Irving Orthopedics & Sports Medicine
Southwest Spine Institute

Registration Form

Patient's Information

Last Name:_____ First Name: _____ Middle Initial:_____

Date of Birth:_____ Primary Contact Number: □ Cell □ Home □ Work

Cell Phone: _____ Home Phone:_____ Work Phone:_____

Email address: _____

Emergency Contact

Full Name:_____ Relationship:_____

Primary Contact Number:_____ □ Cell □ Home □ Work

Alternate Contact Number:_____ □ Cell □ Home □ Work

Contact Preferences

Preferred Communication: □ Cell □ Home □ Work

I wish to be contacted in the following manner: (check all that apply)	OK To leave a message with Detailed information?	Leave message with call back number only
□ Cell □ Home □ Work □ Email	□ Cell □ Home □ Work □ Email (see email request form)	□ Cell □ Home □ Work □ Email

Automated Appointment Reminders

Irving Orthopedics has adopted an outside appointment reminder system of which will send you appointment confirmation requests via email 5 days prior, preferred phone two days prior, and a text one day prior to your appointment with limited information for the purpose of notifying you of your appointment time and the provider to which you will be seeing. I authorize my healthcare provider to disclose to this third party service limited Protected Health Information regarding my upcoming appointments. I consent to receiving these messages via email, phone and and/or text (text message rates will apply).

Disclosure of Medical Information

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

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full 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

Notice of Privacy Practices

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

Facsimile Authorization for Coordination of Care

I, the undersigned, authorize 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. Medical records requests require separate form and authorization from this Facsimile Authorization. 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.**

Signature:_____ Date: _____

IRVING ORTHOPEDICS & SPORTS MEDICINE

Financial Policy

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 most current 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 Blvd., Suite 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 **$350.00** due upfront for all private pay patients on the initial visit. All deposits must be cash or credit card only – no checks accepted. 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. You will be responsible for all charges acquired during follow-up visits.

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 / AMEX, 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

2120 N. MacArthur Blvd., Suite 100, Irving, Texas 75061
Phone (972) 438-4636 ● Fax (972) 438-2077 ● www.irvingortho.com

Irving Orthopedics & Sports Medicine
Southwest Spine Institute

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)

2120 N. MacArthur Blvd., Suite 100, Irving, Texas 75061
Phone (972) 438-4636 ● Fax (972) 438-2077 ● www.irvingortho.com ● www.swspineinst.com

Irving Orthopedics & Sports Medicine
Southwest Spine Institute

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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Irving Orthopedics & Sports Medicine
Southwest Spine Institute

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.

Irving Orthopedics & Sports Medicin
Southwest Spine Institute

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 within Irving Orthopedics and Sports Medicine.** 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 provide the following information:

Patient Name: _____ Date of Birth: _____

Phone number: _____ Email Address: _____

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 #: _____
- ➢ 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.
- ❒ **I choose to waive the option for any email communications.**

_____ _____

Patient Signature Date

2120 N. MacArthur Blvd. • Suite 100 • Irving, Texas 75061 • (972) 438-4636 • Fax (972) 438-2077
www.irvingortho.com • www.swspineinst.com

Medication Policy

John C. Milani, M.D., P.A.
2120 N. MacArthur Blvd., Suite 100
Irving, TX 75061

Our goal is to provide you with the best treatment possible in a pleasant and caring manner. We are sensitive to the pain you may be experiencing and for that reason you may be given medication to help with your pain. The following medication policy is intended for the safety of our patients and to limit the chance of drug interactions.

- Medications are to be taken as prescribed by the physician
- Patients should use one pharmacy for their medications and refills.
- We are available to refill prescription medications during the following hours:

  Monday – Friday 8:00 a.m. to 4:30 p.m.
  ***Please allow 24 hours for all refill requests to be processed by the office.**
- Medications will not be filled on weekends or after hours.
- Patients should contact their pharmacy for refills
- Failure to comply with this policy may result in delayed or denied medication refills.
- Dr. Milani does not prescribe long term narcotic pain medications.
- Those patients requiring long term pain medications will be referred to a pain management specialist for all medication needs.

I certify this policy has been fully explained to me, that I have read it, or have had it read to me, and that I understand it.

_____ _____

Patient Name (print) Date

_____

Patient Signature

Spine Patients History Form Addendum

Do you have numbness? ☐yes ☐no
if *yes*, where is the numbness located? _____

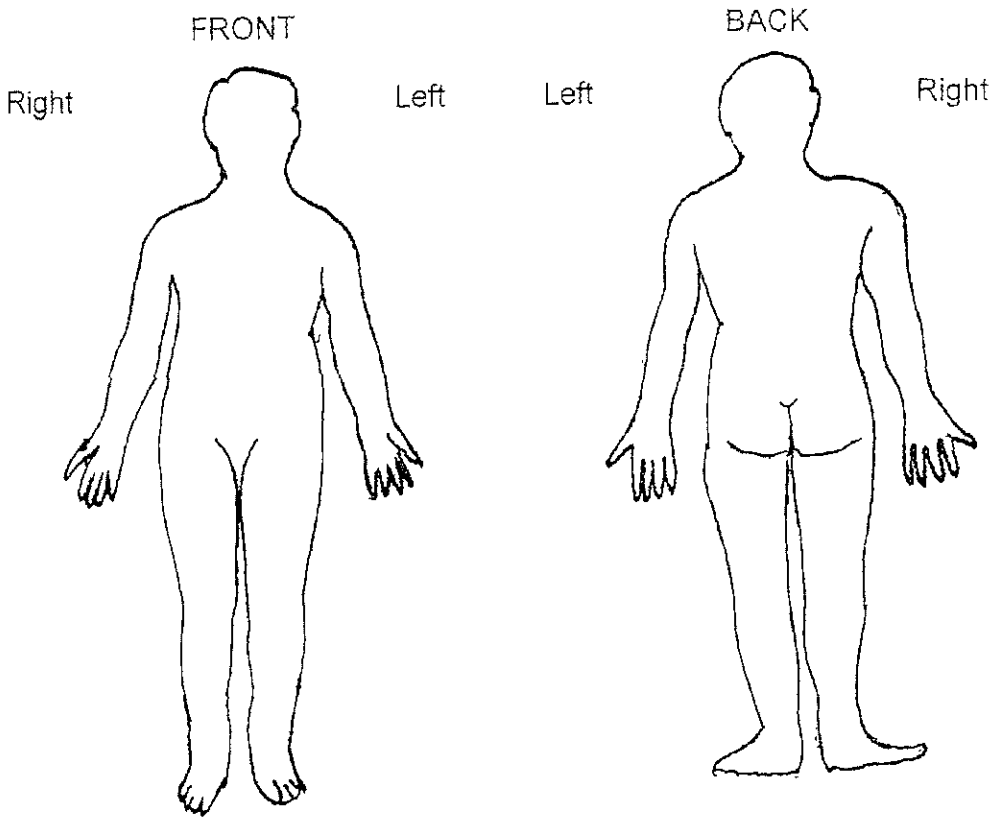
Do you have weakness of any body parts? ☐yes ☐no
if *yes*, where is the weakness located? _____

Do you have normal control of bowel and bladder? ☐yes ☐no
if *no*, what is the problem? _____

Do you have erection problems or sexual dysfunction? ☐yes ☐no
if *yes*, what is the type of problem? _____

Do you use: ☐cane ☐wheelchair ☐crutches ☐braces

Please draw where your pain is
(ensene en donde tiene dolor)



By signing below I am verifying that the information provided above is complete and accurate.

Printed Name: _____ **Signature:** _____

Date of Birth: _____ **Date:** _____