Name:
DOB:
Date:

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PATIENT INFORMATION

Full Name: _____ Date of Birth: _____ Age: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Email Address: _____ Ok to send text or email correspondence: ☐ Y ☐ N
Social Security: _____ Sex: (check) ☐ M ☐ F Marital Status: _____
How did you hear about us: ☐ Family/Friend ☐ Google ☐ Referring Physician ☐ ZocDoc ☐ ER/Facility
Referring Physician: _____ ER/Facility Name: _____
(If patient is under 18) Name: _____ Phone: _____ Date of Birth: _____
Social Security: _____ Relationship to Patient: _____
Is the patient in a Nursing Home/Skilled Nursing Facility? ☐ Y ☐ N If yes, name of facility: _____

INSURANCE INFORMATION (Please fill out if you cannot produce a card)

Primary Insurance
Insurance Name: _____
Address: _____
Policy #: _____ Group #: _____
Subscriber Name: _____ DOB: _____

Secondary Insurance
Insurance Name: _____
Address: _____
Policy #: _____ Group #: _____
Subscriber Name: _____ DOB: _____

ADDITIONAL INFORMATION

Patient's Employment Status: ☐ Employed ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Occupation: _____ Primary Language: _____ Hand Dominance: ☐ Left ☐ Right
Race: (Check): ☐ American Indian ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Pacific Islander ☐ White
Ethnicity: (Check): ☐ Hispanic or Latino Ethnicity ☐ Non-Hispanic or Non-Latino Ethnicity
Emergency Contact: _____ Phone: _____ Relationship: _____

WORKERS COMPENSATION/AUTOMOBILE/LIABILITY INSURANCE

Insurance Carrier: _____ Injury Date: _____
Address: _____ City/State/Zip: _____
Phone: _____ Fax: _____
Contact Person/Adjuster: _____ Claim #: _____
State where injury occurred: _____ Company/Employer: _____

Signature of Patient/Parent/Legal Representative _____ **Date** _____

Name:
DOB:
Date:

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CHIEF COMPLAINT & HISTORY OF PRESENT ILLNESS

Height: _____ **Weight:** _____

What brings you in today: _____ ☐ Right ☐ Left

Injury Date: _____ **If no injury, how long have you had this problem:** _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Mechanism of injury: ☐ N/A ☐ Fall ☐ Bending ☐ Lifting ☐ MVA ☐ Twisting ☐ Sports ☐ Work ☐ Other

Quality of Pain: ☐ N/A ☐ Dull ☐ Aching ☐ Throbbing ☐ Burning ☐ Knots ☐ Electric Shocks ☐ Numbness/Tingling

Severity of Pain: ☐ N/A ☐ Mild ☐ Moderate ☐ Severe ☐ On a scale of 1-10: _____

Frequency of Pain: ☐ N/A ☐ Constant ☐ Intermittent ☐ Wakes me at night

Associated Symptoms: ☐ Swelling ☐ Redness ☐ Popping/Clicking ☐ Catching/Locking ☐ Instability ☐ Buckling ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Weakness ☐ Radiating down leg/arm ☐ Change in bowl or bladder

What makes your symptoms worse: ☐ Standing ☐ Walking ☐ Running ☐ Jumping ☐ Exercise ☐ Sitting ☐ Lifting ☐ Twisting ☐ Stairs ☐ Rising from a chair ☐ Bending ☐ Squatting ☐ Kneeling ☐ Pushing ☐ Pulling ☐ Overhead motion and reaching ☐ Coughing ☐ Lying down

What previous treatments have you tried: ☐ Rest ☐ Ice ☐ Heat ☐ Elevation ☐ OTC Medication ☐ Brace ☐ Cane ☐ Crutches ☐ Walker ☐ Prescribed NSAIDs ☐ Physical Therapy ☐ Home Exercise Program ☐ Cortisone injections ☐ Viscosupplementation injections

How long have you tried the above conservative treatments: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Have you had surgery for this problem: ☐ Yes ☐ No **If yes, date of surgery:** _____ **Surgeon:** _____

Do you have a pain management physician: ☐ Yes ☐ No **If yes, who (physician):** _____

Signature of Patient/Parent/Legal Representative _____ **Date** _____

Name:
DOB:
Date:

REVIEW OF SYSTEMS				
Cardiovascular	☐ None	☐ Chest Pain	☐ Edema	
Constitutional	☐ None	☐ Fever		
ENT	☐ None	☐ Dry Mouth	☐ Mouth Ulcers	
Eyes	☐ None	☐ Dryness	☐ Vision Loss	
Gastrointestinal	☐ None	☐ Heartburn	☐ Nausea/Vomiting	
Genitourinary	☐ None	☐ Difficulty Urinating	☐ Possibly Pregnant/Pregnant	☐ Postmenopausal
Hematologic	☐ None	☐ Easy Bleeding		
Musculoskeletal	☐ None	☐ Joint Swelling	☐ Morning Joint Stiffness	
Neurological	☐ None	☐ Headaches	☐ Numbness/Tingling	☐ Weakness
Psychological	☐ None	☐ Anxiety	☐ Depression	
Respiratory	☐ None	☐ Shortness of Breath		
Skin	☐ None	☐ Non-healing Areas	☐ Skin Wounds	

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, list medication(s) & the reaction:

Medication	**Allergic Reaction**

Current Medications:

Drug Name	**Form (tablet, liquid, etc.)**	**Dose**	**Frequency**

Pharmacy Name: _____ **Phone #:** _____

Address: _____

I give consent for my medication history to be pulled and update my medical record: ☐ **Yes** ☐ **No**

_____ _____

Signature of Patient/Parent/Legal Representative **Date**

Name:
DOB:
Date:

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PATIENT HISTORY

MEDICAL HISTORY

Check all that apply

- ☐ N/A

CARDIOVASCULAR

- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Bleeding Problems
- ☐ Blood Clot
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stroke

PULMONARY

- ☐ Asthma
- ☐ COPD
- ☐ Lung Disease
- ☐ Other Respiratory Problems
- ☐ TB (Tuberculosis)

RENAL

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Kidney Disease
- ☐ Kidney Stones

GASTROINTESTINAL

- ☐ Gastric Bleeding
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Reflux (GERD)
- ☐ Ulcer
- ☐ **CANCER (List)**

_____

OTHER

- ☐ Addiction/Alcoholism
- ☐ Dementia
- ☐ Depression/Anxiety
- ☐ HIV (AIDS)
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder (Epilepsy)
- ☐ Thyroid Disease

SURGICAL HISTORY

Check all that apply

- ☐ N/A
- ☐ Appendectomy
- ☐ Breast Biopsy
- ☐ Cardiac Ablation
- ☐ Cardiac Bypass
- ☐ Carpal Tunnel
- ☐ Cataract
- ☐ Cholecystectomy
- ☐ Colonoscopy
- ☐ C-Section
- ☐ D/C
- ☐ Hysterectomy
- ☐ Joint Replacement (List):

_____

- ☐ Lasik
- ☐ Lithotripsy
- ☐ Mastectomy
- ☐ ORIF (List):

_____

- ☐ Pacemaker
- ☐ Problems with Anesthesia
- ☐ Prostatectomy
- ☐ Tubal Ligation
- ☐ Other Surgeries (List):

_____

_____

_____

SOCIAL HISTORY

Check all that apply

Tobacco Use:

☐ Never ☐ Former ☐ Current

If current, how much? _____

Alcohol Use:

☐ Never ☐ Former ☐ Current

If current, how much? _____

Illicit Drug Use:

☐ Never ☐ Former ☐ Current

What type? _____

FAMILY HISTORY

Check all that apply

- ☐ N/A ☐ Unknown

CARDIOVASCULAR

- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Bleeding Problems
- ☐ Blood Clot
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stroke

PULMONARY

- ☐ Asthma
- ☐ COPD
- ☐ Lung Disease
- ☐ Other Respiratory Problems
- ☐ TB (Tuberculosis)

RENAL

- ☐ Diabetes Type 1
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- ☐ Kidney Disease
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GASTROINTESTINAL

- ☐ Gastric Bleeding
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Reflux (GERD)
- ☐ Ulcer
- ☐ **CANCER (List)**

_____

OTHER

- ☐ Addiction/Alcoholism
- ☐ Dementia
- ☐ Depression/Anxiety
- ☐ HIV (AIDS)
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder (Epilepsy)
- ☐ Thyroid Disease

Name:
DOB:
Date:

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NOTICE OF PRIVACY PRACTICE

Your Choice: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. We will follow your instructions to the best of our ability.

- In these cases, you have both the right and choice to tell us to:
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.

  If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Sharing of psychotherapy notes
- In the case of Fundraising:
  - If we contact you for any community relief efforts, you can tell us not to contact you again.

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your record:
  - We will provide a copy of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee. We may contract with a third party to perform this service.
- Ask us to correct your medical record:
  - You can ask us to correct information that you think is incorrect or incomplete.
  - We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications:
  - You can ask us to contact your in a specific was (for example, by cell phone,) or to send mail to a different address.
  - We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share:
  - You can ask us NOT to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for service or healthcare items in full (out-of-pocket), you can ask us not to share that information with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a copy of this privacy notice:
  - You can ask for a paper copy of this notice at any time.
- Choose someone to act for you:
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Please provide us with a copy of this documentation.

- File a complaint if you feel your right are violated:
  - Please let us know if you have any questions, concerns or grievances. You may contact AOI, 11675 Jollyville Rd., Ste. 207, Austin, TX 78759, 512-856-1000. We have a manager that oversees all locations, who is available for you to speak with.
  - You can file a complaint with the Region VI, Office for Civil Right, U.S. Department of Health & Human Services at 1301 Young St., Ste. 1169, Dallas, TX 75202.
  - We will not retaliate against you for filing a complaint.
- Get a list of those with whom we've shared information:
  - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared with, and why.
  - We will include all the disclosures except for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make).

Our Uses & Disclosures: We typically use or share your health information in the following ways:

- Treat you:
  - We can use your health information and share it with other professionals who are treating you.
  - To access your pharmacy benefits data for formulary check, prescriptive history and electronic prescribing.
- Run our organization:
  - We can use an share your health information to run our practice, improve your care, and contact you when necessary.
  - We use email and text (SMS) technology for appointment remainder and form completion. You have the option to pot out of these messages.
- Bill for your services:
  - We can use and share your health information to bill and get payment from health plans or other entities.

Other Uses: We are allowed or required to share your information in other ways; Usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index/html.*

- Help with public health and safety issues:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Do research:
  - We can use or share your anonymized information for health research.
- Comply with the law, address workers' compensation, law enforcement, and other government requests:
  - We will share information about you if state or federal laws require it, including in compliance with the Department of Health and Human Services.
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- Respond to organ and tissue donation requests:
  - We can share health information about you with organ procurement organizations.

Name:
DOB:
Date:

- Work with a medical examiner or funeral director:
  - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Respond to lawsuits and legal actions:
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it upon request.
- We will not use or share your information other than as described here unless you tell us we can in writing. You may change your mind at any time, by notifying us in writing.

Changes to the Terms of this Notice:

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Signature of Patient/Parent/Legal Representative **Date**

Name:
DOB:
Date:

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AUTHORIZATION FOR CONSENT, RELEASE OF INFORMATION & FINANCIAL AGREEMENT

1

By signing below, I hereby authorize my health information, as more specifically described below, to be used or disclosed: For treatment, payment, or healthcare operations (this health information is referred to herein as "Protected Health Information"). The specific person or class of persons who are authorized to use or disclose my Protected Health Information are as follows: Any employees or agents of Austin Orthopedic Institute (AOI).

2

The duration of this Authorization is indefinite unless otherwise revoked in writing. I understand that I have the right to revoke this Authorization by giving notice in writing to the Privacy Officer. If the revocation is in writing, except if AOI has taken action in reliance upon this Authorization, or if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy. I understand that my Protected Health Information this is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

3

AUTHORITY FOR TREATMENT: I hereby authorize the doctor and the associates or assistants of his/her choice to treat my/the patient's condition, this also includes the treatment of a minor (under the age of 18). I understand that possible risks are present in any treatment or procedure that may be performed, and that my/the patient's physician will explain these prior to initiating any treatment or performing any procedure. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon me. I agree that AOI can request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

4

FINANCIAL AGREEMENT: In consideration of the services to be rendered to me, I hereby individually obligate myself to pay the account of AOI in accordance with the regular rate and terms of AOI. Should the account be referred to an attorney or licensed collection agency for collection, I shall pay reasonable attorney's fees and collection expense. I understand, as a courtesy, Austin Orthopedic Institute will file my primary, secondary and tertiary insurance. I agree that any account balance which is my responsibility will be paid within 12 months from the date of service. Any claim not paid by insurance will be the patient's responsibility. All surgeries which are elective shall be paid in full before the surgery is performed and/or insurance deductibles will be collected. I understand if I have a balance on my account which is considered Bad Debt, I must pay the balance in full before I can be seen. If I have no insurance, I must pay $150 before I can be seen.

5

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare or Medicaid) is correct. I understand that I am financially responsible for payment for medical services rendered by AOI that are not paid by my insurance carrier, Medicare, Medicaid, or its intermediaries within the terms of the applicable insurance policy. I assign to COC all rights to payment or reimbursement for this medical care, authorize that my payments be made directly to COC and agree that COC has the right participate on its own behalf in any claim for payment for these services. I authorize COC to release completed medical information to my insurance carrier, Medicare, Medicaid or its intermediaries as required to obtain payment for these claims.

6

I authorize AOI to release medical, billing and other information about me to (a) any person, company or entity (including but not limited to HMO's, insurance companies, workers' compensation carriers, liability or auto carriers, my employer, CMS and their intermediaries and review organizations, any other payer or its review organization or third party administrator) who is or may be liable for paying a claim for benefits arising out of services provided to me; (b) any physician or independent practitioner providing services for me; (c) any providers who may be providing follow-up care to me after discharge such as home health agencies, nursing homes and physicians; and (d) any licensing or accrediting organization necessary to obtain or maintain licensure or accreditation.

Name:
DOB:
Date:

By signing this Authorization (see page 2), I acknowledge that I have read and understand this Consent and Authorization. Further, I authorize the use of disclosure of my Protected Health Information in accordance with the terms of this Authorization.

A COPY OF THE NOTICE OF PRIVACY PRACTICES IS AVAILABLE UPON REQUEST.

HIPAA AUTHORIZATION FORM

Austin Orthopedic Institute has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy & Accountability Act) does allow us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

I,_____ , am authorizing the person/people listed below to obtain medical information about myself. I understand that Austin Orthopedic Institute is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person

1. Name: _____ Date of Birth: _____
2. Name: _____ Date of Birth: _____
3. Name: _____ Date of Birth: _____
4. Name: _____ Date of Birth: _____

DECLINATION OF RELEASE OF MEDICAL INFORMATION

I,_____, do not authorize Austin Orthopedic Institute to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received Austin Orthopedic Institute's Notice of Privacy Practices ("Notice") and understand a copy is available upon request.

By signing below, I certify that I have read and understand all notices, acknowledgments and policies listed on this document including the Authorization for Consent, Release of Information, Financial Agreement, HIPAA Authorization, Declination of Release of Medical Information and Acknowledgment of Receipt of Privacy Notice.

Signature of Patient/Parent/Legal Representative **Date**