



Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____
 Address _____ City _____ Zip _____
 Home Phone _____ Cell Phone _____
 Office Phone _____ E-mail _____
 Date of Birth _____
 SSN _____
 Drivers License # _____
 Circle one please: Male Female

RESPONSIBLE PARTY (If different than above)

Last Name _____ First Name _____ MI _____
 Address _____ City _____ Zip _____
 Home Phone _____ Cell Phone _____
 Office Phone _____ Drivers License # _____
 Date of Birth _____ SSN _____

EMERGENCY CONTACT

Name _____ Relationship _____
 Phone _____

MEDICAL INFORMATION

Primary Care Physician _____
 Specialist Physicians _____

Can we contact these physicians for your records? Yes No
 Can we send a letter to these physicians after evaluating you? Yes No

Pharmacy Name and City _____

REFERRAL INFORMATION

Please tell us how you were referred here by indicating below:

___ Physician Name: _____
 ___ Other medical professional Name: _____
 ___ Another patient of ours Name: _____
 ___ Internet Name: _____
 ___ Newspaper/Magazine Name: _____
 ___ Emergency Room Name: _____
 ___ Other _____

REASON FOR VISIT

Main problem

(Please be as specific as you can. For example, "Numbness in left leg")

How long has this particular problem been going on? _____

Has it been getting: better worse about the same

Is this related to an: Accident Illness Injury at work

Other related problems, not as severe:

(Please be as specific as you can. For example, "Pain in left hip")

Do you have any other spinal or orthopedic conditions/problems?

Prior to the onset of the above problems, did you feel well? Yes No

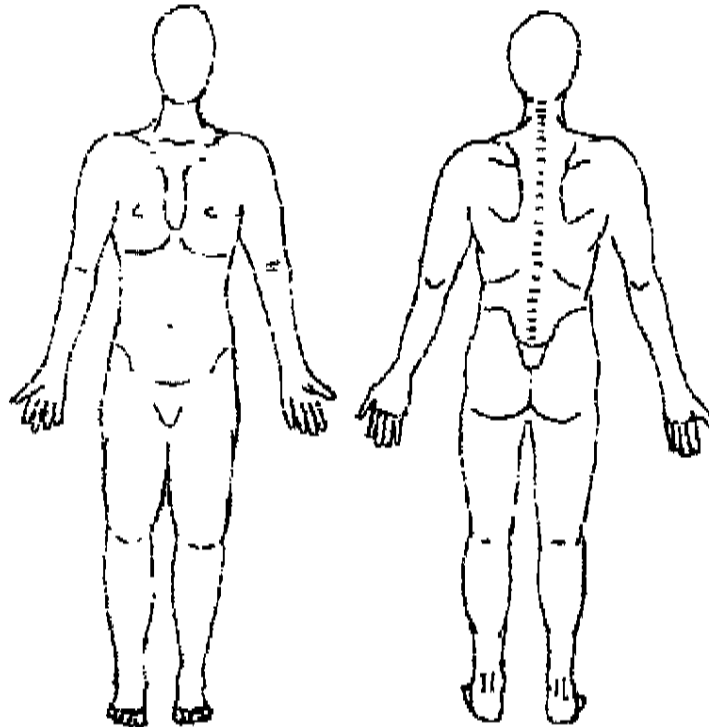
Has another physician treated you for this or a related problem? If yes, please tell us who and describe the treatments, **especially if you have had surgery or injections.**

Have you ever had Xrays, CT scans, or MRI's?

If so, when and where?

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

Key: Pins and Needles = 000000 Stabbing = // // // //
 Burning = xxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

0 = No Pain 10 = Worst Imaginable Pain

PAST MEDICAL HISTORY

Please list any medical conditions for which you are being treated

_____	_____
_____	_____
_____	_____
_____	_____

PAST SURGICAL HISTORY

Please list any surgeries that you have had

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

MEDICATIONS

Please list all medications you take on a regular basis, include dosage
(including non-prescription drugs like Tylenol and Advil)

_____	_____
_____	_____
_____	_____
_____	_____

DRUG ALLERGIES

Yes, please list

No Known Drug Allergies

FAMILY HISTORY

Is there a history of spinal disorders or surgery in you family?

If so, please list who and the problem to the best of your recollection

SOCIAL HISTORY

Please circle one of the following:

Single Married Divorced Widowed Separated

Occupation _____ Employer _____

If you are retired/not working, what was your prior occupation? _____

Do you:

smoke cigarettes? _____ If yes, how much per day? _____

use other tobacco products? _____ If yes, which products? _____

drink alcoholic beverages? _____ If yes, how many per day? _____

REVIEW OF SYSTEMS / MEDICAL HISTORY

Please check if you are experiencing any of the following:

ALLERGIES

- Asthma
- Hay Fever
- Skin eruptions
- Latex allergy
- Nickel allergy

CARDIOVASCULAR

- Irregular heartbeat
- High/low blood pressure
- Poor circulation
- Rapid heartbeat
- Swelling of ankles
- Varicose veins
- Chest pain

CONSTITUTIONAL

- Chills/sweats/fever
- Loss of Sleep
- Weight change

EAR/NOSE/THROAT

- Hearing loss
- Nosebleeds
- Ringing in ears
- Earache
- Hoarseness
- Persistent cough
- Vertigo
- Bleeding gums
- Difficulty swallowing
- Sinusitis

DERMATOLOGY

- Ulcers
- Change in scars/skin/moles
- Lesions or Masses
- Rashes
- Dermatitis or eczema

EYES

- Blurred vision
- Crossed eyes
- Double vision
- Corrective lenses
- Vision flashes/halos

GENITOURINARY

- Blood in urine
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Rectal bleeding
- Abdominal pain

HEMATIC/LYMPHATIC

- Swollen lymph nodes
- Easy skin bruising
- Prolonged bleeding
- Gout
- Excessive thirst
- Anemia
- Blood clots

NEUROLOGICAL

- Fainting
- Headache
- Numbness of arms/legs
- Seizures
- Coordination problems
- Tingling of hands, feet, arms, or legs

PSYCHIATRIC

- Anxiety
- Depression
- Panic attacks
- Restlessness/Nervousness

RESPIRATORY

- Shortness of breath
- Cough
- Blood when coughing

MUSCULOSKELETAL

- Pain, weakness, swelling or numbness in:
 - _____ Hands
 - _____ Wrists
 - _____ Hips
 - _____ Knees
 - _____ Arms
 - _____ Legs
 - _____ Joints
 - _____ Back-low (lumbar)
 - _____ Back-middle (thoracic)
 - _____ Back-neck (cervical)

OTHER CONDITIONS NOT LISTED:

Method of Payment

- In-Network Insurance
 Out of Network Insurance

- Self-Pay (No Insurance Coverage)
 Workers Compensation

In order to file claims with your insurance carrier, please provide a copy of current card(s) and answer the following:

Name of Insured _____ Social Security # _____

Date of Birth _____ Relationship to Patient _____

Effective Date _____

Financial Policy Acknowledgement

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of office-based services. It is your responsibility to inform us of any changes with your insurance. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you will be responsible for payment in full for all services rendered. Center for Orthopaedic Specialties has preferred provider contracts with a number of major insurance companies. Please contact your insurance company to determine if our practice has a contract with your plan.

PLEASE INITIAL IN THE SPACES BELOW:

Any financial portion that is the "member's responsibility" such as a co-pay, deductible, or a non-covered percentage will be collected at the time of service. _____ (Initial) If, for any reason, it is not paid at time of service, we reserve the right to postpone scheduling any follow-up or future appointments until this obligation is paid in full. _____ (Initial) Refill requests must be faxed to our office from your pharmacy and given 48 hours for a response. _____ (Initial)

PPO Insurance Plans: We have agreed to accept discounted rates from plans we participate in, however, all co-insurance and/or deductibles are your responsibility. We will estimate co-payments to the best of our ability. Since the copays are estimates only, we will bill you or credit you for your balance.

HMO Insurance Plans: All copays must be paid at each and every visit. If a service provided is not a covered benefit of your plan, you will be responsible for payment in full at the time of service.

Non-Contracted Insurance Plans: If we are not contracted with your insurance company you will be asked to pay in full at the time of service. We will be happy to file a claim with your company so out of network benefits can be tracked or we can supply you with a billing copy to attach to a claim form provided by your insurance company so that you can request reimbursement be sent to you.

Indemnity Insurance Plans: We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you or credit your account for your balance.

Secondary Insurers: We file secondary coverage in limited circumstances, including Medicare secondary and if you have secondary coverage with a PPO plan we participate with. In all other cases, we can supply you with a billing copy to attach to a claim form provided by your insurance company so that you can request reimbursement be sent to you.

Insurance Changes: If it has been more than 30 days past your effective date and you are first providing us with updated insurance information, there will be a \$25 Service Charge added, per month, due to the amount of time and effort required to correct your account. Also be aware that many insurance policies will not pay for claims that are filed 90 days past the date of service. The patient or their guarantor will be responsible for any claims denied due to timely filing.

Payment: We accept cash, money orders, Visa, MasterCard, Discover Card, American Express, debit cards, and personal checks.

Surgery Prepayment: All estimated insurance copays and/or deductibles or self-pay estimates for surgery are due in full at least 5 business days prior to the surgery date or the procedure(s) will be postponed.

Collection Agency: All balances reaching 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the delinquent balance.

Returned Checks: Checks returned to us by the bank will be assessed a \$25.00 returned check fee, in addition to the original amount of the check. You will have 15 days to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check will be sent to a collection agency. In addition, we will only accept cash or credit card for any future visits.

Medical Supplies: All medical supplies provided by our office under \$50.00 and by special order are due and payable at time of service. Medicare and most commercial insurance plans consider these types of supplies to be the patient's responsibility and will provide no reimbursement if they are billed. Our staff can provide you with cost information before you receive them. We will bill insurance if a supply is considered a covered benefit.

Work-Related Injuries: If you have been injured on the job, but give our office your regular medical insurance information for us to file, please be advised that we will not retroactively go back and file with worker's compensation. All work-related injuries must be pre-screened by our office, verified, and approved by your adjuster or claims carrier before an initial appointment will be scheduled. You will be required to seek treatment for non-reported on the job injuries with another orthopaedic office if this policy is not followed.

I authorize medical care and accept financial responsibility for all services rendered. I authorize the release of any medical or other private health information related to all claims for benefits submitted on behalf of myself and/or dependents. I hereby request payment of insurance benefits be made directly to Center for Orthopaedic Specialties, P.A. and authorize the use of this signature on all insurance submissions. I have read and fully understand the financial policies of Center for Orthopaedic Specialties and agree to the terms. I also understand that the terms of these financial policies may be amended by the practice at any time without prior notification.

Patient/Responsible Party Signature

Date

Privacy Statement Acknowledgement:

I acknowledge Center for Orthopaedic Specialties has provided a Notice of Privacy Practices, both by having a notebook with such policy available and having such policy loaded on it's website, available for my review. If desired, I can request a copy of such notice be available for me to keep. If revisions are made, I understand that it is my responsibility to request a revised copy.

Patient/Responsible Party Signature

Date



Mukund I. Gundanna, M.D.
Diplomate, American Board of Orthopaedic Surgery
Fellow, North American Spine Society
Fellow, American Academy of Orthopaedic Surgery

Troy M. Duley, P.A.-C
Texas Academy of Physicians Assistants

Notice of Physician Ownership

Your physician, Mukund I. Gundanna, M.D. has ordered and/or recommended the following:

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Inpatient Surgery | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Outpatient Surgery | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> Surgery w/23-hour Observation | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Arthrogram | <input type="checkbox"/> _____ |

Dr. Gundanna has an ownership interest in The Physicians Center, a federally recognized "physician owned" specialty hospital. As a patient, you should be aware that alternative healthcare facilities might be available to you. If you feel that the services that have been ordered and/or recommended for you are not proper or are negatively impacted by physician ownership in the facility, please notify either your physician or the practice administrator immediately.

Please sign below to acknowledge your receipt and understanding of this disclosure and that you had an opportunity to ask and receive answers to any questions you may have about this disclosure, including your options, if any, for services at other facilities.

 Patient Signature

 Date

 Printed Name

 Witness

 Date

 Witness Name