NTOS
NORTH TEXAS
ORTHOPAEDIC & SPINE

Patient Information **Date**: _____

Please do not leave anything blank. Mark n/a if not applicable.

Name: _____
First Middle Last

Birth Date: _____ SS#:_____ Sex: [ ] M [ ] F

Address: _____Apartment#: _____

City: _____State: _____Zip:_____

Primary Phone #: _____ Type: [ ] Home [ ] Cell [ ] Work

Secondary Contact #: _____ Type: [ ] Home [ ] Cell [ ] Work

Email Address: _____

Employer name: _____

Employer address: _____

Employer Ph#: _____

Check Appropriate: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Primary Care Physician:_____

Phone.:_____

Pharmacy and Zip Code: _____ Pharmacy Number:_____

How were you referred to our office? _____

Insurance Information

Primary Insurance:_____ Subscriber's Name: _____ ID# _____ Group # _____

Secondary Insurance:_____ Subscriber's Name: _____ ID# _____ Group # _____

Consent to Release Claims Information and Assignment of Benefits

- I hereby assign, transfer and set over to NTOS, LLC all my rights, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company(ies).
- I hereby consent for NTOS, LLC or any of its employees or agents to release and disclose any information required about me (or the above-named patient) to my insurance carrier, claims administrator, managed care company, or review agency, their employees or agents for the purpose of treatment, healthcare operations, and evaluating claims for payment.
- I understand insurance billing is a service provided as a courtesy and that I am always personally responsible for any fees not covered by my insurance carrier. Should any insurance payment be made directly to me or to the insured for monies due on this account, I agree to immediately pay over these funds to NTOS, LLC. I also acknowledge I am responsible for any deductible, copay or other balance not covered by my insurance carrier.
- I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by NTOS, LLC, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient Name:_____**Date:** _____

***Patient Signature (parent or guardian if patient under 18:** _____

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Communication Preferences

May we contact you by phone for appointment reminders?	YES NO	HOME WORK	BOTH

Please let us know who we may share your information with:

Please complete the fields below and select the appropriate checkboxes based on your approval for each person you list.

Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information**

Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information**

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's ***Billing Account*** and ***Medical Conditions*** to the patient or legal guardian. The duration of this authorization indefinite unless otherwise revoked in writing. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Acknowledgement of The Receipt of North Texas Orthopaedic & Spine Notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIIPPA) is a federal government of regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. NTOS, LLC will furnish you with a notice (by request only) which provides information about how NTOS, LLC may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have been informed / offered a copy of NTOS, LLC Notice of Health Information Practices.**

***Patient Signature**: _____ **Date**: _____

NARCOTIC POLICY

Certain narcotic medications can only be filled/refilled with a handwritten prescription or token code sent over by the physician. Therefore, prescriptions will only be written or sent during normal business hours and we CANNOT accommodate walk-in requests. You will need to call in and allow up to 48 business hours for us to obtain a signature/token. We will call when your prescription can be picked up or has been sent in to the pharmacy. Beginning September 1, 2019, the Texas Legislature passed a bill limiting opioid prescriptions to 10 days.

By signing below, I understand that if I do not list someone to pick up my prescription on my behalf below, they will NOT be allowed to pick it up on my behalf.

I authorize _____ and/or _____ (full legal name) to pick up narcotic prescriptions on my behalf. I and they understand they will be required to show valid ID before the office will release the prescription.

***Patient Signature**: _____ **Date**:

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Cancellation Policy/No Show Policy for Doctor Appointments and Surgery

I. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not canceled at least 24 hours in advance you will be charged a seventy-five dollar ($75) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is l 5 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a ($250) fee: this will not be covered by your insurance company.

4. Account balances

We will re-quire that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concern.

Patients with balances over $l00 must make payment arrangements prior to future appointments being made.

_____	_____	____/____/____
Print Name Patient	**Signature Patient/Guardian**	**Date**

Patient Account# _____

(Office Use Only)

North Texas Orthopaedic & Spine – Office Policies

Appointments & Office Hours

- **We can only see you for one condition per visit due to increased regulated documentation requirements.**

Financial Policy

- ***Payment is due at time of service. We accept cash, Visa, MasterCard or Discover.***
- For patients with health insurance, co-payments, co-insurance and/or deductibles will be collected at the time services are rendered. Your insurance policy is a contract between you and your insurance company. In the event of denials, errors, service caps, policy exclusions or non-covered services, the patient is responsible for payment of all services rendered. **It is the patient's responsibility to know whether our providers are in-network with their insurance plan.** Patient will be responsible for any charges incurred whether in or out of network. Please notify the office of any changes in insurance coverage before services are rendered.
- If you do not have insurance, the office staff can provide you with a cost for services which is due in full, at time of service.
- Any account balance you may have must be paid in full prior to scheduling surgery.
- We reserve the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery.
- If you have multiple primary insurance policies, you are responsible for coordinating primary vs. secondary with your insurance companies. Failure to do so will result in claim denials and refusal to pay.

Identity Verification

- If you would like us to bill your insurance carrier, you must present a valid insurance card AND identification prior to being seen at check-in **at every visit** or payment in full will be required.

Fees for Services

- Medical records: $25.00 for first 30 pages, $.25 each page thereafter. Please allow up to 15 business days.
- Disability, FMLA, employer-related or legal forms are $25.00, per occurrence. **(**Our physicians do NOT perform complete disability evaluations for military or worker's compensation reviews.)**

Medication Refill Policy

- All requests for prescriptions must be made 48 hours in advance. Please have your pharmacy request your refill. Medication refills are only addressed during office hours. Narcotic prescriptions must be picked up in person and cannot be mailed or called in. *By signing below, you are authorizing us to view your external Rx history.

I have read and understand the Office Policy and I agree to accept responsibility as described above. I also understand the Policy may be amended from time to time by the practice

Printed Name	Signature	Date

I, _____(print name) have read and understand this Financial Policy. I understand and agree to this Financial Policy. I further understand and agree that my failure to follow this Financial Policy may result in North Texas Orthopaedic and Spine terminating my patient-physician relationship.

_____ _____

Patient's Signature (or Parent/Guardian Signature as applicable) **Date**

Work-Related Injury?

The patient is responsible for: Providing our office with accurate information about the reason for seeking care today. If you feel this visit is or may be covered by **Workers' Compensation** (did your injury occur on or near your office/jobsite or while working for your employer?) it is your responsibility to notify our office at your **first visit**. If you fail to notify our office at your first visit, *you will be responsible for paying for any related, previously billed charges and any further charges up to and if we obtain payment from the work comp insurance company.* If we receive payment from the workers' comp insurance company, we will issue the patient a refund for the claim(s) paid.

DECLINATION: I have read and fully understand this form and by my signature I am attesting that my current medical condition/injury did not happen while at work and/or while at my place of employment.

_____ _____

Patient Signature (parent/guardian if patient under 18) Date

OR

If you think your injury may be or is covered by your employer's workers' compensation policy, please fill out the below sections:

Employer: _____

Name of Supervisor/HR Director: _____ Email: _____

Supervisor/HR Phone: _____

What was the date of your accident? _____

Name of Worker's Comp Insurance Company Accident claim #: _____

Adjuster name: _____

Contact info: _____

_____ _____

Patient signature (parent/guardian if patient under 18) Date

_____

Patient name (please print)

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Comprehensive History & Physical

Please do not leave anything blank. Mark n/a if not applicable.

Height: _____ **Weight**: _____ **Shoe Size:** _____

Please list:

Drug Allergies: **[ ] N/A**

_____
_____
_____
_____
_____

Environmental / Food Allergies: [ ] N/A

_____
_____
_____
_____
_____

Previous Surgeries: [ ] N/A

_____
_____
_____
_____
_____

Medical History:

Have you ever had or been told you have (Check all that apply): [ ] N/A

[ ] Anemia
[ ] AIDS/HIV
[ ] Alcoholism
[ ] Angina or Chest Pain
[ ] Anxiety
[ ] Asthma
[ ] Atrial Fibillation
[ ] Arthritis
[ ] Bilpoar Disorder
[ ] Cancer
[ ] Coronary Artery Disease
[ ] Congestive Heart Failure
[ ] Colitis
[ ] COPD
[ ] Crohn's Disease
[ ] Depression
[ ] Diabetes
[ ] Dialysis
[ ] Deep Vein Thrombosis
[ ] Fibromyalgia
[ ] Fainting Spells/Dizziness
[ ] Gallbladder Disease
[ ] GERD
[ ] Gout
[ ] Heart Attack / Failure
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Kidney Disease
[ ] Liver Disease
[ ] Lupus
[ ] Migraine Headaches
[ ] Multiple Sclerosis
[ ] Obesity
[ ] Osteoarthritis
[ ] Osteoporosis
[ ] Peptic Ulcer Disease
[ ] Pacemaker
[ ] Peripheral Vasular Disease
[ ] Seizures
[ ] Sleep Apnea
[ ] Stroke
[ ] Schizophrenia
[ ] Thyroid Problems
[ ] Other_____

ARE YOU CURRENTLY EXPERIENCING? (REVIEW OF SYSTEMS)

[ ] Fever
[ ] Significant Weight Change
[ ] Vision Problems
[ ] Cold / Cough Symptoms
[ ] Shortness of Breath
[ ] Chest Pain
[ ] Heart Palpitations
[ ] Diarrhea
[ ] Constipation
[ ] Urinary Inconsistance
[ ] Pain with Urination
[ ] Joint Pain
[ ] Chronic Headache
[ ] Rash on affected Limb

Social History	Circle your responses
Females – Any chance you may be pregnant? : Yes No	Do you live alone or with family?
Receiving Hospice Care? Yes No	Are you in Skilled Nursing or an Inpatient Rehab Facility? Yes No
Activity Level: Low Moderate Active	
Current Smoker Former Smoker Non-Smoker	If former how long ago did you quit?
If current how often?	How many per day: / Interested in Quitting? Yes No
Do you consume alcohol? Yes No	How Often: / How Many Drinks?
Have you ever used illegal drugs? Yes No	Type: / Currently?
Have you been addicted to prescription medications? Yes No	Type?
Do you drink caffeinated beverages? Yes No	How many cups per day?

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Please list ALL Current Medication: (including non-prescription, vitamins, and herbal supplements)

Medication Name	**Dosage:**	**Freuency:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Condition, Family Member, and Comment)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Reason for Visit:

Where is your pain? _____
Which side is affected? _____ Was this a result of an accident/injury? [ ] No [ ] Yes
When did they pain start? _____The pain: [ ] started suddenly [ ] progressively became worse
Does the pain move to other ares? [ ] No [ ] Yes
Have you had prior surgery at site of pain? [ ] No [ ] Yes If yes, type of surgery and when:_____
Frequency of pain: [ ] Constant [ ] Rare [ ] Seldom

Quality of you Pain: [ ] Aching [ ] Cramping [ ] Dull [ ] Hot/burning [ ] Numbing [ ] Pins/needles [ ]Pressure
[ ] Sharp [ ] Shooting [ ] Stabbing [ ] Throbbing [ ] Tingling

What makes you pain **worse**:
[ ] Bending
[ ] Changing Position
[ ] Defecation
[ ] Going up stairs
[ ] Going down stairs
[ ] Heat
[ ] Increased Activity
[ ] Lying Flat
[ ] Lifting
[ ] Movement
[ ] Sitting Long
[ ] Sneezing
[ ] Standing Long
[ ] Standing Straight
[ ] Turning Left
[ ] Turning Right

What makes your pain **better**:
[ ] Assistive devices
[ ] Changing Positions
[ ] Cold
[ ] Exercise
[ ] Heat
[ ] Injections
[ ] Lying Flat
[ ] Manipulation
[ ] Medication
[ ] Physical Therapy
[ ] Rest
[ ] Sitting
[ ] Standing
[ ] Walking

Histoy or Vertigo / dizziness? [ ] No [ ] Yes
History of falls? [ ] No [ ] Yes
History of Fibromyalgia? [ ] No [ ] Yes

Do you use any supporting devices? [ ] No [ ] Yes
[ ] Cane [ ] Crutches [ ] Walker [ ] Wheelchair

Have you done any Physical Therapy? [ ] No [ ] Yes If yes, when and for what reason? _____
Have you ever received any pain injections? [ ] No [ ] Yes

Does your pain radiate? [ ] No [ ] Yes If yes, where to? _____

At its **WORST**: 1 2 3 4 5 6 7 8 9 10
On **Average**: 1 2 3 4 5 6 7 8 9 10
At its **BEST**: 1 2 3 4 5 6 7 8 9 10
At the **Moment**: 1 2 3 4 5 6 7 8 9 10

Where is your pain located <u>NOW?</u> Mark the areas below where you feel the described sensations using the symbols provided. Include all affected areas.

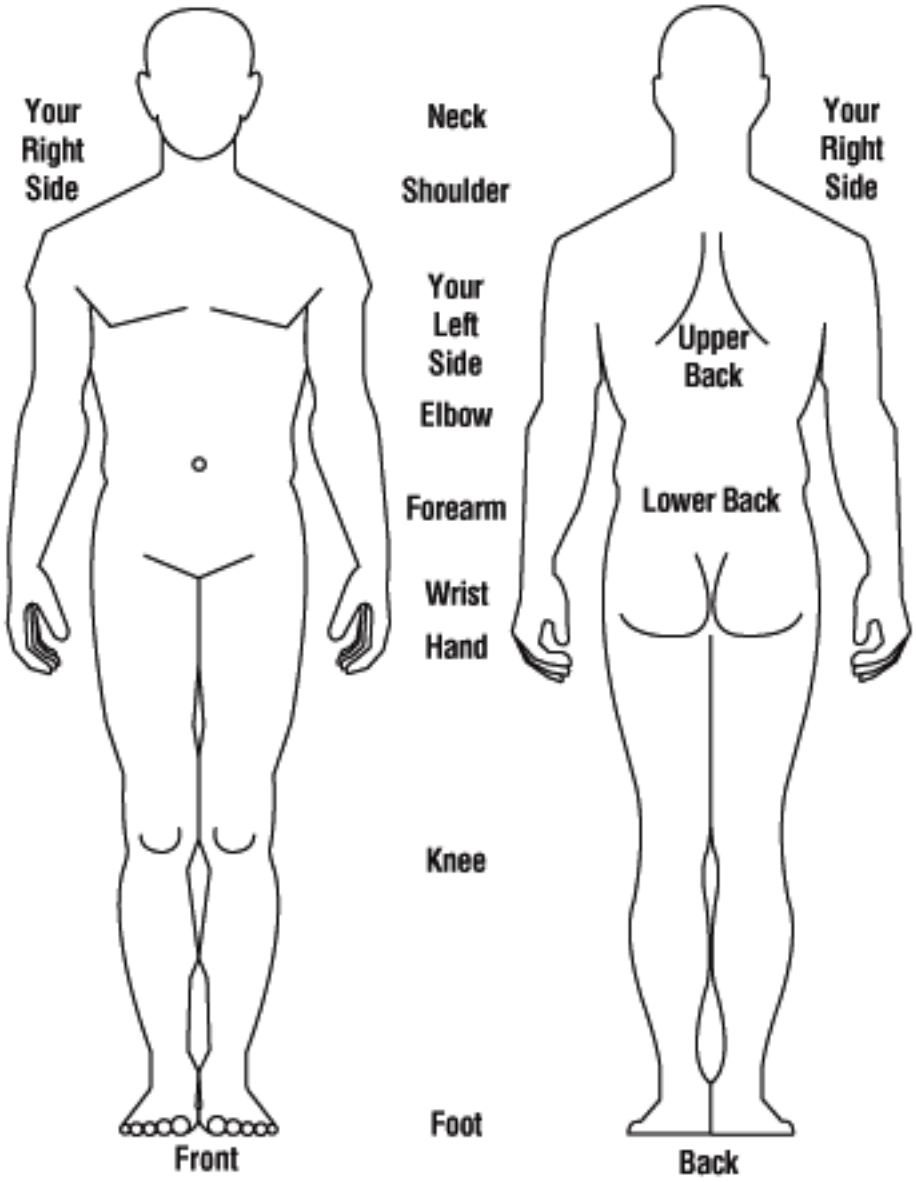
/\/\/\ Ache

ooo Numbness ===

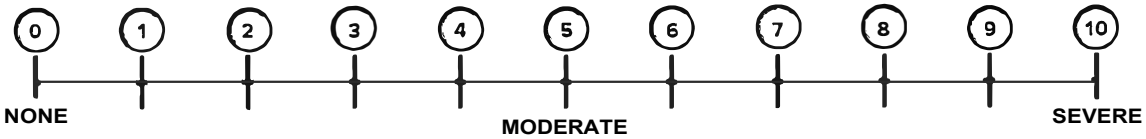
Pins & Needles / /

/ Stabbing

xxx Burning



PLEASE INDICATE BELOW: How bad is your pain on a scale from O to 10?



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Authorization for Release of Patient Information

Patient Name: _____ **Date of Birth**: _____

Social Security#: _____ **Maiden Name**: _____

I request and authorize: _____

(Physician/ Clinic or Practice to release records)

To release the medical records for the above-mentioned patient to:

Name of Recipient: _____

Address: _____

Phone and fax#: _____

Reason for Release: _____

This request and authorization is for: (initial appropriate line)

_____ **Healthcare information relating to the following treatment condition or dates of service**:

_____

_ _____ **All healthcare information**

_____ **I understand I have the right to revoke this authorization by providing a written request to do so to the above-named physician. I understand that the revocation will not apply lo information that has already been released**.

There is a fee for all records released to an individual. The fee is waived as a courtesy if records are released to a providers' office of hospital.

_____ _____

Signature of Patient or Authorized Representative **Date**

_____

Relationship or status if signed by anyone other than the patient (parent. legal guardian, representative)

Unless otherwise revoked this authorization will expire six months from the date signed. I understand that the authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by confidentiality rules.

North Texas Orthopaedic & Spine
4090 Mapleshade Lane, Suite 100
Plano, TX 75093
Ph:214 532-9955 Fax 214-592·9935

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Disclosure of Physician Ownership

Vudhi Slabisak, MD is the owner NTOS, LLC and has ownership and/or investment interests in:

Legent Health: Legent Hospital for Special Surgery, Plano, TX. & Legent Outpatient Surgery, Frisco, TX.
Clover Anesthesia, LLC
NTOS Physical Therapy d/b/a Rise Physical Therapy
NTOS Durable Medical Equipment

Bruce Markman, MD has investment interests in:

Peak Health Surgicare Richardson
Legent Hospital for Special Surgery
NTOS Durable Medical Equipment

Rahul Banerjee, MD has investment interests in:

Peak Health Surgicare Richardson
NTOS Durable Medical Equipment

James Stanley, MD has investment interests in:

Peak Health Surgicare Richardson
NTOS Durable Medical Equipment

Khawaja Ikram, DO has investment interests in:

NTOS Durable Medical Equipment

Amir Malik, MD has investment interests in:

NTOS Durable Medical Equipment

Steve Hong, MD has investment interests in:

NTOS Durable Medical Equipment

Services provided by these 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 and you have the option to choose the healthcare facility.
You will not be treated differently by Dr. Slabisak, Dr. Markman, Dr. Banerjee, Dr. Stanley, Dr. Ikram, Dr. Malik, and Dr. Hong if you choose to have services performed at a different facility.

I have read and acknowledged the Disclosure of Physician Ownership at NTOS

_____
Patient / Legal Guardian Signature

_____
Print Name

_____
Date