



IRVING ORTHOPEDICS & SPORTS MEDICINE

SOUTHWEST SPINE INSTITUTE

Please PRINT AND complete All sections below!

Is your condition a result of work injury? YES NO An auto accident? YES NO Date of injury _____

PATIENT'S INFORMATION

Marital Status: Single Married Divorced Widowed Sex: Male Female

Name: _____
last name first name initial

Street Address: _____ (Apt# _____) City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Mobile Phone: (____) _____

Date of Birth: ____/____/____ Driver's Lic.: (state & #) _____ Social Security # _____
month day year

Employer Name: _____ Full Time Part Time

Spouse's Name: _____ Spouse's Work Phone: (____) _____
last name first name initial

RESPONSIBLE PARTY INFORMATION

If different than patient.

Responsible Party: _____ Date of Birth: ____/____/____
month day year

Relationship to Patient: Self Spouse Other _____ Social Security # _____

Responsible Party's Home Phone: (____) _____ Work Phone: (____) _____

Address: _____ (Apt# _____) City: _____ State: _____ Zip: _____

Employer's Name: (____) _____ Phone Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Your Occupation: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Company's Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____ Relationship to Insured: Self Spouse
 Other Child

Insurance ID Number: _____ Group Number: _____

SECONDARY Insurance Company's Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____ Relationship to Insured: Self Spouse
 Other Child

Insurance ID Number: _____ Group Number: _____

PATIENT'S REFERRAL INFORMATION

Name of Physician that referred you: _____

PCP Name (If different than Referring Physician): _____

HOW DID YOU HEAR ABOUT US?

How did you hear about us? Physician Referral Internet Health Expo Telephone Book Other _____

Assignment of benefits * Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to **Irving Orthopedics and Sports Medicine**, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Method of Payment: Cash Check Credit Card

AR 32103

Form Continued on Reverse Side

PATIENT REGISTRATION

Please PRINT AND complete ALL sections below !

EMERGENCY CONTACT

Name of Person not living with you: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Mobile Phone: (____) _____

PHARMACY REFERENCE

Name: _____ Phone: _____

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birthdate: _____

Signature: _____ Date: _____

IOSM FACSIMILE AUTHORIZATION FORM

I, the undersigned, authorizes IOSM to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories and other medical caregivers in the necessary coordination of care for the patient listed below.

I may revoke this authorization by giving IOSM five (5) days written notice. This revocation may be by facsimile transmission, however a **written copy of the revocation must be mailed to IOSM as well.**

Patient Name: _____

Patient Signature: _____

CONTACT AUTHORIZATION

Circle where you can be reached during business hours: Home Work Cell

May we contact you at home: Yes No

May we contact you at your place of business? Yes No

Leave message with:

Leave message with:

Yes No Voicemail / Answer Machine

Yes No Voicemail / Answer Machine

Yes No Mobile Phone

Yes No Mobile Phone

Yes No Family Member

Yes No Co-Worker

May we contact you via email? Yes No E-mail Address: _____

Patient Signature: _____

I hereby give permission to Irving Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following members (relatives, or close personal friends):

Name

Relationship

Name

Relationship

Name

Relationship

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical conditions.

PATIENT HISTORY FORM

This is a confidential record and information contained here will not be released without your consent.

Today's Date ____/____/____ Date of Injury ____/____/____

Last Name _____ First Name _____ Middle _____

Social Security No. _____ Date of Birth ____/____/____

Primary Care Physician _____ Who referred you to us? _____

Do you want a report sent to this physician? ____ yes ____ no

CHIEF COMPLAINT: What is the main reason for your visit today? Describe problem in detail.

Work related? _____ Sports related? _____ Motor Vehicle Accident? _____

HISTORY OF PRESENT ILLNESS

When did you first notice this problem? _____

What actions/activities make the problem worse? _____

What actions/activities make the problem better? _____

How long does the problem usually last?

Minutes _____ Hours _____ Constant _____ Occasional _____

Does the problem interfere with your normal functions? (Explain)

Have you seen another physician for this problem? (Explain)

Have you had any diagnostic studies or treatments for this problem? (X-rays, MRI, EMG, Bone Scan, Bone Density?) If so, when and where?

Pain Level ____ 0-3 (mild) ____ 4-6 (moderate) ____ 7-10 (severe)

Signature _____

Please see other side

PAST MEDICAL HISTORY

List all previous illnesses that have required medical treatment: _____

List all previous surgeries: _____

List all medications you are taking including vitamins or herbal supplements: _____

List all known drug allergies: _____

Do you smoke and how much? _____

Do you consume alcohol and how much/daily/weekly? _____

FAMILY HISTORY

List all serious illnesses in your immediate family. (Example: diabetes, cancer, etc.)

REVIEW OF SYSTEMS

Please answer yes or no to any problems related to the following systems.

Constitutional

Fever _____

Chills _____

Headache _____

Neurological

Tremors _____

Seizures _____

Dizziness _____

Numbness _____

Endocrine

Excessive thirst _____

Too cold/hot _____

Tired _____

Eyes

Blurred vision _____

Double vision _____

Pain _____

Allergic/Immunologic

Hay Fever _____

Drug allergies _____

Integumentary

Skin rash _____

Boils _____

Itching _____

Musculoskeletal

Joint pain _____

Neck pain _____

Back pain _____

Ear/Nose/Throat

Ear infection _____

Sore throat _____

Gastrointestinal

Abdominal pain _____

Heartburn _____

Nausea/Vomiting _____

Indigestion _____

Genitourinary

Urine retention _____

Painful urination _____

Incontinence _____

Frequency _____

Hematologica

Swollen glands _____

Blood clotting _____

Anemia _____

Other _____

Psychological

Depression _____

Suicidal _____

Respiratory

Wheezing _____

Cough _____

Shortness of breath _____

Cardiovascular

Chest pain _____

Varicose veins _____

Hypertension _____

Palpitations _____

Heart murmur _____

Signature _____

IRVING ORTHOPEDICS & SPORTS MEDICINE

Thank you for choosing Irving Orthopedics & Sports Medicine as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Full payment is due at the time of service
We accept cash, checks, or Visa/ MasterCard/ American Express
We offer an extended payment plan with prior approval

INSURANCE

We may accept assignments of insurance benefits upon your first visit; however, we do require your portion of the bill to be paid at the time of service (i.e. co pay, deductible, etc.). Because the bill is your responsibility, should your insurance company not pay – you will receive a bill for the remaining balance. We will do everything reasonably required to facilitate the filling of your insurance claim. This necessitates you providing us with your insurance information, along with all other relevant documents (i.e. accident reports, secondary insurance, workman’s compensation, etc.). Your insurance policy is a contract between you and your insurance company. Please be aware that your insurance may deny coverage that is usual, customary, and in our opinion medically necessary- declaring the treatment not necessary or not covered. Should this occur, you will be responsible for the entire bill. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency.

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to: **Irving Orthopedics & Sports Medicine** or if my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows: **2120 N. MacArthur Ste 100, Irving, TX 75061**

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize my doctor to initiate a complaint on my behalf to the Insurance Commissioner for any reason.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

PRIVATE PAY

There is a minimum deposit of \$250.00 (cash or credit card only – no checks accepted) due upfront for all private pay patients on the initial visit. Due to the bill being your responsibility, should your charges add up to more than your deposit, you will be billed the remaining balance. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency.

MINOR PATIENTS

The adult accompanying a minor and the parent (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, VISA / MasterCard, or payment by cash or check at the time of service. Minor patients must also have a signed consent form by their parent or guardian in order for our professionals to treat the minor.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit (subject to extenuating circumstances). Please help us serve you better by keeping scheduled appointments.

RETURNED CHECKS

There will be a \$30.00 service charge on returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

By signing below, I am stating I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date

Robert E. Bayless, M.D.
Steven B. Sanders, M.D.
R. Mills Roberts, M.D.
John G. Westkaemper, M.D.
Mark A. Kazewych, M.D.
Yong T. Pak, M.D.



Orthopedic Surgery
Sports Medicine
Arthroscopy
Joint Replacement
Fracture Care
Comprehensive Back & Neck Care
Open MRI & Bone Densitometer
Hand and Upper Extremity Care

Member Authorization Form for a Designated Representative to Appeal a Determination

TO: _____
[Your Insurance Carrier's Name]

Date: _____

Member Name: _____

Member#: _____

I hereby authorize Irving Orthopedics & Sports Medicine/Southwest Spine Institute to appeal _____'s determination concerning my coverage for medical
[Your Insurance Carrier's Name]

care provided on _____ on my behalf, as my Designated
[Date(s) of Service]

Representative, and, as part of the appeal, I hereby authorize _____
[Your Insurance Carrier's Name]

to send all decision letters in connection with the processing of my claim and to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain medical and financial information that relates to my appeal.

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

Members or Legal Guardian

Designated Representative Signature

Designated Representative (Print Name)

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**Physician Assistant
 Consent For Treatment**

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

“Supervision” does not required the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include, but are not limited to:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and understand that health care services may be provided by a physician assistant.

I understand that at any time I can request to see the physician.

Name:	Date:
Signature:	Witness (optional):

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Important Information About Provider/Patient Email

As a patient of a Irving Orthopedics & Sports Medicine (IOSM), Southwest Spine Institute, and Southlake Orthopedics & Sports Medicine you have the right to request we communicate with you by electronic mail (email). It is also your right to be informed in sufficient detail about the risks of communicating via email with your health care provider or office, and how IOSM will use and disclose provider/patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition. If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you – and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and/or your PDA have inherent privacy risks – especially when your email access is provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the post office.

Email messages may be inadvertently missed. To minimize this risk, IOSM or any of the DBA's will require that you respond appropriately to a test email message before we will allow health information about you to be communicated with you via email. You can also help minimize this risk by using only the email address that you are provided at the successful conclusion of the testing period to communicate with IOSM.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. In order to forward or to process and respond to your email, individuals at IOSM other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider. Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

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Patient Request for Email Communications

Communications over the Internet and/or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way. Nevertheless, you may request that we communicate with you via email. To do so, you must complete this form and return it to Irving Orthopedics & Sports Medicine (IOSM).

Please be advised that:

- (1) **This Request applies only to the health care provider or office that you indicate below. If you would like to request to communicate via email with another health care provider or office, you must complete a separate Request for that office.**
- (2) IOSM will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS information, substance abuse treatment records information, mental health information) via email even if we agree to communicate with you via email.
- (3) Your Request will not be effective until you receive and respond appropriately to a test email message from IOSM.

Please select the test question you want to use below, and provide us with your answer.

Please provide the following information:

Patient Name: _____ Date of Birth: _____

Phone number: _____

Address: _____

Please specify the email address to which communications should be addressed:

Please select the question you want to use (by checking the one of the boxes below) for your test email and provide your answer.

The last four digits of my Social Security Number: _____

My mother's maiden name: _____

My middle name: _____

The street number of my residence: _____

Please initial each blank and sign below:

____ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.

____ I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL form, and I have read and understand it.

____ I understand and acknowledge that communications over the Internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.

____ I understand that all email communications in which I engage may be forwarded to other providers, including providers not associated with IOSM, for purposes of providing treatment to me.

____ I agree to hold IOSM and individuals associated with it harmless from any and all claims and liabilities arising from or related to this Request to communicate via email.

Signature of patient or personal representative

Date _____

If personal representative, authority to act on behalf of patient _____

2120 N. MacArthur Blvd., Suite 100, Irving, Texas 75061

Phone (972) 438-4636 Fax (972) 438-2077 www.irvingortho.com