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: ☐ **Yellow Pages** ☐ **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

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

Name: _____ Date of birth: _____/_____/_____ Age: _____

Height: _____'_____' Weight: _____lbs. Pharmacy Name/Phone Number: _____

Referring Physician Name: _____

Please describe problem(s) you are here for today: _____

_____

How long have you had the problem? _____

If an injury, where did it occur? ❒ Home ❒ School ❒ Auto ❒ Other _____ Date of Injury: ___/____/____

Where is the majority of your pain? ❒ Leg Pain Rt / Lt / Both ❒ Back { %} Leg { %} Back

❒ Arm Pain Rt / Lt / Both ❒ Neck { %} Arm { %} Neck

Pain Scale (Check One Number): MILD MODERATE SEVERE

❒ None ❒ 1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

Onset of Pain: ❒ Sudden ❒ Chronic ❒ Gradual Worsening

Duration of Pain: ❒ Occasional ❒ Intermittent ❒ Frequent ❒ Constant

Describe Pain: ❒ Sharp ❒ Aching ❒ Stabbing ❒ Burning ❒ Numbness ❒ Cramping

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 the pain wake you from your sleep? ❒ Yes ❒ No

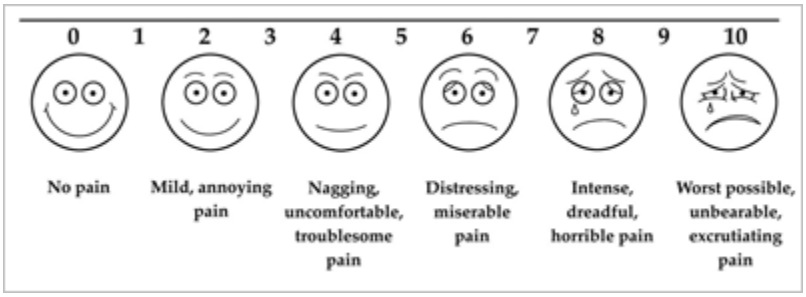
What does the pain keep you from doing? _____

_____

_____

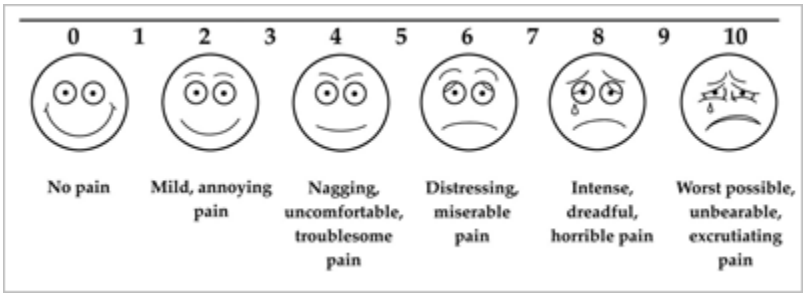
What is your level of Back or Neck Pain?

Please circle only **ONE**



What is your level of Leg or Arm Pain?

Please circle only **ONE**



PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing (Please list name of facility and date of service):
❒ CT _____
❒ MRI _____
❒ EMG _____
❒ X-Ray _____
❒ Other _____

Anti-Inflammatories: ❒ Helpful ❒ Not Helpful Name of Anti-Inflammatory: _____

Injections: ❒ Helpful ❒ Not Helpful Type of Injection(s) and Date of Injection: _____

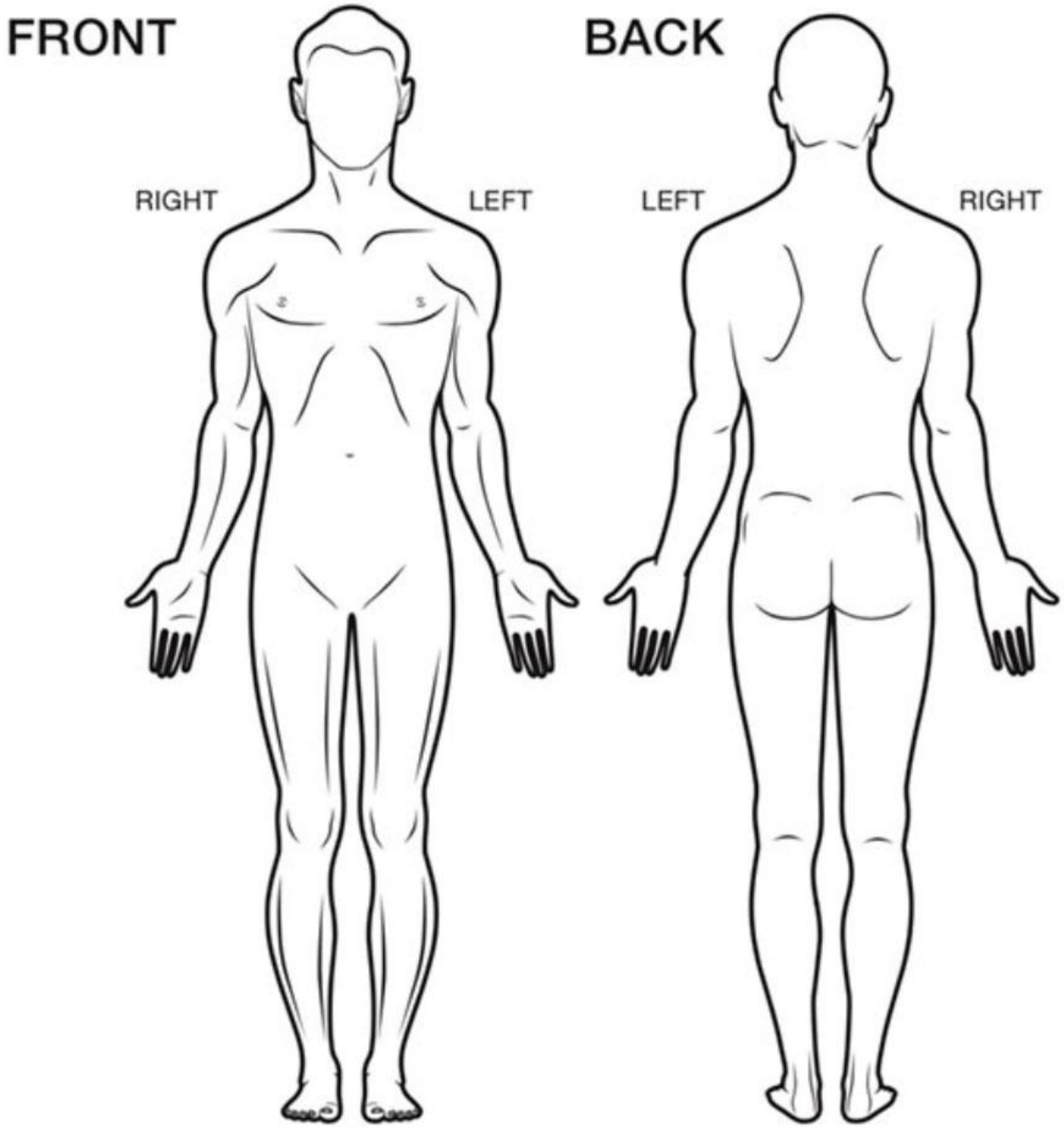
Physical Therapy: ❒ Helpful ❒ Not Helpful Name of PT Facility and Duration of PT: _____

Chiropractics: ❒ Helpful ❒ Not Helpful Name of Facility and Duration of treatment: _____

Other Treatment: _____

Using these symbols, mark the drawing below to describe the pain that you are having.

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 x x x x x x	Cramping	+ + + + + + + + + +



ALLERGIES ❒ NKDA *List your allergies and reactions*

Medication Allergy	Reaction

MEDICATION *List your medication name, strength and frequency*

Name of Drug	Strength	Frequency

CURRENTLY ON BLOOD THINNERS? ☐ Yes ☐ No

CURRENTLY ON DIABETIC INJECTIBLES? ☐ Yes ☐ No

REVIEW OF SYSTEMS *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		Seizure			
Pulmonary EMB/DVT		Headache			
Cough		Other:			
Other:					

MEDICAL HISTORY *Check the boxes that correspond to diagnoses you have been given in the past*					
ADD/ADHD		Diabetes Mellitus		Inflammatory Bowel Disease	
Allergies		Eating Disorder		Liver Disorder	
Anemia		Emphysema		Nerve/Muscle Disease	
Anxiety		Genitourinary Disease		Obesity	
Arthritis		GERD		Osteoporosis	
Asthma		Glaucoma		Pneumonia	
Bleeding Disorder		Headaches		Seizures	
Cancer		Hearing Loss		Skin Disease	
Congestive Heart Failure		Heart Disease		Stroke	
COPD		Hepatitis		Substance Abuse	
Coronary Artery Disease		HIV/AIDS		Thyroid Disease	
Dementia		Hyperlipidemia		Ulcers (GI)	
Depression		Hypertension		Vision Problems	

SURGICAL HISTORY *Check the boxes that correspond to surgeries you have had in the past*					
Abdomen Surgery		Eye Surgery		Spine Surgery	
Adenoidectomy		Gallbladder Surgery		Stent	
Appendectomy		Heart Surgery		Tonsillectomy	
Breast Surgery		Hernia Repair		Tubal Ligation	
CABG (Bypass Surgery)		Hysterectomy		Upper GI Endoscopy	
Colonoscopy		Joint Replacement		Valve Repair	
Cosmetic Surgery		Orthopedic Surgery		Weight Loss Surgery	
C-Section		Sinus Surgery			

SOCIAL HISTORY	
Alcohol	Do you drink alcohol? ❒ Yes ❒ No If yes, how many drinks per week? _____
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?

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	