OUCH – Orthopedic Urgent Care Home

David S. Brown, M.D. OUCHORTHO (800) 682-4220

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____ Male ☐ Female ☐

Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Number: _____ Alternate: _____

Patient Date of Birth: _____ (MM/DD/YYYY)

Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address/Intersection: _____

Referring Physician: _____ Phone Number: _____
(First and Last Name)

Primary Care Physician: _____ Phone Number: _____
(First and Last Name)

CONTACT INFORMATION

Mother's/Guardian's Name: _____ Phone Number: _____

Father's/Guardian's Name: _____ Phone Number: _____

INSURANCE INFORMATION

1. Primary Insurance: _____

Member/Subscriber ID No: _____ Group Number: _____

Name of Policy Holder: _____ DOB: _____ (MM/DD/YYYY)

Address (if different than patient): _____

2. Secondary Insurance: _____

Member/Subscriber ID No: _____ Group Number: _____

Name of Policy Holder: _____ DOB: _____ (MM/DD/YYYY)

Address (if different than patient): _____

GUARANTOR INFORMATION (Person responsible for billing/payments)

☐ Check if Guarantor is same as Primary Insurance Policy Holder

Name: _____ DOB: _____ (MM/DD/YYYY)

Phone Number: _____

Address (if different than patient): _____

PAYING INSURANCE BENEFITS:

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to Orthopedic Urgent Care Home, PLLC. ("OUCH"). This assignment is for services rendered to me by "OUCH". This assignment will remain in effect until revoked by myself in writing. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify "OUCH" of any changes of insurance coverage will result in the financial obligation to rest fully on me regardless of any contract between the insurance company and "OUCH".

PATIENT NAME (Please Print): _____ Date of Birth: _____/_____/_____

SIGNATURE OF PATIENT/GUARDIAN: _____ Date Signed: _____/_____/_____

- **FINANCIAL POLICY PATIENT CONSENT FORM**

"OUCH" RECOGNIZES THE NEED FOR A CLEAR UNDERSTANDING BETWEEN PATIENT AND MEDICAL PROVIDERS REGARDING PROTECTED HEALTH INFORMATION AND FINANCIAL ARRANGEMENTS FOR HEALTHCARE. THE FOLLOWING INFORMATION IS PROVIDED TO AVOID ANY MISUNDERSTANDING CONCERNING PROTECTED HEALTH INFORMATION AND PAYMENT FOR PROFESSIONAL SERVICES.

I. PAYMENT/REFUNDS/COLLECTIONS: PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

The guarantor is responsible for copayment, deductible, coinsurance and/or any non-covered services. It is the responsibility of the parent/guardian to notify "OUCH" of any changes to the health insurance coverage. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25.00 charge for returned checks. If not paid within sixty (60) days, "OUCH" will begin various collection activities including, but not limited by, submitting the past due account to a collection agency. Refunds will only be issued in the event of overpayment by the guarantor and will be issued within 30 days of the credit. Refunds will not be issued for returned DME unless it is unopened/unused & must have approval by the medical staff and/or business manager.

II. SELF PAYMENT (PRIVATE, CASH PAYMENT):

If you do not have insurance coverage, we ask that you coordinate your care with our business office prior to your surgery/procedure. We require an advance payment for professional service.

III. MANAGED CARE:

ALL MANAGED CARE (HMO, PPM, etc) CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

By signing below, patient acknowledges that it is the patient's responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by the plan.

IV. CHILDREN OF DIVORCED PARENTS:

Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of "OUCH".

V. SECONDARY INSURANCE:

The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider, if applicable. You agree to provide such information as outlined below. You agree to notify the provider in the future immediately of any additions, changes or deletions in primary or secondary coverage.

Initial/Complete as applicable:

_____I have NO SECONDARY INSURANCE COVERAGE.

_____I have SECONDARY INSURANCE COVERAGE AS DESCRIBED ON THE ATTACHED PATIENT DEMOGRAPHIC FORM.

"OUCH" firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies, please call us at 1-800-682-4220.

_____ _____/_____/_____

PATIENT NAME (PLEASE PRINT) (DATE OF BIRTH IN MM/DD/YYYY)

_____ _____/_____/_____

PATIENT/PARENT SIGNATURE (DATE SIGNED - MM/DD/YYYY)

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Consent for Treatment

The following information is to be completed by the patient or by the patient's legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Orthopedic Urgent Care Home will share patient health information according to federal and state law for the treatment, payment, and operations.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider to pay Orthopedic Urgent Care Home for services rendered.

_____ _____/_____/_____
Signature of Patient (if 18 or older) Date

_____ _____/_____/_____
Signature of Legally Authorized Representative Date

Relationship of Legally Authorized Representative: _____

- **HIPAA DISCLOSURE**

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. PROTECTED HEALTH INFORMATION (PHI) MAY ORIGINATE IN YOUR MEDICAL RECORD AT "OUCH", OR MAY BE RECEIVED FROM OUTSIDE HEALTH ENTITIES AND FILED IN YOUR MEDICAL RECORD. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED BY "OUCH" TO: A) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY OR INDIRECTLY, B) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS, C) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSURANCE THROUGH "OUCH" OR NETWORKING ORGANIZATIONS. I HAVE BEEN INFORMED BY YOU OR YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DISCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATIONS. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACE PRACTICES FROM M Y OFFICE OR BY CONTACTING THEM AT 431 E. STATE HWY 114., SUITE 120, SOUTHLAKE, TX 76092. I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

_____ _____/_____/_____
PATIENT NAME (PLEASE PRINT) (DATE OF BIRTH IN MM/DD/YYYY)

_____ _____/_____/_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN (DATE IN MM/DD/YYYY)

_____ "OUCH" MAY NOT DISCUSS MY HEALTHCARE AND MAY NOT DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ANYONE.

_____ "OUCH" MAY DISCUSS MY HEALTHCARE AND MAY DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ONLY THE FOLLOWING INDIVIDUALS LISTED BELOW:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

OUCH MAY LEAVE A MESSAGE ON MY PHONE: _____

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Patient History Form

This is a confidential record and information contained here will not be released without your consent.

Today's Date: _____ Date of Birth: _____

Patient's Name (First, Middle Last): _____

Who referred you to us? _____ **Primary Care Physician**:_____

Chief Complaint: What is the main reason for your visit today? Describe problem in detail. (Ex. What hurts?)

_____

Where did this injury occur? (i.e. home, playground, school, work) _____

Sports related? Yes ☐ No ☐ Motor vehicle accident? Yes ☐ No☐

When did you first notice this problem? _____ Date if injured: _____

What makes the problem worse? _____

What makes the problem better? _____

How long does the problem usually last? Constant: _____ Occasional: _____

Does the pain interfere with your normal functions? (Explain) _____

Have you seen another physician for the problem? (Explain) _____

Have you had any diagnostic studies or treatments for this problem? (X-rays, MRI, EMG, Bone Scan, Bone Density)

If so, when and where? _____

Pain Level: _____0-3 (mild) _____4-6 (moderate) _____7-10 (severe)

Developmental History

☐ Full Term ☐Premature at _____ wks. gestation. Complications/Developmental Delays? _____

If premature, was patient in the NICU? _____ Age when first walked? _____

Female Patients: Date when menses began (mo/yr): _____ Regular or Irregular? _____

Medical Diagnoses: _____

_____

Previous Surgeries: _____

_____

Family History: _____

Social History (who does the patient live with?): _____

Patient History of: Smoking: Yes ☐ No ☐ Alcohol Use: Yes ☐ No ☐ Drug Use: Yes ☐ No ☐

Current Medications: _____

_____

Drug Allergies: _____

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Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS:

	Yes	No	Comments
Constitutional:			
A. Recent weight change?	☐	☐	_____
B. Weakness, fatigue, or chills?	☐	☐	_____
Eyes:			
A. Difficulty seeing?	☐	☐	_____
B. Temporary loss of vision?	☐	☐	_____
Ears, Nose, Throat:			
A. Problems with hearing?	☐	☐	_____
B. Hoarseness, sore throat?	☐	☐	_____
Cardiovascular:			
A. Chest pain/discomfort?	☐	☐	_____
B. Palpitations?	☐	☐	_____
Respiratory:			
A. Shortness of breath?	☐	☐	_____
B. Cough?	☐	☐	_____
C. Wheezing?	☐	☐	_____
Gastrointestinal:			
A. Constipation?	☐	☐	_____
B. Frequent Heartburn or indigestion?	☐	☐	_____
C. Abdominal Pain?	☐	☐	_____
D. Blood in stool?	☐	☐	_____
E. Difficulty swallowing?	☐	☐	_____
Gentourinary:			
A. Blood in urine?	☐	☐	_____
B. Urinary frequency/urgency?	☐	☐	_____
C. Pain when urinating?	☐	☐	_____
D. Urethral discharge?	☐	☐	_____
Endocrine:			
A. History of high or low blood sugar?	☐	☐	_____
B. Thyroid problems?	☐	☐	_____
Musculoskeletal:			
A. Joint pain?	☐	☐	_____
B. Joint swelling?	☐	☐	_____
Neurological:			
A. Fainting?	☐	☐	_____
B. Problems with concentration?	☐	☐	_____
C. Sense of smell and taste?	☐	☐	_____
D. Coordination?	☐	☐	_____
Psychiatric:			
A. Depression?	☐	☐	_____
B. Anxiety?	☐	☐	_____
C. Other psychiatric problems?	☐	☐	_____
Skin:			
A. Rashes?	☐	☐	_____
B. Skin cancers?	☐	☐	_____
C. Other major skin problems?	☐	☐	_____
Heme/lymph:			
A. Bleeding tendencies/bruising?	☐	☐	_____
B. Any history of anemia?	☐	☐	_____
C. Do you have sickle cell disease?	☐	☐	_____

Patient signature/Legal Guardian: _____ Date: _____

Provider Signature: _____ Date: _____