OF FINANCIAL INTEREST

Initials

Plano Orthopedic Sports Medicine & Spine Center, P.A. physician you are seeing may have a financial interest in the facilities listed on page 2. 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 of care for you. Should you have any concerns regarding this notice, please ask your physician or a member of the staff. My initials above verify that I have read and understand the above statement and information.

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

POSMC POLICIES & CONSENT TO TREAT

(PLEASE INITIAL ALL SECTIONS, SIGN & DATE FORM)

Baylor Medical Center at Frisco 5601 Warren Pkwy Frisco, TX 75034 214-407-5000	**Plano Therapy Center** 3405 Midway Ste 500 Plano, TX 75093 972-473-0229
Texas Health Center for Diagnostic & Surgery 6020 W Parker Rd Plano, TX 75093 972-403-2700	**Allen Therapy Center** 1223 W McDermott Ste 50 Allen, TX 75013 972-359-1288
Methodist Hospital for Surgery 17101 N Dallas Pkwy Addison, TX 75001 469-248-3900	**North Star MRI (Frisco)** 8501 Wade Blvd Ste 220 Frisco, TX 75034 214-618-3420
Surgery Center of Plano 1620 Coit Road Plano, TX 75075 972-519-1100	**North Star MRI (Plano)** 3700 W 15th St Bldg D Ste 200 Plano, TX 75075 972-758-9000
Preston Plaza Surgery Center 17950 Preston Rd Ste 75 Dallas, TX 75252 972-267-5400	**North Star MRI (Allen)** 997 Raintree Circle Ste 110 Allen, TX 75013 972-954-8001
Baylor SurgiCare North Garland 7150 N. President George Bush Hwy Garland, TX 75044 (214) 703-1800	
➢ Dr. Stephen Courtney, a POSMC physician also has a financial interest in Eminent Spine, a company that manufactures and designs spinal implants. ***Eminent Spine & Eminent Extremity*** 7200 N. IH 35 Bldg #1 • Georgetown, TX 78626 • 512-868-5980 ➢ Dr. John E. McGarry, a POSMC physician also has a financial interest in ***T5 Ortho***, a company that distributes medical products.	

ACKNOWLEDGEMENT:

- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I have read and understand the "Physician's Consent" and the "Disclosure of Financial Interest"
- I further acknowledge and understand that I accept the terms outlined in each of the policies.

X _____ _____

Patient or Legal Authorized Representative Date

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

PATIENT HIPAA & PRIVACY PRACTICES AUTHORIZATION FORM

(Required by Health Insurance Portability & Accountability Act)

I hereby authorize Plano Orthopedics Sports Medicine & Spine Center, P.A. to use and/or disclose my protected health information which specifically identifies me or which can reasonably be used to identify me to carry out my medical treatment, billing or claims payment and other health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Plano Orthopedics Sports Medicine & Spine Center, P.A. can refuse to see me. I have been provided with access to either review and/or receive a copy of "Notice of Privacy Practices" for Plano Orthopedic Sports Medicine & Spine Center, P.A. which more fully describes the uses and disclosures, and I understand that I have the right to review such "notice" prior to signing this consent. I understand I can revoke this consent at any time by notifying Plano Orthopedics Sports Medicine & Spine Center, P.A. in writing. I understand Plano Orthopedics Sports Medicine & Spine Center, P.A. has the right to change its privacy policies and that I can receive such changed notices upon request. I understand that I have the right to request that Plano Orthopedics Sports Medicine & Spine Center, P.A. restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or other healthcare operations. I understand that Plano Orthopedics Sports Medicine & Spine Center, P.A. does not have to agree to such restrictions, but that once such restrictions are agreed to, Plano Orthopedics Sports Medicine & Spine Center, P.A. must adhere to such restrictions.

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our "Notice of Privacy Practices" policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION:

I give Plano Orthopedics Sports Medicine & Spine Center, P.A. authorization for the release of "Medical Records/Privacy Information", which includes your PHI, any medical conditions and/or billing and financial information to the following:

Name: _____ Relationship to Patient: _____

EFFECTIVE TIME PERIOD/RIGHT TO REVOKE: This authorization shall be in force and valid for one year from the signature date or written permission is accepted for withdrawal.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____DATE: _____

Signature of Individual or Legally Authorized Representative

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

UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM

ALL BOXES MUST BE COMPLETED BEFORE SEEING A PHYSICIAN

PATIENT NAME: _____ ***TODAY'S DATE:*** _____ /_____ /_____

PLEASE COMPLETE THE FOLLOWING STATEMENTS. MOST INSURANCE COMPANIES REQUEST ACCIDENT DETAILS. THIS INFORMATION MAY BE FORWARDED WITH YOUR INSURANCE CLAIM OR PROVIDED TO AN ADJUSTER TO COMPLETE YOUR CLAIM.
WE MUST HAVE "*BOX 1: CONDITION OR DATE OF INJURY*" COMPLETED TO FILE YOUR CLAIM.

1. Please check: ____ CONDITION INJURY INJURY DATE: _____ / _____ / _____ (ON OR ABOUT)
   THIS DATE IS REQUIRED FOR INSURANCE FILING

How did the injury or pain occur, what were you doing? (Brief Summary) _____

_____

2. Did the injury occur during work? ____ YES ____ NO
3. Were you clocked in? ____ YES ____ NO
4. Were you at lunch? ____ YES ____ NO

THIRD PARTY LIABILITY

5. Is there a possible third party liability? ____ YES ____ NO

(INJURY OCCURRED SOMEWHERE OTHER THAN HOME OR WORK? SUCH AS AUTO, HOMEOWNER'S PROPERTY, ETC.?)

IF YES, A letter of subrogation should be provided before seeing the physician. Your health insurance will deny the claim if the letter is not obtained.

I certify that this information to be 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 charges incurred.

SIGNATURE: _____ ***TODAY'S DATE:*** _____ /_____ /_____

(PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE)

WILLIAM K. MONTGOMERY, M.D.

5228 W. Plano Parkway
Plano, TX 75093
972-250-5681
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. New Patient Packet
   - New Patient Registration Form
   - Consent/HIPAA/Financial Release Form
   - Required Government Form
   - Universal Accident & Condition Form
2. Prior Medical History and Review of Systems (4 pages)
3. Patient Assessment and Treatment Outcomes (2 pages)
4. Regarding Insurance Correspondence
5. Medical Record Release Form

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

WILLIAM K. MONTGOMERY M.D. P.A.

PATIENT ASSESSMENT AND TREATMENT OUTCOMES

Name:_____ Date: _____

1) How much pain do you have in your hip or knee?

HIP		KNEE
R L	No pain	R L
R L	Slight, occasional, no compromise in activity	R L
R L	Mild, slight effect on ordinary activity, pain after stairs or unusual activity, use aspirin	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

2) When does your hip or knee pain bother you?

HIP		KNEE
R L	No pain	R L
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

3) How often does hip or knee pain limit your activities?

HIP		KNEE
R L	Never	R L
R L	1-3 times a month	R L
R L	About once a week	R L
R L	Several days a week	R L
R L	Daily	R L

4) How often does stiffness, limited motion or weakness in your hip or knee limit your activities?

HIP		KNEE
R L	Never	R L
R L	1-3 times a month	R L
R L	About once a week	R L
R L	Several days a week	R L
R L	Daily	R L

5) How much does your hip or knee limit your ability to do sports or physical recreation?

{ } No limitations
{ } Slightly limits me
{ } Moderately limits me
{ } Greatly limits me
{ } Totally limits me

6) How often has your hip or your knee interfered with your ability to get together with friends or relatives?

{ } All of the time
{ } Most of the time
{ } Some of the time
{ } None of the time

7) How much does your hip or knee limit your ability to work?

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	

8) Work capacity for the past three months:

{ } 0%
{ } 25%
{ } 50%
{ } 75%
{ } 100%
{ } Not applicable

9) What level of activity are you routinely doing?

{ } 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: occasional low stress sports, (golf, swimming, biking)
{ } Moderate manual labor.
{ } Heavy manual labor, high stress sports (racquet sports, basketball, baseball, skiing, tennis, running)

10) Do you need support when walking?

{ } Yes { } No

If yes, what kind?

{ } Cane
{ } Walker
{ } Unloader brace
{ } Wheelchair

11) PAIN routinely limits my walking distance to:

{ } 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 than1 block
{ } Indoors only

12) PAIN routinely limits my walking time to:

{ } 31 - 60 minutes
{ } 11 - 30 minutes
{ } 2 - 10 minutes
{ } Less than 2 minutes or indoors only

13) How do you climb up stairs? (Answer only if you are able to walk.)

{ } Normally { } Need 1 rail
{ } Need 2 rails { } Unable to climb stairs

14) How much do you limp when you don't use support?

{ } No limp { } Slight limp
{ } Moderate limp { } Severe limp

15) How difficult is it for you to put on your shoes and socks?

{ } No trouble
{ } Able, but with difficulty
{ } Extremely difficult
{ } Unable

16) How do you go down stairs?

{ } Normally, no rails
{ } Need 1 rail
{ } Hip or knee creates instability or balance issues

17) How does your hip or knee affect your ability to get in and out of a car?

{ } Do it with ease
{ } With difficulty
{ } Unable

18) How difficult is it for you to go from sitting to standing?

{ } Can stand up from chair without arms
{ } Must use arms to stand up from chair
{ } Unable to stand up

19) Does your hip or knee pain cause:

{ } Sense of grinding
{ } Instability or giving way
{ } Falls

20) Does your hip or knee interfere with your sleep cycle?

{ } Difficulty falling asleep
{ } Pain or discomfort awakens you from sleep
{ } No effect on sleep

21) Conditions other than current problem which impair ambulation (select all that apply).

{ } Back
{ } Foot/ankle
{ } Lungs
{ } Heart
{ } Neurologic (stroke, paralysis)
{ } Psychological
{ } Other

22) Activities you want to do but can't because of your hip or knee (select all that apply).

{ } No limits { } Golf { } Skiing
{ } Baseball { } Hiking { } Stairs
{ } Softball { } Jogging { } Stooping
{ } Basketball { } Lawn mowing { } Swimming
{ } Biking { } Lifting { } Tennis
{ } Carrying { } Sex { } Walking
{ } Gardening { } Skating { } Other

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?

_____

_____

_____

_____

_____

Have you seen any other physician for this problem?

_____

Physician Notes Only:

D:

N:

P:

I:

S:

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:

_____

_____

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

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: _____