ORTHOPAEDIC SPECIALISTS OF AUSTIN

NEW PATIENT INFORMATION

Salutation | First Name | MI | Last Name | Nickname

Date of Birth:	Address:	
SSN:	City:	State: Zip:
Home Phone:	Daytime Phone:	Mobile Phone:
Which number do you prefer we use to contact you?	☐ Home ☐ Work ☐ Cell	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed		
Name of Spouse: First MI Last		
Spouse Date of Birth:	Spouse Phone:	Spouse SSN:
Spouse's Employer:		
☐ ☐ ☐ ☐ ☐ ☐		
Whom should we contact in case of an emergency?		
Relation:	Phone:	Alternate 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

Employer:	Occupation:	
Employer Address:		
City: State: Zip:	Employer Phone:	
ARE YOU HERE FOR A WORK-RELATED INJURY? ☐No ☐ Yes*	*If you answered YES, please inform the receptionist	

GUARANTOR INFORMATION (If patient is a minor)

Guarantor First MI Last

Relation:	Address:	
Date of Birth:	City: State: Zip:	
Guarantor SSN:	Phone:	Alternate Phone:

PRIMARY INSURANCE – MUST BE COMPLETED

Insurance Company:	Policy Number:	Group:
Claims Address:	Phone:	
City: State: Zip:	Phone:	
Name of Insured (as it appears on the card)	Date of Birth:	SSN:
Address of Insured (if different from patient)		
City State Zip:	Relation:	

SECONDARY INSURANCE

Insurance Company:	Policy Number:	Group:
Claims Address:	Phone:	
City: State: Zip:	Phone:	
Name of Insured (as it appears on the card)	Date of Birth:	SSN:
Address of Insured (if different from patient)		
City State Zip:	Relation:	

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CONSENTS

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

ORTHOPAEDIC SPECIALISTS OF AUSTIN

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 whether our providers participate with your insurance. 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 2 days 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. Please note that 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 with our front office. If you have an unmet deductible, we request payment of $150 toward your deductible. This $150 payment will be applied to your final balance once your insurance company processes your claim, and you will be responsible for the remaining balance. Please note that your bill could be significantly 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 provisions of the Texas Workers' Compensation Act, any injury/condition caused while performing services for the employer 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.

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

_____

Printed name of patient or responsible party

_____ _____

Signature of patient or responsible party Date

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MEDICAL HISTORY – SPINE

PATIENT NAME:			DATE:	
			Primary Care MD:	
Date of Birth:			Patient Address:	
Weight:	Height:	Age:		
☐ Left Handed	☐ Right Handed		Patient Phone:	

HISTORY OF PRESENT ILLNESS

Describe the reason for your visit:

Is this the result of an injury? ☐ YES ☐ NO	Date of Injury:	Location of Injury on body:
	How did this injury occur?	

EVALUATION OF PAIN/DISCOMFORT

Where is the majority of your pain?	Give relative % of back or neck pain vs. leg or arm pain
☐ Leg Pain Rt / Lft / Both ☐ Back	[%] Leg [%] Back (Total should be 100%)
☐ Arm Pain Rt / Lft / Both ☐ Neck	[%] Arm [%] Neck

	Mild			Moderate				Severe		
Pain Scale (Circle one number)	None	1	2	3	4	5	6	7	8	9	10

Onset of Pain: ☐Sudden ☐Chronic ☐Gradual Worsening

When did the problem start?

Duration of pain: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

Description of pain: ☐ Sharp ☐ Ache ☐ Burn ☐ Numb ☐ Cramp ☐ Stab

What makes it feel better?	☐ Bending Forward	☐ Sitting	☐ Standing
	☐ Bending Back	☐ Walking	☐ Lying Flat
What makes it feel worse?	☐ Bending Forward	☐ Sitting	☐ Standing
	☐ Bending Back	☐ Walking	☐ Lying Flat

Is your pain activity-related? ☐Yes ☐ No	Does pain wake you from sleep? ☐ Yes ☐ No

What does the pain keep you from doing?

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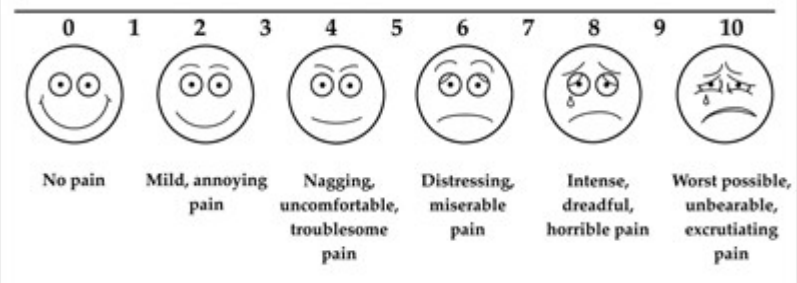
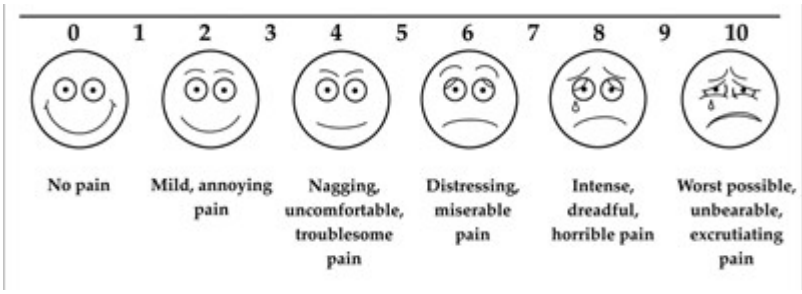
Visual Analog Score Back or Neck Pain

Please circle only **ONE**



Visual Analog score Leg or Arm pain

Please circle only **ONE**



PREVIOUS TREATMENT FOR THIS PROBLEM					
Diagnostic Testing:	☐ CT	☐ MRI	☐ EMG	☐ X-ray	☐ Other
Anti-Inflammatories:	☐ Helpful	☐ Not Helpful		Other Treatment:	
Injections:	☐ Helpful	☐ Not Helpful			
Physical Therapy:	☐ Helpful	☐ Not Helpful			
Chiropractics:	☐ Helpful	☐ Not Helpful			
Acupuncture	☐ Helpful	☐ Not Helpful			
Is this condition being covered by Worker's Compensation?				☐ Yes	☐ No

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PAST MEDICAL HISTORY (check all that apply)

☐ Diabetes	☐ Bleeding tendencies	☐ HIV / AIDS
☐ High blood pressure	☐ Blood clots	☐ Hepatitis
☐ Stroke	☐ Cancer	☐ Vascular disease
☐ Heart disease	☐ Ulcers	☐ Anesthesia difficulties

PAST SURGICAL HISTORY

Describe:	Year:	Describe:	Year:
Describe:	Year:	Describe:	Year:
Describe:	Year:	Describe:	Year:

CURRENT MEDICATIONS (Please list all prescription and non-prescription medications that you are currently taking).

Medication Name	Dose	How often	Medication Name	Dose	How often

ALLERGIES (medications, metals, etc.)

List:

FAMILY HISTORY (check all that apply)

☐ Cancer	☐ Diabetes	☐ Musculoskeletal disease
☐ Heart disease	☐ Malignant hyperthermia	☐ Anesthesia difficulties
☐ Stroke	☐ Bleeding disorder	

SOCIAL HISTORY (check all that apply)

☐ Married	☐ Single	☐ Divorced	☐ Widowed
☐ Live Alone	☐ Live with Family	☐ Live with Friends	☐ Live in Nursing Home

Do you smoke?	☐ Yes	☐ No	How many years?	How many packs/day?	
Do you drink?	☐ Yes	☐ No	How often?	☐ Minimal ☐ Moderate	☐ Heavy
Your occupation:				Last day worked:	

REVIEW OF SYSTEMS (check all that apply)

Skin	☐ Rash	Throat	☐ Sore throat	GI	☐ Weight loss or gain
	☐ Psoriasis		☐ Hoarseness		☐ Abdominal pain
Heme	☐ Bleeding tendencies		☐ Snoring		☐ Liver disease
	☐ Bruise easily	CV	☐ Heart attack		☐ Constipation
Eyes	☐ Visual Loss		☐ Irregular Heartbeat	GU	☐ Kidney stones
	☐ Double vision		☐ Chest pain or pressure		☐ Bladder infections
Ears	☐ Decreased hearing	Lungs	☐ Shortness of breath		☐ Blood in urine
	☐ Ringing in ears		☐ Asthma	Endo	☐ Diabetes
Nose	☐ Sinus problems		☐ Bronchitis		☐ Thyroid
	☐ Breathing problems		☐ Pulmonary emb/DVT	Skeletal	☐ Osteoporosis
Psych	☐ Depression	Neuro	☐ Seizures		☐ Rheumatoid Arthritis
	☐ Hallucinations		☐ Headaches		☐ Gout

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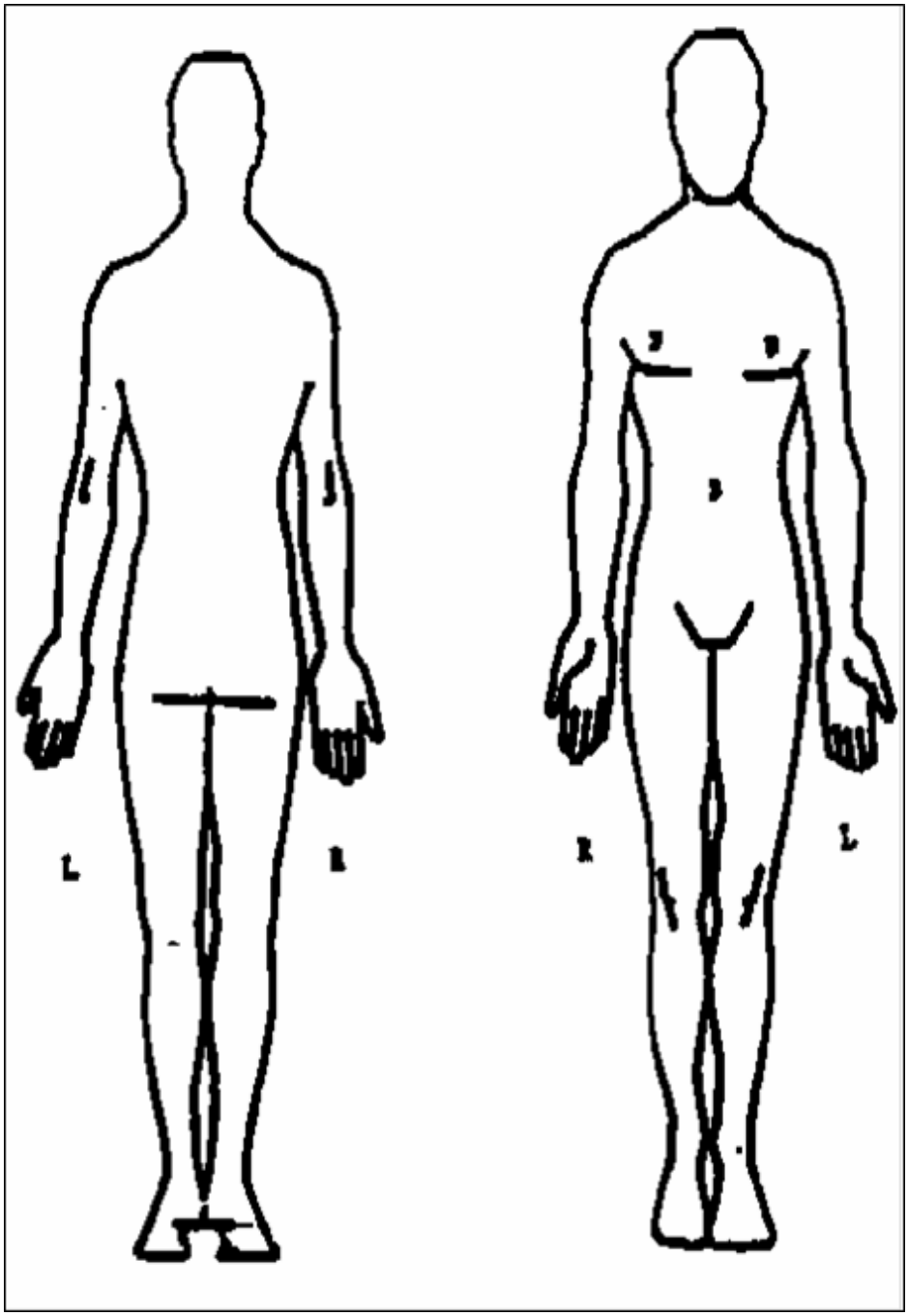
Using these symbols, mark the drawing below to describe your pain					
Numbness	= = = = = = = = =	Aching	^ ^ ^ ^ ^ ^ ^ ^ ^ ^	Pins and Needles	o o o o o o o o o o
Stabbing	/ / / / / / / / / / / /	Burning	x x x x x x x x x x	Cramping	+ + + + + + + + + +



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INJURY ADDENDUM

Patient Name:	Date

CIRCUMSTANCES OF INJURY

Date of Injury:				
Make and model of YOUR car:				
How did the accident happen? (Ran red light, etc.)				
Make and model of OTHER car:				
How fast were YOU moving?		How fast was the OTHER car moving?		
Description of Accident:	☐ Passenger Side	☐ Driver side	☐ Frontal	☐ Rear
How much did it cost to repair YOUR car? $				
Were you wearing a seatbelt?	☐ Yes	☐ No		
Were you:	☐ Driving	☐ Passenger		
Comments:				

PREVIOUS TREATMENT FOR THIS PROBLEM

Have other doctors seen you for this condition?	☐ Yes	☐ No	If yes, who?
Have you ever had this type of pain before?	☐ Yes	☐ No	
Have you ever had back or neck pain before?	☐ Yes	☐ No	
Have you ever had an MRI of your back or neck?	☐ Yes	☐ No	
	☐	☐	