ORTHOPAEDIC SPECIALISTS OF AUSTIN

NEW PATIENT INFORMATION

Salutation **First Name** **MI** **Last Name**			
Date of Birth:	**Address:**		
SSN:	**City:**	**State:**	**Zip Code:**
Mobile Phone:	**Home Phone:**	**Work Phone:**	
Email Address:	**Preferred Contact #:** ☐ Mobile ☐ Home ☐ Work		
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed			
Spouse: **First Name:** **MI** **Last Name**			
Spouse's Date of Birth:	**Spouse Phone:**	**Emergency Contact:** ☐ **YES** ☐ **NO**	
Referral From: ☐ **Internet** ☐ **Attorney** ☐ **Insurance** ☐ **Family** ☐ **Doctor:**			
Additional Emergency Contact:			
Relation:	**Phone:**	**Alternative Phone:**	
Are you Hispanic/Latino: ☐ **Yes** ☐ **No**	**What is your preferred language:**		
What is your Race: ☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **Black/African American** ☐ **Hawaiian/Pacific Islander** ☐ **White**			

EMPLOYMENT INFORMATION (For work related injury ONLY)

******IF THIS IS A WORK – RELATED INJURY, PLEASE NOTIFY THE RECEPTIONIST******

Employer:	Occupation:		
Employer Address:			
City:	State:	Zip Code:	Employer Phone:

GUARANTOR INFORMATION (If patient is under 18 years of age)

First Name: MI Last Name:			
Relation to patient:	Address:		
Date of Birth:	City:	State:	Zip Code:
Guarantor SSN:	Phone:	Alternative Phone:	

DISCLOSURE OF PHYSICIAN OWNERSHIP

Dear Patient,

Dr. Catlett has ownership and/or investment interests in Hyde Park Surgery Center.

Dr. Dodgin has ownership and/or investment interests in Hyde Park Surgery Center, Lakeway Surgery Center, and The Hospital at Westlake Medical Center.

Dr. Ebert has ownership and/or investment interests in Hyde Park Surgery Center and June Buck, LLC.

Dr. Heinrich has ownership and/or investment interests in Hyde Park Surgery Center, The Hospital at Westlake Medical Center, P&D Imaging, HEMO LLC, Lakeway Surgery Center and Phantom 4 LLC. In addition, Dr. Heinrich serves as an education consultant for DePuy, DJO, Medtronic, and OrthoAlign.

Dr. Josey has ownership and/or investment interests in Hyde Park Surgery Center, TexSpine Consultants, and Osteocentric Technologies.

Dr. Kay has ownership and/or investment interests in Hyde Park Surgery Center.

Dr. Moghimi has ownership and/or investment interests in Sydney Concepts Implants, NOOR Concepts consulting, Backbone Ti LLC Implant distributorship, Lakeway Surgery Center and The Hospital at Westlake Medical Center. In addition, Dr. Moghimi serves as a consultant for Spineart.

Dr. Seade has ownership and/or investment interests in Hyde Park Surgery Center.

Services provided by these companies/facilities may be out of network, and as a result you may receive an out of network bill. However, *you have the right to choose the provider of your healthcare services*. Therefore, you have the option to use the healthcare facility of your choice. You will not be treated differently by Drs. Catlett, Dodgin, Ebert, Heinrich, Josey, Kay, Moghimi, and Seade or Orthopaedic Specialists of Austin if you choose to have services performed at a different facility or by a different company.

I have read and acknowledged the Disclosure of Physician Ownership at Orthopaedic Specialists of Austin

★ _____ ★ _____

Patient / Legal Guardian Signature **Date-of-Birth**

★ _____ _____

Print Patient Name (Must Be Legible) **OSA Account # (Office Use Only)**

★ _____

Date

Assignment of Benefits:

I hereby authorize Orthopaedic Specialists of Austin to bill my insurance carrier, attorney's office, or any other payment source.

I assign all benefits and authorize payment directly to Orthopaedic Specialists of Austin for any benefits otherwise payable to me for all claims for such services provided or submitted prior to, or after, the date provided on this form.

I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. This assignment and authorization of benefits in no way releases me from said responsibility and imposes no obligation on Orthopaedic Specialists of Austin to collect money on my behalf.

I acknowledge and agree that Orthopaedic Specialist of Austin and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as a dialing service or prerecorded message. I also agree that I will notify Orthopaedic Specialist of Austin, if I have given up ownership or control of any such telephone number.

★_____

Printed name of patient or responsible party

★_____

Signature of patient or responsible party Date

Acknowledgement of Receipt of Notice of Privacy Practices:

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Please note! Orthopaedic Specialists of Austin might contact you for scheduling purposes, appointment reminders, payment reasons, or other aspects of your care. Unless you give us written notification otherwise, we will leave a message on your answering machine or with someone who answers your phone, if you are not home.

★_____

Printed name of patient or responsible party

★_____

Signature of patient or responsible party Date

FINANCIAL POLICIES

Our primary goal is to provide excellent health care to all our patients. It is necessary, however, to establish policies to avoid misunderstandings. We would like to clarify the following policies that are followed by our practice:

Insurance Coverage We accept many, but not all insurance plans. Your insurance is a contract between you and your insurance plan. Therefore, it is your responsibility to know how your insurance will cover your treatment. To find out whether your doctor is participating with your specific insurance plan, please call them directly or refer to your provider directory. If our doctors do not participate with your specific plan, payment is due at the time of service. Our office will attempt to verify your benefits prior to your appointment, but knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions about your coverage or claims processing.

Proof of Insurance All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current, valid proof of insurance. If you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the charges incurred. If any information changes, you must notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Co-Payments and Balances Co-payments are due at the time you check in. This arrangement is part of your contract with your insurance company. Orthopaedic Specialists of Austin physicians are specialty physicians, and higher co-pays might apply. If you cannot pay your co-payment, you might have to re-schedule your appointment. Outstanding balances are always due upon checking in. If you have an unmet deductible, we request payment of $150 toward your deductible. This $150 payment will be applied to your final balance. Your bill could be more than $150 if you receive x-rays and/or injections or other services.

Referrals/Authorizations It is your responsibility to obtain valid authorizations from your primary care physician (PCP) if your insurance company requires them. Authorizations must be provided by your insurance plan to our office prior to your appointment. If our office does not have your authorization, your appointment will be rescheduled, or payment will be required at the time of your appointment.

Work-Related Injuries You must tell our office if your injury/condition is work-related, and we must verify your claim before your appointment. If you work for an employer who is covered under the Texas Workers' Compensation Act, any injury caused while working must be filed under Workers' Compensation according to Texas law. If your Worker's Compensation claim is found to be fraudulent or non- compensable, you will be fully responsible for all charges.

Non-Payment Statements are due and payable in full upon receipt. In the event that your bank returns payment made by a personal check, a service fee of $25.00 will be billed to your account. If any balance is outstanding, we might refer your account to a collection agency, and you might be discharged from this practice. If this office must take action to collect an outstanding balance on your account, you will be responsible for payment of all costs of such collection efforts, such as certified mail costs and 30-50% collection agency fees.

Disclosures Some physicians at Orthopaedic Specialists of Austin have ownership/investments in various healthcare companies. Services provided by these companies/facilities may be out of network, and as a result you may receive an out of network bill. However, **you have the right to choose the provider of your healthcare services**. Therefore, you have the option to use the healthcare facility of your choice. You will not be treated differently by anyone at Orthopaedic Specialists of Austin if you choose to have services performed at a different facility or by a different company.

I have read and understand the financial policies and agree to abide by all guidelines:

★_____ _____

Printed name of patient or responsible party OSA Account# (Office Use Only)

★_____

Signature of patient or responsible party Date

ORTHOPAEDIC SPECIALISTS OF AUSTIN

INJECTION DISCLOSURE

Dear Patient,

At Orthopaedic Specialists of Austin, we value the privilege of providing your orthopedic care.

Recent changes in your insurance coverage have resulted in a policy that does not cover both an orthopedic office evaluation and an orthopedic injection during the same visit. As a result, we'll need to schedule your orthopedic injection visit on a separate date from your evaluation.

We understand that this may cause some inconvenience, and for that, we sincerely apologize. However, it is crucial for us to adhere to these guidelines in order for us to be reimbursed for our services.

Should your doctor determine that an injection is necessary, our scheduling team will work diligently to arrange a suitable date and time for your orthopedic injection visit. Rest assured; we will make every effort to schedule this appointment at your earliest convenience.

Thank you for your understanding and cooperation. We truly value the opportunity to serve as your healthcare provider and remain committed to supporting your orthopedic care needs.

Warm regards,

Orthopaedic Specialists of Austin

Consent to Share Limited Medical Record Information

Protecting patient privacy is important to Orthopaedic Specialists of Austin. We follow the HIPAA Rules for sharing your Protected Health Information. We also want to support your wishes when it comes to sharing some of your health information with others involved in your care.

The type of information we would share includes but is not limited to appointment reminders, test results, care instructions, billing information, or prescription information.

If you would like us to talk to and share some information about you with others, please list their name(s) and relationship to you below.

_____ I DO NOT WISH TO HAVE ANYONE OTHER THAN MYSELF RECEIVE MY MEDICAL INFORMATION.

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

By signing below:

- I am agreeing that Orthopaedic Specialists of Austin may share my Protected Health Information with the individuals listed.
- I understand that I can change my preferences by notifying Orthopaedic Specialists of Austin in writing, but it will not have any effect on any information that was shared prior to the receipt of my change.
- I understand that this form does not allow anyone listed to make treatment decisions for me.
- I understand the information shared may include information about alcohol and drug abuse treatment, behavioral or mental health services, and/or communicable diseases and infections, such as sexually transmitted infections or HIV/AIDS.

Patient Name (Printed):_____ Date of Birth:_____

Signature:_____ Date:_____

If the person signing is not the patient, please print the name and type of authority to sign. Supporting documentation should be provided at the time of the request. _____

Patient Name:_____

Date:_____

Acct #_____

Advanced Directives Questionnaire

(Patients 65 and over)

1. Do you have a living will on file? _____
   (A written statement detailing a person's desires regarding their medical treatment in circumstances in which they are no longer able to express informed consent, especially an advance directive.)

2. Do you have a Health Care Power of Attorney? _____
   (A healthcare power of attorney (HCPA) is a legal document that allows an individual to empower another person to make decisions about his or her medical care.)

Fall Screening

1. Do you feel unsteady when standing or walking? ❒ Yes ❒ No

2. Do you worry about falling? ❒ Yes ❒ No

3. Have you fallen in the last year? ❒ Yes ❒ No

   - If yes, how many times? _____
   - If yes, were you injured? _____

ORTHOPAEDIC SPECIALISTS OF AUSTIN

MEDICAL HISTORY	
Patient Name:	Date:
Date of Birth: Age:	Patient Address:
Weight: Height:	
☐ Left-Handed ☐ Right-Handed	
Primary Care MD:	Patient Phone:
Pharmacy Name & Location:	

HISTORY OF PRESENT ILLNESS
Describe the reason for your visit:
How long have you had this problem?
If an injury, when did occur?

EVALUATION OF PAIN / DISCOMFORT
What body part(s) is/are affected?
On Set of Pain: ☐ Sudden ☐ Chronic ☐ Gradual Worsening
Duration of Pain: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant
Describe Pain: ☐ Sharp ☐ Aching ☐ Stabbing ☐ Burning ☐ Numbness ☐ Cramping
What makes if feel better?
What makes it feel worse?
What does the pain keep you from doing?

PREVIOUS TREATMENT FOR THIS PROBLEM			
Diagnostic Test (Please list name of facility and date of service):			
☐ CT_____ ☐ EMG_____ ☐ X-Ray_____ ☐ MRI_____			
☐ Other:_____			
Anti-Inflammatories: ☐ Helpful ☐ Not Helpful		Injections: ☐ Helpful ☐ Not Helpful	
Chiropractic: ☐ Helpful ☐ Not Helpful		Physical Therapy: ☐ Helpful ☐ Not Helpful	
Other Treatment:_____			

Office Notes:

ALLERGIES ☐ NKDA *List your allergies and reactions*

Medication Allergy	Reaction

MEDICATIONS *List your medication name, strength and frequency*

Name of Drug	Strength	Frequency

CURRENTLY ON BLOOD THINNERS? ☐ Yes ☐ No

CURRENTLY USING DIABETIC INJECTIBLES? ☐ Yes ☐ No Name of medication:

REVIEW OF SYSTEM *Check the boxes that correspond to any symptoms you are **CURRENTLY** experiencing*

SKIN		CARDIOVASCULAR		ENDOCRINE	
Rash		Heart Attack		Diabetes	
Psoriasis		Irregular Heartbeat		Thyroid	
Other:		Chest Pain		Other:	
EYES		Chest Pressure		**HEMATO-IMMUNOLOGIC**	
Vision Loss		Other:		Bleeding Tendencies	
Double Vision		**GASTROINTESTINAL**		Bruise Easily	
Other:		Weight Loss		Recurrent Infections	
EARS		Weight Gain		Other:	
Decreased Hearing		Abdominal Pain		**PSYCHIATRIC**	
Ringing in Ears		Liver Disease		Depression	
Other:		Constipation		Hallucinations	
NOSE		Other:		Anxiety	
Sinus Problems		**GENITOURINARY**		Other:	
Breathing Problems		Kidney Stones			
Other:		Bladder Infection			
THROAT		Blood in Urine			
Sore Throat		Other:			
Hoarseness		**MUSCULOSKELETAL**			
Snoring		Osteoporosis			
Other:		Rheumatoid Arthritis			
RESPIRATORY		Gout			
Shortness of Breath		Other:			
Asthma		**NEUROLOGICAL**			
Bronchitis		Seizures			
Pulmonary EMB/DVT		Headaches			
Cough		Other:			
Other:					

MEDICAL HISTORY *Check the boxes that correspond to diagnoses you have been given in the past*					
Diabetes		Bleeding tendencies		HIV / AIDS	
High Blood Pressure		Blood clots		Hepatitis	
Stroke		Cancer		Vascular disease	
Heart Disease		Ulcer		Anesthesia difficulties	
Dementia		Hyperlipidemia		Ulcer (GI)	
Depression		Hypertension		Vision Problems	

SURGICAL HISTORY	
Describe:	Date:
Describe:	Date:
Describe:	Date:
Describe:	Date:
Describe:	Date:
Describe:	Date:
Describe:	Date:
Describe:	Date:

SOCIAL HISTORY				
	☐ Married	☐ Single	☐ Divorced	☐ Widowed
	☐ Live Alone	☐ Live with family	☐ Live with friends	☐ Live in nursing Home
Alcohol	Do you drink alcohol? ☐ Yes	☐ No		
Tobacco	Do you use tobacco? ☐ Yes	☐ No		
	☐ Cigarettes:_____ packs per day	☐ Dip:_____ # per day	☐ E-Cig/Vape	
	☐ Pipe:_____ # per week	☐ Cigars:_____ # per week		
	How many years have you used tobacco?_____	What year did you quit?_____		
	☐ Currently Smoking			
Drugs	Do you currently use recreational or street drugs? ☐ Yes	☐ No		
	If yes, what kind?			
Your occupation:		Last day worked:		

FAMILY HISTORY *Check the boxes that correspond to your family history* ☐ Adopted			
Anesthesia difficulties		Early Death	
Arthritis		Heart disease	
Asthma		High Cholesterol	
Bleeding disorder		Hypertension	
Cancer		Malignant hyperthermia	
Depression		Musculoskeletal disease	
Diabetes		Stroke	