TRINITY ORTHOPEDICS

809 West Harwood Road, Suite 101, Hurst, Texas 76054
4444 Heritage Trace, Suite 408, Keller, Texas 76244
817-283-5252, Fax: 817-283-5283
www.trinityorthopedics.com

Instructions: All sections must be completed. If not applicable, please indicate as "N/A".

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: ____ ❑ MALE ❑ FEMALE

Home Address: _____ City: _____ State: ____ Zip: _____

Date of Birth: _____/_____/_____ Age: ___ Social Security #: _____-_____-_____ Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

Home Phone: ( ) _____ Cell Phone: ( ) _____ E-mail Address: _____

Race: _____ Ethnicity: ❑ Latino ❑ Hispanic Preferred Language: ❑ English ❑ Spanish ❑ Other

Employer/School Name: _____ Employed: ❑ Full Time ❑ Part Time Student: ❑ Full Time ❑ Part Time

Employer/School Address: _____ City: _____ State: ___ Zip: _____ Phone: ( ) _____

Driver's License #: _____ State Issued: ____ Primary Care Physician's Name: _____

Pharmacy Name: _____ Pharmacy Phone: ( ) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: ( ) _____ ❑ Home ❑ Work ❑ Cell

REFERRED BY

Doctor: _____ Clinic: _____ Patient: _____

Family Member: _____ HMO/PPO: Directory _____ Employer: _____

Print Advertising: _____ Internet: _____ School: _____

____Yes ____No Is this injury the result of a Motor Vehicle Accident?

____Yes ____No Were You Injured on the job?

If yes, have you filed a Worker's Comp Claim? ____Yes ___ No

____ Yes ____No Do you have Medicaid?

____ Yes ____No Have you had surgery in the last 90 days?

If yes, who was the Doctor? _____

If yes, what was the procedure? _____

____ Yes ____No Are you prepared to pay your portion today?

Signed_____ Date _____

Revised 03/2014

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Patient Name: _____ Date: _____

PRIMARY INSURANCE	SECONDARY INSURANCE
(Please complete blanks with subscribers/primary insurance holders information)	(Please complete blanks with subscribers/primary insurance holders information)
Subscribers Name: _____	Subscribers Name: _____
❑ Male ❑ Female Date of Birth: _____/_____/_____	❑ Male ❑ Female Date of Birth: _____/_____/_____
Social Security #: _____	Social Security #: _____
Patient's Relationship to Subscriber: _____	Patient's Relationship to Subscriber: _____
Employer: _____	Employer: _____
Employers Address: _____	Employers Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Insurance Co. Name: _____	Insurance Co. Name: _____

GUARANTOR

❑ Patient Is Guarantor

Last Name: _____ First Name: _____ M.I.: ____ ❑ MALE ❑ FEMALE

Home Address: _____ City: _____ State: ____ Zip: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Driver's Licence #: _____ State Issued _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Relationship to Patient: _____ Have you ever been treated by one of the physicians at Trinity Orthopedics: ❑ Yes ❑ No

If Yes, which physician: _____ Approximate Date: _____

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GENERAL CONSENT FOR TREATMENT:

I, knowing that I am suffering from a condition requiring diagnostic, medical, and/or surgical treatment, do hereby voluntarily consent to such procedures and care, and to such medical, surgical, or other services under the general and specific instructions of the Trinity Orthopedics physicians, their assistants or designees, as necessary in their judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examinations by any of the physicians at Trinity Orthopedics, or their representative and or designees.

PRESCRIPTION POLICY:

You must talk with one of the physicians at the time of your appointment about your medication(s). The physicians will not refill your medications if you call the office for a refill. You must have your pharmacy fax a request for a refill to our offices. Allow up to 48 hours for a refill to be approved. Do not wait until you are out of medication to request a refill. Please do not try and refill your prescription at more than one pharmacy or have the same medications filled by other physicians. This will result in you being dismissed from our care.

HIPAA:

I acknowledge and understand the "Notices of Privacy Practices" that is available at the front desk or online and that I have been given access to a copy of the Privacy Practices.

DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I understand that any and all medical care that I receive at the offices of Trinity Orthopedics will be treated with the utmost confidentiality. To facilitate my medical care I hereby authorize Trinity Orthopedics to disclose PHI about my treatment and medical condition to the following individuals:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

If you have an answering machine, may we leave messages regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Trinity Orthopedics?

Check One Yes _____ No _____ N/A_____ Phone #:_____

May we send electronic message (such as email or cellular text messages) regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Trinity Orthopedics.

Cellular/Mobile Phone Number _____ Yes _____ No _____

Email Address _____ Yes _____ No _____

_____ _____
Patient's printed name **Date of Birth**

_____ _____
Signature of patient or responsible party **Date**

Revised 03/2014

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Larry Kjeldgaard, D.O. • Scott Gibson, D.O. • Nicholas Iagulli, M.D.

FINANCIAL POLICIES

- First and foremost, we would like to express our appreciation to you for selecting Trinity Orthopedics. We will do everything we can to answer all your questions and make this a positive experience for you.
- This form represents our office policies and guidelines concerning financial matters. We ask that you read and sign this form indicating that you understand and agree to these guidelines. If you have any questions, please consult with the appropriate member of our office staff
- We require a copy of your current insurance card prior to, or at the time of your visit. If you are unable to present your card, your appointment may be considered a "fee for service" visit and full payment may need to be collected. If you are an established patient, you must verify that all the information is current and accurate. If any changes have occurred, you must notify our front office staff before you are seen by a doctor.
- As a rule, we try to verify all insurance and benefits prior to your appointment, but in some cases this is not possible. It is ultimately **your responsibility** to make sure that we are a participating provider on your health insurance plan and that you have active health insurance. In the event that your insurance claim is denied, you will be responsible for all billed amounts.
- We will file your claims on your behalf; however, you will be responsible for any co-pays, deductibles, or coinsurance amounts according to your insurance benefits at the time of service is rendered.
- HMO's and other insurance policies sometimes require a referral from your primary care physician (PCP). It is your responsibility to obtain this referral prior to your first visit. Most of the time, a phone call from you to your PCP will get this done and the referral can be faxed to our office. You are financially responsible without this referral, if required by insurance.
- From time to time, insurance companies request further information from you in order to process your claim. Failure to comply with this request in a timely manner may result in denial of your claim and you become responsible for the entire amount.
- All deductibles are due at the time services are rendered. For surgical patients, all deductible, coinsurance, and copays are due at least one week prior to the scheduled procedure.
- **Work Related Injuries:** These must be disclosed at the time you are scheduled. Due to the complexity of Texas Worker's Comp., these cannot be changed from an "on the job" injury to an injury off work and vice versa. In other words, either you were injured at work or you were not. For Work related injuries, we will verify the claim with your employer, adjustor and any other appropriate entity, including other physicians, in order to best care for you and your situation. You will not be billed for any medical care or treatment related to an accepted injury and related body area that is injured. If, however, your claim is denied, you will be billed and you become responsible for the balance in full. We will work with you and assist you with understanding your situation to the best of our ability.
- We accept cash, personal checks, and most major credit cards. We also offer a "pay on line" service at no extra cost to you. Log on to www.trinityorthopedics.com for that information.

- **I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF TRINITY ORTHOPEDICS AS SET FORTH IN THE PRECEDING PARAGRAPHS. MY SIGNATURE INDICATES MY WILLINGNESS TO COMPLY FULLY OR ACCEPT RESPONSIBILITY FOR PAYMENTS OF ANY CLAIM DENIED DUE TO NONCOMPLIANCE. MY SIGNATURE ALSO AUTHORIZES THIS OFFICE TO FILE CLAIMS FOR ME AND ASSIGN ALL MEDICAL RIGHTS AND BENEFITS DUE FOR THESE SERVICES TO TRINITY ORTHOPEDICS. MY SIGNATURE AUTHORIZES THIS OFFICE TO RELEASE MEDICAL RECORDS AS NECESSARY TO MY INSURANCE CARRIER.**

Printed Name: _____ **Date:** _____

Signature: _____

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NOTICE OF PRIVACY PRACTICES

Effective Date: 9/15/2012

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Practice Privacy Official by dialing the main practice number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test result, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel, agents of the practice, or your personal doctor.

Our Responsibilities We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures:

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other practice personnel who are involved in taking care of you at the practice. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the practice also may share health information about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays.

We also provide your physician or a subsequent, healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this practice.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party. For example: we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes, and we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it:
- To remind you that you have an appointment for medical care:
- To assess your satisfaction with our services:
- To tell you about possible treatment alternatives:
- To tell you about health-related benefits or services:
- To contact you as part of fundraising efforts, unless you elect not to receive any such communications:
- For population based activities relating to improving health or reducing care costs: and
- For conducting training programs or reviewing competence of health care professionals.

When disclosing information, primarily appointment reminders and billing/collections effort, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Affiliated Covered Entity: Protected health information will be made available to practice personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Practice Privacy Official for further information on the sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care cost. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the practice. Any request for an amendment must be sent in writing to the Practice Privacy Official. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for the treatment**,** payment or health care operations. You also have the right to request a lift on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Practice Privacy Official.
- We are required to agree to your request only if 1)except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other request, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example: you may ask that we contact you at work instead of your home. The practice will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the practice and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may request a copy of this notice at any time.

To exercise any of your rights, please contact the Privacy Official in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be available in the practice and on our website and include the effective date.

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Date _____

Last Name _____ First Name _____ Date of Birth _____

WHAT IS YOUR INJURY

❑ Shoulder _____ Right _____ Left
Are you right or left handed? _____ Right _____ Left
❑ Knee _____ Right _____ Left
❑ Other (please specify area) _____ Right _____ Left
a.) Date of Injury _____

b.) Was your injury triggered by: (☑ all that apply)
❑ Sport _____
❑ Daily Activity _____
❑ Other _____
❑ No specific trigger can be identified
c.) How long have you been feeling pain? _____

SYMPTOMS

SHOULDER: (☑ all that apply)
❑ Pain (☑ intensity): _____ Mild _____ Moderate _____ Severe Scale of 0 - 10: _____
When does the pain occur? (e.g., activity, night, etc.) _____
❑ Swelling (☑ intensity): _____ Immediate (less than 4 hours) _____ Delayed _____ Recurring
❑ Dislocation - Has this happened before? _____ Yes _____ No
❑ Weakness
❑ Is motion restricted? _____ Yes _____ No
❑ Other _____

KNEE: (☑ all that apply)
❑ Pain (☑ intensity): _____ Mild _____ Moderate _____ Severe Scale of 0 - 10: _____
When does the pain occur? (e.g., activity, night, etc.) _____
❑ Swelling (☑ intensity): _____ Immediate (less than 4 hours) _____ Delayed _____ Recurring
❑ Dislocation - Has this happened before? _____ Yes _____ No
❑ Weakness
❑ Is motion restricted? _____ Yes _____ No
❑ Other _____

OTHER: (☑ all that apply)
❑ Pain (☑ intensity): _____ Mild _____ Moderate _____ Severe Scale of 0 - 10: _____
When does the pain occur? (e.g., activity, night, etc.) _____
❑ Swelling (☑ intensity): _____ Immediate (less than 4 hours) _____ Delayed _____ Recurring
❑ Unstable Sensation / looseness
❑ Popping or "crash" in joint
❑ Other _____

TREATMENT

❑ None / Rest _____
❑ Brace / Cast _____
❑ Anti-Inflammatory / Medications (for this injury-e.g. Aleve/Advil) _____
_____
❑ Injection _____
❑ Rehabilitation / Therapy _____
❑ Surgery _____
❑ Return to Activity (& Date) _____

ACTIVITY

a.) Primary Sport _____
b.) What level? (e.g., College, Recreational) _____
c.) Other Sports _____

d.) Runner? _____ miles x ____ days/week = _____ miles / week
e.) How does this injury affect your daily activities? _____
_____

OCCUPATION

a.) What is your profession? _____
b.) What is your job description? _____
c.) How has your injury affected your job? _____
_____