WEST TEXAS ORTHOPEDICS

5615 Deauville Blvd, Suite 220 | Midland, TX 79706 | 432-221-4004 | midlandhealth.org

PATIENT INFORMATION

Appointment date: _____ Seeing Dr. _____
Primary Care Dr. _____
Have you previously been seen by a WTO Dr.? Yes No
If yes, Who_____ When_____
How did you hear about us_____

PATIENT INFORMATION
Last Name: _____ First: _____ M.I. _____
Address: _____ City/St/Zip: _____
Home Phone #: _____ Mobile #: _____ Work #: _____
DOB: _____ SS#: _____ Email: _____
Driver's license # _____ Issuing State: _____
Please circle: Male Female Single Married Widowed Divorced
Primary Language: _____ Race: _____ Ethnicity: _____
Employer/School: _____
Address _____
Medical History Authority? Yes No

GUARANTOR INFORMATION
Last Name: _____ First: _____ M.I. _____
Address: _____ City/St/Zip: _____
Home Phone #: _____ Mobile #: _____ Work #: _____
Relationship: _____
DOB: _____ SS#: _____ Email: _____

EMERGENCY CONTACT:
Name: _____
Address: _____ City/St/Zip: _____
Phone: _____ Relationship: _____

INSURANCE INFORMATION

Category of insurance:

Commercial Medicare Medicaid Medicare Disability Cash Workers Comp
Auto at Fault Not at Fault

Primary Insurance Name: _____

Primary Insurance Phone number: _____

Policy Holders Name: _____

ID# _____ Group # _____

Relationship to insured: Self Spouse Child Other

DOB of policy holder: _____ SS# of Policy holder: _____

Employer name: _____ Employer phone: _____

Secondary Insurance Name: _____

Secondary Insurance Phone number: _____

Policy Holders Name: _____

ID# _____ Group # _____

Relationship to insured: Self Spouse Child Other

DOB of policy holder: _____ SS# of Policy holder: _____

Employer name: _____ Employer phone: _____

Workers Comp Info: Employer _____ Date of Accident: _____

Employers Address: _____ Workers Comp Claim # _____

Employer Phone #: _____ Employer Fax #: _____

Description of Accident and Injured Body Part _____

_____

_____

Contact Name: _____ Contact Phone #:_____

Assignment of Benefit/Release of Medical information: I authorize West Texas Orthopedics (WTO) to release any medical information that may be necessary to process my medical/surgical claims. I request that payment of my insurance benefits be made on my behalf to WTO for any service furnished to me. This assignment will remain in effect until revoked by me in writing.

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE

Disclosure of interest: Drs. Dean, Nelson, Mallams have ownership interest in the Texas Surgical Center, and as a result, may financially benefit from the referral of services to the TSC in the form of increased dividends or distributions. Please let us know if you have any concerns regarding the financial relationship between the doctors listed above and TSC. You do have the option of using an alternative healthcare facility.

_____ _____

Signature of Patient or Guarantor Date

Financial Policy

Thank you for choosing West Texas Orthopedics as your healthcare provider. Our offices are committed to providing the best medical care through communication and understanding. Confirmation and updating of personal address and phone/cell numbers for contact will assure our ability to communicate with you. At any time, you have questions or concerns requiring further information, whether it is medical or business, or staff is available to assist you.

The following information outlines our policies regarding the payment of your doctor's bill.

The cost of medical care is determined by the nature and complexity of the illness. There is no "flat rate for examinations and treatment. You are given an **estimated** amount at time of visit before checkout. After reviewing the physicians/providers documentation for the visit additional services/procedures maybe added to the visit.

Out-Of-Network Insurance Patients will be expected to pay the Out-of-Network Co-Insurance and Deductibles at the time services are rendered. West Texas Orthopedics will file with you Insurance Company as a courtesy.

Contracted Insurance Patients at each visit, your current insurance cards(s) will require presentation when *"signing in"* at the front desk. The Patient, or (in the case of minors) the accompanying Parent/Guardian, will be responsible for any co-pays, deductibles, or non-covered services at the time of the visit. The contracted allowable fees, of the specific contracted insurance, will be considered when payment is requested. Co-pays will not be billed since this is a requirement on your part by your insurance. If the insurance company is unable to process a claim due to inaccurate or missing information for you, you are responsible for the bill.

Non-Insured Patients will be expected to pay in full the estimated total at the time of service.

A statement of your unpaid balance plus additional services not covered by insurance will be sent to you for full payment within 30 days. To avoid collection procedures your account must be kept current.

Please sign to acknowledge you agree and understand policy:

_____

Patient Name(print):

_____ _____

Patient or Legal Guardian Signature Date

Release my protected health information to the following persons(s)/entity

Name _____ Relation _____ phone _____

Name _____ Relation _____ phone _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Midland Health Compliance officer: Pamela Porras
400 Rosalind Redfern Grover Parkway Midland, TX 79701

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in it actions. Also, a revocation is not effective of this authorization was obtained as a condition of obtaining insurance coverage. As other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. I have reviewed **Midland Health** Notice of Privacy Practices. **Midland Health** is authorized to use and disclose health information about patient listed below for treatment, payment and healthcare operations purpose consistent with its Notice of Privacy Practice**. The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. As a best practice policy for Midland Health we require all information forms be updated annually.**

_____ _____ _____

Print Patient Name Date of Birth Date

_____ _____

Signature of patient Signature of personal representative

_____

Relationship to Patient (Or Other Authority)

(Midland Health policy we require all information forms be updated annually)

Health Insurance Portability and Accountability Act

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the acknowledgement and consent

This acknowledgement of notice and consent authorizes **Midland Health** to use and disclose health information for treatment, payment and health care operations purposes.

Notice of Privacy Practices. **Midland Health** has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment. I voluntarily consent to receive medical and health care services provide by **Midland Health**, employees and such associates, assistants, and other health care providers. I understand that such services may include diagnostic procedures, examinations and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that **Midland Health** may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

Please mark if you agree to accept artificial messages by: Phone calls Yes No Text messages Yes no
Emails yes no

Authorization Form for Release of Protected Health Information

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by patient, or an agent given medical power of attorney, your private health information and/or treatments will not be discussed.

By signing this for, I authorize you to use and disclose the protected health information described below.

The health information you release subject to the authorization is as follows:

All Medical **All Financial** **Other** _____

WEST TEXAS ORTHOPEDICS – WORKERS' COMPENSATION DISCLAIMER

(PLEASE READ CAREFULLY AND CHECK THE PROGRAM THAT APPLIES TO YOU)

NOT WORK-RELATED

The injury/condition that I am seeking treatment for today is **NOT** work-related. I will **NOT** be filing a workers' compensation claim. I understand that failure to disclose this information truthfully will result in all becoming my responsibility. I understand that in the event I inform my personal health insurance company this injury /condition is work-related, m personal insurance company may not accept responsibility for the charges incurred; therefore, I will be responsible for payment in full.

_____ _____ _____

Print Patient Name Patient Signature Date

WORK-RELATED:

The injury/condition that I am seeking treatment for today **IS** work-related and **I HAVE** filed a workers' compensation claim. I understand that the workers' compensation rules of the State of Texas are as follows: (Please mark the appropriate box below)

1. **Workers' Compensation Under Texas Workers' Compensation Guideline:** Your first report of injury must be on file with the workers' compensation insurance company and the first office visit must be approved.
2. **Non-Subscriber:** Your employer has elected not to carry traditional Texas Workers' Compensation insurance but does provide coverage for their employees.
3. **Occupational Workers' Compensation:** Patient must have approval of insurance company prior to initial visit. The insurance company will not offer open medical for life on compensable injury. Occupational policy is for a predetermined time frame and it is your responsibility to know that time frame. All Charges after that date will become your responsibility and payment is expected at time of service.
4. **Employers with no coverage:** Payment is due at the time of service.
    a. Employers will need to sign a contract prior to your visit
    b. Payment is due in full at each visit
    c. Employers will need to sign a separate contract regarding any necessary or elective surgical procedures

_____ _____ _____

Print Patient Name Patient Signature Date

Workers Compensation information

Date of Accident: _____

Employer: _____ Employer Phone: _____

Employer address: _____ Workers' Comp Claim #: _____

Employer phone: _____ Employer Fax: _____

Description of Accident and Injured Body Part: _____

_____

Contact Name: _____ Contact phone #: _____

WEST TEXAS ORTHOPEDICS – MEDICAL HISTORY

Last Name _____ First Name _____ MI_____

DOB _____ Age_____ SS# _____ Referred by _____

Describe your current problem/complaint (Specify LEFT or RIGHT body part) _____

_____

Describe how the injury occurred _____

_____

Date of injury or date problem began _____

Was this an on-the-job injury? Yes No Was your employer notified? Yes No

Is this injury/problem due to an auto accident? Yes No At fault? Yes No

Insurance/Attorney? _____

Have you had prior treatment for this injury? Yes No By whom _____

If yes, please describe treatment _____

Have you had any of the following diagnostic studies for this injury?

X-Rays Yes No Date: _____ Where _____

MRI Yes No Date: _____ Where _____

CAT Scan Yes No Date: _____ Where _____

Myelogram Yes No Date: _____ Where _____

Discogram Yes No Date: _____ Where _____

EMG/NCV Yes No Date: _____ Where _____

Family Physician/Location: _____

Cardiologist: _____

Height: _____ Weight _____ BMI (body mass index, if know) _____

Is there any possibility of you being pregnant? Yes No

(if yes, please tell X-Ray tech prior to any x-rays)

History of: Endometriosis Osteoporosis Post-Menopausal Hormone Replacements

Pharmacy _____ Location _____

Medication	Dosage	Frequency

Food allergies: _____

Medication allergies & reactions: _____

_____

Have you ever had an Allergic reaction to:

IV contrast	yes	no
Topical Iodine	yes	no
Latex?	Yes	No
Metal?	Yes	No
Tape?	Yes	No

Past Medical/Family History

	Notes: Please indicate Self or Family member (Father, Mother, Brother, Sister, Maternal or Paternal Grandfather or Grandmother)		Notes: Please indicate Self or Family member (Father, Mother, Brother, Sister, Maternal or Paternal Grandfather or Grandmother)
AIDS/HIV		High Cholesterol	
Anxiety/Depression		Hypertension	
Arthritis		Kidney Disease	
Asthma		Liver Disease	
Atrial Fibrillation		Meniere's Disease	
Bleeding Disorder		Migraines	
Blood Transfusion		Nasal Polyps	
Respiratory		Orthotics	
Cancer		Osteoporosis	
Chronic Ear Infection		Pacemaker	
Coronary Artery Disease		Peripheral Vascular Disease	
Deep Vein Thrombosis		Pulmonary Embolism	
Dementia		Rheumatoid Arthritis	
Diabetes		Seizures/Epilepsy	
Difficulty Swallowing		Stroke	
Gout		Thyroid Problems	
Heart Attack or Heart problems		Tuberculosis	
Hepatitis		Ulcers	
Hernia		Other	

Event	Description	Date
Surgeries		
Hospitalizations		
Illnesses		

Other information you feel the doctor should know: _____

_____

_____

SOCIAL HISTORY

Status: Single Married Divorced Separated Widowed # 0f children _____

Do you currently smoke? Yes No _____packs/day? Smokeless tobacco products(chew/dip) yes No

Have you previously smoked? <1 year >5 years Tobacco-years of use ____

Do you drink alcohol? No Rarely 1-2 times/week daily/how much?

Caffeine ____cups/day Coffee/tea _____oz/day soft drinks ____/day

Do you use recreational drugs yes no if yes, what _____

Diet? Regular Vegetarian diabetic Gluten Free Cardiac other _____

General Stress level? Low Medium High

Do you exercise Never Rarely Moderately Daily Sporting activity _____

Hand Dominance (please circle) RIGHT LEFT Is blood transfusion acceptable in an emergency yes no

Are you currently employed Yes No Occupation _____

Do you live alone yes no

Do you have difficulty dressing or bathing yes no

Do you have walking or climbing yes no

Do you have difficulty hearing yes no

Blind or serious difficulty seeing yes no

History of Methicillin-resistant staphylococcus (MRSA) Yes No

Do you have any non-healing wounds Yes No

Do you have any body piercings? Yes No

Have you had steroids within the last six months? Yes No

Have you ever had general anesthesia? Yes No

Did you have any problems yes no describe _____

PATIENT PRESCRIPTION POLICY/CONTRACT

Pain medications (Narcotics) can be very useful but have high potential for misuse and abuse and are, therefore, closely, controlled by the local, state, and federal governments. Used properly, they are very effective in relieving pain symptoms. If use excessively, however, they can cause adverse effects such as vomiting, constipation, lethargy, or even death. To insure these medications are used properly, I agree to the following conditions:

1. I am responsible for my pain medications. If my prescription is lost, misplaced, stolen, or completely used before the refill date, I understand it will not be refilled.
2. I will not request nor accept pain medications from any other physician or individual while I am receiving such medication from my doctor at West Texas Orthopedics
3. I agree to use one and only one pharmacy
4. Refills: Please call your pharmacy regarding refills. All refill requests must be approved by the prescribing physician. Refills may take up to 24 hours for processing. Do no call after hours. The on-call doctor will no approve refills
5. For all NSAIDS (anti-inflammatory medications) lab work may be required every 6 months
6. I understand that if I violate any of the above conditions my prescriptions/refills will be canceled, and my physician may terminate my treatment and care. If the violation involves obtaining controlled substances from another individual or physician, I may also be reported to my primary physician, local medial facilities, pharmacies or other local authorities.

I attest that the information given above in my medial history is true and correct to the best of my knowledge. I also agree to the terms and conditions outlined in the above prescription contract.

_____ _____

Patient Name (Print) Date

_____ _____

Patient or Legal Guardian Signature Physician signature