PLANO ORTHOPEDIC
& SPORTS MEDICINE CENTER

NEW PATIENT REGISTRATION FORM

Legal Name: _____ _____ _____ _____
Last First Middle Preferred

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

Best Number to Reach You: _____

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 Center, and hereby authorize payment directly to Plano Orthopedic & Sports Medicine Center 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
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POSMC POLICIES & CONSENT TO TREAT

_____FINANCIAL RESPONSIBILITY AGREEMENT:

Initials

I agree to assign insurance benefits to Plano Orthopedic & Sports Medicine Center. We bill all primary 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 Center, 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 Center.

_____CONSENT OF TREATMENT:

Initials

I authorize Plano Orthopedic & Sports Medicine Center 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 Physician's Assistant-Certified (PA-C) to assist in the delivery of orthopedic medical care. I acknowledge a PA-C) is not a physician. The state medical board licenses a PA-C and, under the supervision of a physician, can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care and assist in surgery. "Supervision" does NOT require the constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. POSMC, its employees, affiliates, or designated business associate may bill your insurer or plan administrator fiduciary separately to obtain payment. 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 PA-C 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 Orthopedic & Sports Medicine Center 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 Center physician you are seeing may have a financial interest in the facilities listed on page 3. 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
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_____PATIENT REFERRAL:

Initials

Should this facility or my physician refer me to a physician or non-physician practitioner out of the preferred provider panel, this facility or physician will disclose to me that the referral is out of the preferred provider panel and any ownership interest. I understand this facility or my physician is not restricted from referring me to an out-of-network provider, and I may have more-out-of-pocket costs from a non-participating provider.

PLANO ORTHOPEDIC
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POSMC POLICIES & CONSENT TO TREAT

Baylor Medical Center at Frisco 5601 Warren Pkwy Frisco, TX 75034 214-407-5000	**Frisco Therapy Center** 6363 Dallas Parkway Ste 207 Frisco, TX 75034 972-250-5700
Methodist Hospital for Surgery 17101 N Dallas Pkwy Addison, TX 75001 469-248-3900	**Plano Therapy Center** 3405 Midway Ste 500 Plano, TX 75093 972-473-0229
SurgCenter of Plano, LLC 6101 Windhaven Pkwy #195 Plano, TX 75093 469-209-7054	**Allen Therapy Center** 1223 W McDermott Ste 50 Allen, TX 75013 972-359-1288
Preston Plaza Surgery Center 17950 Preston Rd Ste 75 Dallas, TX 75252 972-267-5400	**Richardson Therapy Center** 2040 E President George Bush Highway #100 Richardson, TX 75082 972-250-5690
Legent Orthopedic Hospital 1401 Trinity Mills Rd Carrollton, TX 75006 972-810-0700	**Central Plano Sports Surgical Alliance PLLC** 5228 W Plano Pkwy Plano, TX 75093 972-250-5648

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
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PATIENT HIPAA & PRIVACY PRACTICES AUTHORIZATION FORM

(Required by Health Insurance Portability & Accountability Act)

I hereby authorize Plano Orthopedic & Sports Medicine Center 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 Orthopedic & Sports Medicine Center 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 Center 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 Orthopedic & Sports Medicine Center in writing. I understand Plano Orthopedic & Sports Medicine Center 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 Orthopedic & Sports Medicine Center 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 Orthopedic & Sports Medicine Center does not have to agree to such restrictions, but that once such restrictions are agreed to, Plano Orthopedic & Sports Medicine Center 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 Orthopedic & Sports Medicine Center 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: _____

Name: _____Relationship to Patient: _____

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_____DATE _____

Signature of Individual or Legally Authorized Representative

PLANO ORTHOPEDIC
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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)