PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc ☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_____-_____-_____Phone number: _____

Address:_____

City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____

City, State:_____ZIP: _____

Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patient name: _____
Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, TEXAS BONE & JOINT may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge TEXAS BONE & JOINT may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to TEXAS BONE & JOINT any insurance or other third-party benefits available for health care services provided to me. I understand TEXAS BONE & JOINT has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to TEXAS BONE & JOINT, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to TEXAS BONE & JOINT by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for TEXAS BONE & JOINT or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that TEXAS BONE & JOINT or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or TEXAS BONE & JOINT or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

Texas Bone & Joint
First Point of Contact Screening

Patient Name_____ **Date**_____
Please print full legal name

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? YES NO

   If yes, please circle the symptoms you have now, or have had, over the past seven days?
   - **Fever**
   - **Night sweats**
   - **Sneezing or runny nose**
   - **Cough**
   - severe headache
   - stiff neck
   - muscle or joint pain (circle one or both)
   - new rashes or open sores on your skin or in your mouth
   - redness, swelling, or discharge of your eyes (pink eye)
   - unexplained bleeding
   - vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? YES NO

   If yes, please list where: _____

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? YES NO

   If yes, please list where: _____

Thank you for your help and support in caring for our patients and community.

TO BE FILLED OUT BY OFFICE STAFF

Reviewed by:_____

Action taken:
- No action taken
- Isolate
- Cough/ hand washing etiquette provided
- Mask provided
- PM/ Lead clinical notified

Thank you for trusting us with your healthcare!

TEXAS BONE & JOINT - PATIENT CONTROLLED SUBSTANCE AGREEMENT

Controlled substances are drugs we prescribe to reduce, but not cure your pain. As doctors, we want to provide the best care for your problem; however, because of the concerns we have when we prescribe controlled substances, we feel it is necessary to notify you of our expectations.

When taking controlled substances, it is important to understand that the medications can lose their effectiveness if not taken as prescribed. Side effects may occur, including constipation, drowsiness and sedation. If this occurs, please notify us. It is also important for you to know that, in rare cases, psychological addiction may occur. We do not want psychological addiction to be a problem for our patients; if this occurs, your controlled substance prescription may be stopped. As doctors, we are under strict regulation by the law, and have guidelines we must follow in prescribing all drugs.

Rules of this Controlled Substance contract are for your comfort and to yield maximum benefit:

1. You agree that if you lose your controlled substances or prescriptions for any reason, you will not get a replacement prescription for your controlled substance.
2. You agree that your prescriptions will be given to you on your appointment day only; do not call the clinic for controlled substance medications.
3. You agree to use only one pharmacy to fill your controlled substance prescriptions.
4. You agree to show up for all your appointments here, and provide notification at least 24 hours in advance if you are unable to come to your appointment.
5. You agree that you will take the controlled substance medications exactly as prescribed and will not take more pills in one day than allowed.
6. You agree that you will obtain controlled substances only from this office. If you have an injury or develop a new pain problem between your clinic visits here (i.e. go to the Emergency Room etc.), and receive controlled substance medications you agree to notify us immediately of the medicine, the dosage, and the number of pills given.
7. You agree that you will not sell or share your controlled substances.
8. You agree to notify this office immediately if you become pregnant.
9. You agree that a drug screen may be performed from time to time without notice.
10. You agree that if any of these rules are broken, controlled substance therapy may stop.
11. You agree that if your doctor gives you a referral to see a Pain Specialist, it is your responsibility to make an appointment with that doctor/group. The Pain Specialist will manage your pain medications form that point forward. After the referral has been completed, we will not refill your pain medications in this office.
12. You agree as a part of your treatment plan to see a specialist as referred. This may include Orthopedist, Physical Medicine specialist, and or Psychiatrist. Non-compliance with these referrals can result in your dismissal from this practice.

You have read and understand all the above expectations and agree to be held to the terms in full. If these terms are not upheld, the physician may decide, with proper notice to stop treating you completely.

Patient's Signature_____ Date_____

Physician's Signature_____ Date_____

TEXAS
Bone & Joint

X-RAY CONSENT FORM

_____
Patient Name

_____
DOB

During your examination the doctor may feel that x-rays will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required in order to administer treatment.

Please Choose One

_____ I understand that my doctor may need x-rays in order to diagnose my condition. I give permission for all x-rays needed.

_____ I understand that my doctor may need x-rays in order to diagnose my condition. I choose **NOT** to have x-rays at this time and release my doctor of all liabilities.

With full understanding of the above and believing I am currently not at risk, I wish to have x-rays performed today if requested by my doctor.

_____ _____
Signature Date

Texas Bone and Joint

NEW PATIENT ASSESSMENT

NAME: _____ Age: _____ Height _____ Weight _____

Did your injury happen on the job? ____ Yes ____ No
If yes, on what date did the injury occur? _____
Did you report the accident to your employer? ____ Yes ____ No
Why are you here today? _____

_____

Which hand do you eat/write with? (circle one) Left Right Both

Physician Information

Primary Care Physician Name: _____ Phone Number: _____
Referring Physician Name: _____ Phone Number: _____

Medications:

Medication	Dose

Allergies:

Drugs/Foods	Reaction

Past Medical History

Have you ever had any of the following (circle all that apply)

Problem	Yes	No	Comments
High Blood Pressure			
Diabetes (sugar)			Pill or Insulin?
Chest Pain (angina)			
Shortness of Breath			
Stroke			
Chronic Bronchitis			
Asthma			
Hepatitis			What Type?
Stomach Ulcer			
Frequent Bladder Infections			
Cancer or Tumor			
Arthritis			Where?
Thyroid Problems			
Gout			
Anema (low blood count)			
Depression			
Blood Clots			
Rheumatic Fever			
Kidney Problems			
Other Problems:			Explain:

Surgical History

Type of Surgery	Date of Surgery

Family History:

What illnesses have there been in your family?

	Major Illnesses, or had the same problem as you do now	Living?	Age of Death
Father			
Mother			
Sibling			
Grandparent			
Child			

Social History:

Tobacco: Do you smoke now? ___Yes ___ No If Yes, how many packs per day? _____ How many years? ____
Have you quit? ___Yes ___No If yes, when? _____
Do you use alcohol? ____ Yes ____ No If Yes, how many drinks per week? _____
Have you ever used Illegal drugs? ___ Yes ___ No If yes, what kind?_____
Who lives at home with you? Mother Father Husband Wife Children Other

ROS: What else is troubling you today?

General:	Fever	Chills	Night sweats	
Skin	Open Sores			
Eyes	Blurred Vision	Double Vision	Eye Pain	
Respiratory	Shortness of Breath	Frequent Cough		
Cardiology	Chest pain	Irregular Heartbeat		
Genitourinary	Pain/Burning During Urination	Trouble Starting Urination		
Gastroenterology	Abdominal pain	Vomiting Blood	Blood in Stool	Dark Black Stool
Musculoskeletal	Pain in Joints	Pain in Muscles	Morning Stiffness	Swollen Joints
Psychology	Anxiety	Depression	Hearing Voices	
Neurology	Headaches	Dizziness	Poor Coordination	Numbness

Pharmacy

Pharmacy Name: _____ Pharmacy Address: _____
Pharmacy Phone #: _____ Pharmacy Fax #: _____

Immunizations

Have you had the Flu shot this Flu Season? ___ Yes ____ No If Yes, when? _____
Have you had the Pneumococcal vaccine? ___ Yes ____ No If Yes, when? _____

Signature: _____ Date: _____