Orthopedic Institute of North Texas

Dr. Justin Kane
Dr. Leroy Butler
Dr. Vikas V Patel
Dr. Christopher Kowalski
Dr. Michael McHugh

PATIENT REGISTRATION

Section 1: Demographics

DEMOGRAPHICS

ACCT #_____

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

Address: _____

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

Date of Birth: _____ **Social Security Number:** _____

Email Address: _____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other (please indicate): _____

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hawaiian ☐ Pacific Islander ☐ Other

ADDITIONAL INFORMATION

Primary Care Physician: _____ **Referring Physician:** _____

Pharmacy Name: _____ **Pharmacy Type:** ☐ **Retail** ☐ **Mail Order**

Pharmacy Phone Number: _____ **Pharmacy Fax Number:** _____

Pharmacy Address: _____

Employment: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed **Student:** ☐ Full-Time ☐ Part-Time

Employer/School Name: _____

Please provide an EMERGENCY CONTACT:

Name: _____ **Home Phone:** _____

Cell Phone: _____ **Relationship to Patient:** _____

Baylor Frisco Professional Building # 1
5575 Warren Parkway, Suite 115, Frisco, Texas 75034| Ph: 972-591-6468 Fax: 972-591-6469

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SECTION 2: INSURANCE INFORMATION

Is your visit today in regards to an injury at work ? ☐ **YES** ☐ **NO**

If YES, PLEASE NOTIFY FRONT DESK. THERE ARE ADDITIONAL FORMS THAT ARE REQUIRED.

MEDICAL INSURANCE

Primary Insurance Carrier: _____ **ID #:** _____ **Group #:** _____

Secondary Insurance Carrier: _____ **ID #:** _____ **Group #:** _____

Subscriber Info: ☐ **Patient** ☐ **Other** *(if other, please complete fields below)*

First Name: _____ **Last Name:** _____ **DOB:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Relationship to Patient:** _____

WC INSURANCE

Insurance Carrier: _____ **Policy Number:** _____

Date of injury : _____ **Claim Number:** _____

Full Claim Address: _____

Adjuster/Case Manager Information:

Name: _____ Phone: _____ Fax: _____

Attorney Information (If Applicable):

Name: _____ Phone: _____ Fax: _____

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SECTION 3: CONSENT FOR COMMUNICATIONS

I request that all communications to me by Orthopedic Institute of North Texas and/or its staff be handled in the following manner:

Address for Written Communication: ☐ *Select if same as address above*

_____

For Oral Communication: Please indicate preferred method (*based on phone numbers provided above*)

☐ **Home** ☐ **Cell** ☐ **Work** **Other:**

_____

I give my permission for Orthopedic Institute of North Texas to leave a message on my machine.

☐ **Yes** ☐ **No**

Would you like to receive text messages in regard to **non-urgent** updates such as appointment reminders, normal test results or authorizations for procedures?

☐ **Yes** ☐ **No**

If Yes, please review and sign consent below:

I hereby consent to receive text messages from the practice to my cell phone. I understand that this request to receive text messages will apply to all future appointment reminders, test results, and non-urgent communications.

The practice does not charge for this service, but standard text messaging and carrier rates may apply. All patients have the right to change their minds and have this service stopped. If you no longer wish to receive text messages please notify reception by phone or in-writing. Please note we cannot accept incoming text messages. If you change your mobile number please inform us, so that we can update our records.

Patient Signature: _____ **Patient Name:** _____

Date: _____

SECTION 4: FINANCIAL POLICY

Thank you for choosing us as your health care providers. The health care industry is rapidly evolving and with the constant changes in insurance policies and the growing costs of maintaining quality health care services, we have implemented the following financial policy which we ask that you read, accept and acknowledge.

REGARDING COMMERCIAL INSURANCES:

- ***We must have a copy of your current insurance card*.** Therefore it is the responsibility of the patient to make sure you offer your insurance card to the Receptionist for copying if your insurance has changed since your last visit.
- ***If you have an HMO plan with whom we have a contract***, a proper referral from your Primary Care Physician is necessary for you to be seen for both testing and regular office visits. This referral must contain the diagnosis, number of visits allowed and have an expiration date. It is the patient's responsibility to keep track of the number of remaining referrals. You may call our office at any time to verify this information prior to your visit. **If you are seen without a valid referral, you will be responsible for the bill.**
- ***If you have a co-pay on your card***, you will be responsible for the payment of that co-pay on the day of your appointment. All co-pays are collected upon arrival.
- ***If you have a PPO plan with which we have a contract*,** you will be responsible for the co-pay if listed on your card. If you have not met your deductible, or if you have a co-insurance that remains after the insurance company has paid their portion, you will be responsible for this balance and payment will be expected.
- ***If your insurance requires a co-pay for testing,*** you are responsible for payment of both the co-pays.
- ***If your insurance has lapsed in coverage***, or is not in effect at the time of service, You will be responsible for payment of services

REGARDING MEDICARE PATIENTS:

- ***Patients are responsible for meeting their annual deductible each year***.
- ***Once the deductible has been met*,** patients without secondary insurance will be required to pay their 20% portion at the time of their visit.
- ***If you have secondary/supplementary insurance*** it is the responsibility of the patient to provide our staff with a copy of that card.
- ***We will file with secondary/supplementary carriers***; however, in the event that the secondary insurance does not pay, patients will be billed for the balance.

Patient Initials: _____

NON-PARTICIPATING INSURANCES AND SELF-PAY PATIENTS:

- ***If you have presented us with a health insurance card with which we do not participate***, you will be expected to pay 100% of our billed amount at the time the services are rendered.
- ***Once payment is made by you***, the claim will be submitted to your health insurance carrier on your behalf. Any reimbursement due you for out of network benefits should be sent directly to you. If your insurance company mails the payment to our office, a refund check will be sent to you in the amount paid by the insurance company.

PARTIAL PAYMENTS/PAYMENT PLANS:

- ***Partial payments will only be accepted if prior arrangements have been made***.
- ***If you wish to proceed with the prescibed treatment plan*** and would like to set up a payment plan, this can be arranged with our staff. Payment plans can only be set up with credit or debit card information.
- ***Once a payment plan is arranged***, payments must be made consistently or the balance will be considered delinquent. You may be subject to finance charges or eventually turned over to our collection agency.

DELINQUENT ACCOUNTS:

- ***Delinquent accounts will be subject to monthly billing charges until the account is settled in full***.

OUR CANCELLATION POLICY:

- ***We require 24 hour notice for all canceled appointments*** or your account will be charged. Please be aware that this charge is your responsibility and is not covered by your insurance.
- ***There will be a $50.00 charge for all Follow-up office Visit no-shows and $100 charge for New patient No shows.***

INSURANCE AUTHORIZATION AND ASSIGNMENT: (FOR ALL PATIENTS)

I request payment of Medicare and / or participating managed care products be made payable to Orthopedic Institute of North Texas on my behalf for any services provided to me by this Practice. I authorize the release of any information about me to Medicare and / or other participating managed care products and its agents that may be needed to determine these benefits.

Patient Initials: _____

FINANCIAL RESPONSIBILITY FOR PAYMENT

I am aware that due to any of the reasons listed below, it may be possible that my insurance carrier will deny payment for services rendered to me today. In that event, I understand that I will be financially responsible for those charges.

- I do not have my insurance card with me
- I do not have a valid referral for this visit
- This office does not participate with my insurance carrier
- I do not have health insurance and will pay for my visit today

I have read the above Financial Policy and understand and agree with its terms.

Patient / Legal Guardian Name: _____ **Date:** _____

Patient / Legal Guardian Signature: _____ **Date**_____

SECTION 5: Patient Consent for Use and Disclosure of Protected Health Information (Medication History)

I hereby give, **Orthopedic Institute of North Texas** authorization to obtain my medication history to carry out treatment and provide me with healthcare services.

With this consent, **Orthopedic Institute of North Texas** may call my home or other alternative locations like the pharmacy or other physician's office or electronically from my health plan information regarding my medication history.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient / Legal Guardian Name: _____ **Date:** _____

Patient / Legal Guardian Signature: _____ **Date:** _____

SECTION 5: HIPAA COMPLIANCE AND PRIVACY POLICIES

Our office is fully committed to compliance with HIPPA guidelines by:

1. Providing appropriate security for our patient records
2. Protecting the privacy of our patient's medical information
3. Providing our patient with proper access to their medical records
4. Appropriately maintaining our patient information and billing processes in compliance with national standards

I have read and understood the terms of the HIPAA. I have been advised of the details of the HIPAA Omnibus Notice of Privacy Practices and am acknowledging my right to obtain a copy of this document at any time that I choose.

_____ _____ _____
Signature Print Name Date

Patient Protected Health Information Disclosure Authorization

Listed below are the names of the individuals with whom the physicians and staff at the **Orthopedic Institute of North Texas** have my permission to disclose and discuss my protected health information with. Any information that relates to my past, present or future physical/mental health or condition and other related healthcare services may be discussed. I understand that his authorization will remain in effect until I make a written request to change it.

1) Name: _____ Relationship: _____

2) Name: _____ Relationship: _____

3) Name: _____ Relationship: _____

4) Name: _____ Relationship: _____

Patient Name: _____ Patient Signature: _____

Patient Date of Birth: _____ Date: _____

14. Please indicate the situation that best describes your employment status:

- ☐ Disabled Permanently
- ☐ Disabled Temporarily
- ☐ Homemaker
- ☐ Retired
- ☐ Unemployed
- ☐ Working Full Time
- ☐ Working Part Time

Occupation:_____

15. **Have you missed any work as a result of this injury?** ☐ **YES** ☐ **NO**

16. If you are currently NOT WORKING, how long have you been off work due to your pain?

_____

How did you hear about us?

Please specify:

- ☐ *Referral (e.g. doctor, family, friend, attorney)* _____
- ☐ *Online Search (e.g. Google, Yahoo, Bing)* _____
- ☐ *Social Media Page (e.g. Facebook, Yelp, Google+)* _____
- ☐ *Health Ratings Site (e.g. HealthGrades, Vitals, RateMDs)* _____
- ☐ *Other (e.g. health insurance portal, newspaper ad, etc.)* _____

Feedback

We hope you had a great experience here! We want to ensure that prospective patients can experience the same high quality of care that we were able to provide you.

We would greatly appreciate if you would take some time to share your feedback and experience on any of our various social media sites.

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