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TEXAS ORTHOPAEDIC & SPORTS MEDICINE PATIENT REGISTRATION FORM

Date____________________Home Phone________________Work Phone_____________Cell Phone____________________

☐ I give Texas Orthopaedic & Sports Medicine permission to leave messages on my phones.

Patient Last Name________________________________First Name___________________________Initial_______________
Street Address:____Apartment #____________
City____State______________________________Zip_____________
Billing Address (If different from above)____
City____State___________________________Zip________________
Sex: M / F Age____________Date of Birth______________________Marital Status: Single / Married / Widow / Divorced
Social Security #________________________________Driver's License # ____________________State_________________

Email Address:____

☐ I give Texas Orthopaedic & Sports Medicine permission to use my email for correspondences.

Referring Physician or Primary Doctors Name and phone number:____
IS YOUR VISIT DUE TO A JOB-RELATED INJURY OR ACCIDENT? Yes / No (**Workman's Compensation**)
If yes, please notify the receptionist. Your appointment must be approved through your Work Comp Insurance prior to your visit. If your injury is job related and proper information is not completed the patient will be responsible for any financial acquired.

PATIENTS EMPLOYER / SCHOOL (If Applicable)
Company or School Name: ____Occupation______________________
Address____Phone_________________________Full Time / Part Time
City_____________________________________State___________________Zip_____________Years Employed___________

GUARANTOR/PERSON RESPONSIBLE FOR BILL
Name of person responsible for the account (Person signing all forms) (Parent if Minor)___________________________
Address (If different from patient)____
Sex: M / F Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Child ( ) Care Taker ( ) Other
Home#__________________Work#________________Cell#___________________Email___________________________
Date of Birth:__________________Social Security #____________________Driver's License#_______________________
Employer Name:____Employer Phone#______________________
Employer Address:____
Street Address City State Zip Code

FIRST INSURANCE INFORMATION (PRIMARY) ** If school Insurance we **MUST** have the completed school insurance form at the time of visit.

Insurance Name:____I.D. Number:__________________________
Claims Address:____Group Number:____________________
Policy Holder (Subscriber):____Effective Date:_____________________
Subscribers Address (If different from patient):____
Sex:_: M / F Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Child ( ) Care Taker ( ) Other

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Home#________________Work#____________Cell#________________
Date of Birth:__________Social Security #__________Driver's License#____________
Employer Name:____________________Years Employed:____________
Address:____________________Employer Phone Number:____________
City____________________State________________Zip________

SECOND INSURANCE INFORMATION (SECONDARY)

Insurance Name:____________________I.D. Number:____________
Claims Address:____________________Group Number:____________
Policy Holder (Subscriber):____________________Effective Date:____________
Subscribers Address (If different from patient):____________________
Sex:_: M / F Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Child ( ) Care Taker ( ) Other
Home#________________Work#____________Cell#________________
Date of Birth:__________Social Security #__________Driver's License#____________
Employer Name:____________________Years Employed:____________
Address:____________________Employer Phone Number:____________
City____________________State________________Zip________

PATIENT AGREEMENT & AUTHORIZATION FOR THE RELEASE OF MEDICAL AND HEALTH PLAN DOCUMENTS FOR THE CLAIMS PROCESSING & REIMBURSEMENT AS REQUIRED BY FERDERAL AND STATE LAWS. LEGAL ASSIGNMENT OF BENEFITS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

In considering the amount of medical expenses to be incurred, 1 , the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and /or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider(s) managed care network participation status. I understand and agree that I am legally responsible for all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA. Thereby authorize any plan administrator or fiduciary, insured and my attorney to release to such provider(s) all plan, documents insurance policy and or settlement information upon written request from such provider(s) to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.
I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to ERISA 502(a)(1)(B) and 502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim liability or tort claim, choose in action, appropriate equitable relief, surcharge, remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor: (2) submitting evidence ; (3) making statements about facts or law (4) providers to pursue such claim, chose in action or tight against any liable party or employee group health plan, including, if necessary bring suit be such providers against any such liable part or employee group health plan in my name with derivative standing but at such provider(s) expenses, Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of the assignment is to be considered as valid as the original. I have read and fully understand this agreement.

____________________ ____________________
Signature of Patient or Legal Guardian Date

____________________ ____________________
Print Name Print Patient Name is Patient is a Minor DOB

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FINANCIAL POLICY

Thank you for choosing us as your orthopaedic care facility. Our goal is to provide you with the highest quality orthopaedic care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- We may accept any assignable insurance with applicable coverage
- We offer financial assistants (Discount, Waiver or Reduction of Deductible, Copays and Coinsurance) under our indigence policy to all eligible patients on case lo case basis. Once indigence has been proven.
- Full payment is due at time of service unless arranged otherwise
- We accept cash, checks or Visa/MasterCard and American Express.
- We offer an extended payment plan with prior credit approval
- We accept all health savings account (HAS) payments.

Dishonored checks will be charged back to the patients account with a service lee of $25.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collections.

Regarding Insurance

We accept assignment of insurance benefits at our discretion is acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients verifiable and assignable insurance will be billed by this orthopaedic office. However, you will be personally responsible for your account balance regardless of whether insurance pays your claims.

Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card with authorization to charge that amount for the balance due. If your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary.

If you have a month-to-month insurance plan. (Personal insurance, self-contracted, exchange plans, etc.,) and we cannot verily the premium has been paid we will ask for lull payment up front or ask you to provide a credit card with authorization to charge the amount for the balance due. If payment is made up front and insurance does pay your account will be refunded per the insurance EOB.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient but will treat the account as a self-pay.

We may offer Affordable Care Act (ACA) Discounts to uninsured (Cash Pay) patients. On an unadvertised basis for uninsured patients, and after determining in good faith that you are in financial need or after reasonable collection efforts failed. Unless expressly prohibited by any specific terms of the health plan, we are fully in compliance with the terms of health plan applicable federal and state laws under our corporate indigency agreement.
You may apply for financial indigency ACA discount assistance by asking our staff to determine if you are eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon's charge as clearly as practically possible before your medical or surgical procedures if it is known to us. We do not always know ahead of time the amount insurance will pay. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.
As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. In the case that you do have surgery you shall not be surprised that you will receive separate surgical facility fees, anesthesiologist, diagnostic labs, radiologist, pathologist, and others in addition to the surgeons bills for your surgery. If you have any questions about your surgical bills, please direct your questions to the surgical center

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.
The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

Regarding PPO and HMO Network Participation
As you may know, you may have a choice to choose a surgeon or surgical facility with or without PPO or HMO participation under different insurance coverage and benefits levels. We provide highest quality care to every patient. However, we have no power to change your insurance coverage or network limitations. Most health care plans, or insurance policies may provide coverage to non-PPO providers and facilities, but at low percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers we will always disclose to you as to our participation status to your insurance plan.

We will verify your insurance coverage and obtain precertification if applicable for all services as a courtesy to you. **Please understand that all insurance verification is not a guarantee of insurance payment.**

Compliance & Disclosure under Texas Occupation Code ~ Section 102.006
In compliance with Section 102.006 of Texas Occupation Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out of network coverage and cost sharing, my attending doctor(s) and/or clinic facility have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety as a result of by informed consent and personal choice of doctors and or facility. (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and () that he/she will receive, directly or indirectly, remuneration for referring upon my such request and excising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by any health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupation Code Doctor or Facility with affiliation and remuneration: Executive Surgery Center, Signature pharmaceutical Solutions

Patient Refunds or Credits
Most Refunds will not generate and cannot be refunded until after insurance pays. Credits on accounts are posted to any outstanding balances prior to refund being given. This includes all patients under the same guarantor. Once insurance pays on all visits under the account number and all outstanding balances have been paid or adjusted the credit refund can be completed.

Your Responsibility for Cooperation
If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan during insurance claim processing, such as insurance inquiries, requests for addition information, claims status verification or any inquires for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment check(s) from your services tendered by this doctor, you agree to submit such insurance reimburse check(s) to our office within five business days after your receipt of insurance check(s). In a failure or refusal to forward or send us the insurance reimbursement check(s) for the medical services from this provider, all your discount arrangements will be voided, and the total balance will be due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we must retain any legal services to collect past dues.
The Guarantor is the Person financially responsible for the account. The Guarantor must be present to sign the financial forms. In cases of Divorce and child custody the parent or guardian bringing the child in is responsible for the financial balance. If a patient or a parent/guardian refuse to sign the financial form the patient will be treated as cash pay and the estimated payment will be expected up front.

Navicure Payment System
I agree to provide Texas Orthopaedic & Sports Medicine and/or its designated payment agent with my debit/credit card or ACH information.

I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.
The card or ACHİ information will be obtained through a card swipe, manual entry from the card, voided check, orally in person or over the phone.

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If warranted, this practice may offer the option of paying my share of costs via automated payment plan.

I authorize Texas Orthopaedic & Sports Medicine and/or it's designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures, or supplies, including amounts agreed as part of a payment plan, co-payments, co-insurance, and any amounts not covered by insurance.

Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

I authorize Texas Orthopaedic & Sports Medicine and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is any responsibility to maintain a current email address on file and that I will not receive an email copy of any electronic statement.

We, at Texas Orthopaedic & Sports Medicine, will make every attempt to contact you for balances due. Unpaid accounts past 90 days will be turned over to American Credit Bureau.

We are committed to serving you with highest quality care possible at affordable cost. Every staff member at our office is ready to always help you.

If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

____

Signature of Patient or Responsible Party | Patient Name (Print) | Date

____

Signature of Co-Responsible Party | Your Name (Print) | Date

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PATIENT CERTIFICATION OF NO WORKERS COMPENSATION CLAIM

1. As the patient, I represent and certify that I have not, and will not at any time in the future, make a workers compensation claim related to the injury for which I am currently seeking treatment at Texas Orthopaedic and Sports Medicine (TOSM), or any related condition currently existing or arising from my injury at any time in the future. I understand that TOSM will bill my insurance company, if applicable, for my treatment and that I will be responsible for any fees not paid by my insurance company and will ensure that such fees are timely paid.

2. I understand that if I violate this agreement and make any claim for workers compensation after receiving treatment from TOSM and, as a result of such claim, my insurance company refuses to pay TOSM's fees for my treatment or requires that any fees that it has paid TOSM be refunded, I will be responsible for timely paying the full amount of those fees to TOSM, I acknowledge that if neither workers compensation funds nor insurance benefits are available to pay for my treatment, or are paid to TOSM and then recouped, I will not have any argument, nor will I attempt to argue, that I do not owe TOSM the full amount of such fees.

3. I acknowledge that if I am responsible for any financial amount to TOSM as a result of an unwillingness of the workers compensation program or my private insurer to pay the fees for my treatment, or the recoupment from TOSM of any funds paid to TOSM by the workers compensation program or my private insurer, I understand that TOSM will bill me directly for such amount, and I will be solely responsible for paying such amount timely and in full.

4. I acknowledge that I understand that if I fail to timely pay any amount owed to TOSM, such debt may be turned over to a collection’s agency, and I will then be solely responsible to satisfy the demands of such collection’s agency.

5. I acknowledge that I have read this Certification and that I understand it.

____
Please Print Patient Name

____
Signature of Patient or Guardian if patient is a minor Date

____
Print Name of Guardian if applicable

TOMBALL: 13603 Michel Road Tomball, TX 77375
THE WOODLANDS: 9319 Pinecroft Drive, Suite 200 The Woodlands, TX 77380
Tel 281.351.7261 Fax 281.351.2515
www.tosm.org

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MEDICATION PROTOCOL

The Medication Protocol of Texas Orthopaedic & Sports Medicine is outlined below. As our patient, you are required to read, acknowledge, and abide by this protocol. Unless your physician personally consents to any deviation, this protocol will be explicitly followed.

1. All refill requests shall be made through your pharmacy.
2. Your pharmacy will contact this office regarding the refill request.
3. Medication refill request will be handled Monday – Friday during regular office hours. (Regular business hours are Monday thru Thursday 8:00am to 5:00pm, Friday 8:00am to 12:00pin) We require 24 to 48 hours to accommodate refill request.
4. Patients are responsible for monitoring the amount of medication remaining in the current prescription to avoid running out of medication before a refill can be accomplished.
5. All medications are to be taken as prescribed. If there are any questions or concerns with the medication, please contact your physician's Medical Assistant or Patient Consultant. The Medical Assistant or Patient Consultant will notify the physician as appropriate. If there is an urgent or emergent issue, the physician will be notified, and you will be directed to go to the nearest emergency facility.
6. No refills will be granted if the medication is requested prior to the time the current prescription should have run out or if medication is being prescribed from another physician.
7. If a request for refill has been denied, the patient will be notified as soon as possible and provided an explanation regarding the refusal. A patient maybe requested to schedule an appointment for examination to ensure that the medication requested continues to be appropriate for the condition.
8. Laboratory testing may be required at intervals to continue the prescription.
9. Narcotic medications requiring specific forms or Department of Public Safety / Drug Enforcement Agency stickers will not be used. Physicians do not have such documents readily available.
10. Narcotic pain medications, such as those associated with a recent injury or surgery, are not listed for long term or chronic pain. Patients with such requirements will be referred to a pain management specialist.
11. I give permission to Texas Orthopaedic & Sports Medicine to import my prescription history.

I have reviewed the Medication Protocol of Texas Orthopaedic & Sports Medicine. I understand and agree to its provisions.

____

Please Print Patient Name

____

Signature of Patient or Guardian if patient is a minor Date

____

Print Name of Guardian if applicable

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NOTICE OF PRIVACY PRACTICES AND RIGHTS OF PATIENTS

Patients' disclosures and records shall be treated with confidentiality and privacy as required by federal and state law. The patients' written permission will be obtained before their medical records are made available to anyone not directly concerned with their care. The exceptions to written permission will be for suspected abuse, neglect, and public health hazards when reporting is permitted or required by law.
Uses and disclosures of health information

- Physicians and the Health Care Providers treatment to you.
- To obtain payment for the services we provide you.
- Health care operations such as quality assessment, improvement activities, review of overall service and treatment, conducting training programs, accreditation, and certification licensing or credentialing activities.
- Your written authorization will release your health information to anyone for any purpose and can be revoked by you at any time with a written request. Health information can be released to family and friends for treatment, payment, or health care operations with your authorization.
- Your information may be used to assist in the notification of (including identifying or locating) a family member, personal representative, or another person responsible for your care, of your location, your general condition or death. If present you will have the opportunity to object to such uses or disclosures. In the event of incapacity or emergency circumstances, we will disclose health information based on professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care. Professional judgement will also be used to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar health information.
- Health information may be used to provide you with appointment reminders on postcards, letters, or voice mail, please notify us in writing if you prefer another method of notification. The Privacy Policy is intended to provide an understanding to new policies concerning Protected Health Information (PHI). We reserve the right to change our privacy practices and the terms of this notice at any time, provided applicable law permits such changes. Prior to making changes a new notice will be made available upon request.
- You may request a copy of our Privacy Policy notice at any time. Additional Information regarding Health Insurance Portability Accountability Act (HIPAA) of 1996 can be found at http://ww.hhs.gov/ocr/hipaa

PATIENTS RIGHTS

Patient shall be provided, to the degree known, appropriate information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information shall be provided to a person designated by the patient or to a legally authorized person. Patients will have access to copies of their health information with a written request for a reasonable cost-based fee fox expenses such as copies and staff time. Patients can request format and we will attempt to meet it. In the case we are unable to meet format requested paper copies will be provided. Patients shall be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

Patients have the right to request an alternative means of communication or location regarding health information. Request MUST be made in writing and specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location requested.

Patient has the right to request of instances in which their health information was disclosed for purposes other than treatment, payment, healthcare operations and certain other activities beginning 04/14/2003. If request is made more than once in a twelve-month period a reasonable, cost-based fee will be charged.

Information will be available to patients and staff of Texas Orthopaedic and Sports Medicine concerning:

1. Patient rights, including those specified in this section
2. Patient conduct and responsibilities
3. Services available
4. Provisions for after-hours and emergency care
5. Fees for services
6. Payment policies
7. Patients" right to refuse to participate in experimental research
8. Options for reporting complaints and suggestions
9. Information provided in advertising or marketing regarding the competence and capabilities of the staff will not be misleading to patients.

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MEDICAL INFORMATION DISCLOSURE

I give permission for Texas Orthopaedic & Sports Medicine to discuss my medical information with the following person(s):

Name:____Relationship:__________________________________

Name:____Relationship:__________________________________

____ _______________________

Patient Name (please print) Date of Birth

____

Signature of Patient or Guardian (if patient is a Minor)

____

Printed Name of Guardian (if applicable)

____

Date

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INJURY/PAIN QUESTIONAIRE

Patient Name:__________________________DOB:___________Height:____'_____Weight: ______________

Present Orthopedic Problem: ____

Please describe how this injury occurred: ____________________________________

Date of onset of this problem:____________________or how long has this been going on: ______________

Referring Physician: ______________________Do you have a current: ☐X-ray ☐MRI ☐CAT scan ☐EMG?

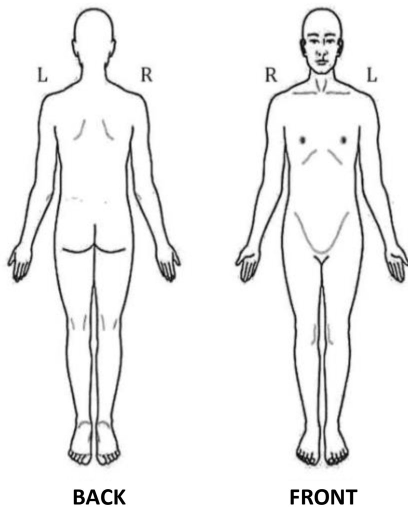
Preferred Pharmacy Name: ____________________Pharmacy Phone: ______________________

Pharmacy Address: ____

Current Medications (including vitamins&herbal supplement)
☐ I brought my list of meds ☐ I am NOT currently taking medications
____
____
____

Allergies (Please describe type of allergic reaction):
____
____
____

Please indicate on the diagram below where you are injured and/ or where your site of pain is located



Describe your pain (*check all that apply):*

☐Aching ☐burning ☐catching ☐cramping
☐Dull ☐electric ☐grinding ☐locking
☐Popping ☐pressure ☐radiating ☐sharp
☐Stabbing ☐throbbing ☐tingling ☐worsening

Does your pain radiate? If so, where?______________________________

Severity of pain (*circle#):* 0 1 2 3 (mild) 4 5 6 (moderate) 7 8 9 (severed)

Frequency of pain: ☐ Persistent ☐ Intermittent

Conservative Treatment (you have tried and failed):

☐Acupuncture ☐Aquatic Therapy ☐ Brace/ Spint/ Cast
☐Cane/Crutches ☐Chiropractor ☐ ESI Injection
☐Heat/ Ice ☐Home exercises ☐Massage Therapy
☐ Narcotics ☐NSAID's ☐Physical Therapy
☐ Rest ☐TENS Unit ☐Wheel Chair/ Scooter
☐Other:______________________________

How long have you tried conservative treatment/ physical therapy?

Do you have any associated symptoms? *(Check all that apply)*

☐Decreased Mobility ☐Freq.Falls ☐Headaches ☐ Stiffness
☐Nocturnal awakening ☐Spasms ☐Tenderness ☐Weakness
☐Limping/ Gait Disturbance ☐Freq.Tripping/ Stumbling
☐Difficulty Initiating Sleep ☐Extremity Numbness/ Tingling

Please any of the following you find it difficult to do:

☐Bathing ☐Driving ☐Community Activities ☐ Computer Work ☐ Getting In/ Out of car
☐Seat belt ☐Shopping ☐Sitting ☐Standing ☐Yard Work ☐ Walking

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Please check if these apply to you:

☐ Pain is affecting my daily living ☐ Pain is restricting me from performing my daily job/ daily living
☐ I am currently off work due to my injury/ pain

HISTORY AND INTAKE FORMS

(PLEASE CHECK ALL THAT APPLY)

PAST MEDICAL HISTORY

☐ Anemia, Chronis
☐ Anxiety
☐ Asthma
☐ Atrial Fibrillation
☐ Breast Cancer
☐ Chronic Pain
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes, Insulin Dependent
☐ Diabetes, Non-Insulin Dependent
☐ End Stage Renal Disease
☐ GERD
☐ Hepatitis
☐ HIV/AIDS
☐ High Cholesterol
☐ Hyperthyroidism
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Multiple Myeloma
☐ Obesity, Morbid
☐ PBPH
☐ Prostate Cancer
☐ adiation Therapy
☐ Seizures
☐ Strokes
☐ Other:________________________
☐ **NONE**

FAMILY MEDICAL HISTORY

Please Indicate family members' medical history by marking the appropriate boxes:

	Mother	Father	Sister	Brother	Daughter	Son	Other
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes							
Other							

☐ **NO FAMILY HISTORY** (Checking this box indicates no past family medical history)

PAST SURGICAL HISTORY

☐ Appendix (Appendectomy)
☐ Bladder Removal
☐ Breast Mastectomy
◯ Right ◯ Left ◯ Both
☐ Breast Lumpectomy
◯ Right ◯ Left ◯ Both
☐ Colectomy: Colon Cancer Resection
☐ Colectomy: Diverticulitis
☐ Colectomy: IBD
☐ Colon: Colostomy
☐ Gallbladder Removal
☐ Heart: Biological Valve Replacement
☐ Heart: Coronary Artery Bypass
☐ leart Transplant
☐ Heart Mechanical Valve R Replacement
☐ Heart: PTCA
☐ Kidney Stone Removal
☐ Kidney Transplant
☐ Liver Transplant
☐ Liver Shunt
☐ Ovaries Removed: Ovarian Cancer
☐ Ovaries: Tubal Ligation
☐ Pancreas: Pancreatectomy
☐ Prostate Removed: Prostate Cancer
☐ Prostate Removed: TURP
☐ Rectum: APR
☐ Rectum: Low Anterior Resection
☐ Skin: Basal Cell Carcinoma
☐ Skin: Melanoma
☐ Skin: Skin Biopsy
☐ Skin: Squamous Cell Carcinoma
☐ Hysterectomy: Caesarean
☐ Hysterectomy: Uterine Cancer
☐ Hysterectomy: Cervical Cancer
☐ Other:________________________
☐ **NONE**

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PAST ORTHODPEDIC HISTORY

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections (Spine)
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ Other: ______________________
- ☐ **NONE**

PAST ORTHOPEDIC SURGERY

- ☐ Uncle Fracture ORIF
  ◯ Right ◯ Left ◯ Both
- ☐ Carpal Tunnel Release
  ◯ Right ◯ Left ◯ Both
- ☐ Cervical Spine Surgery: ACDF
  ◯ Right ◯ Left ◯ Both
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  ◯ Right ◯ Left ◯ Both
- ☐ Intramedullary Nailing Femur
  ◯ Right ◯ Left ◯ Both
- ☐ Intramedullary Nailing Tibia
  ◯ Right ◯ Left ◯ Both
- Joint Replacement: Hip
  ◯ Right ◯ Left ◯ Both
- ☐ Joint Replacement: Knee
  ◯ Right ◯ Left ◯ Both
- ☐ Joint Replacement: Shoulder
  ◯ Right ◯ Left ◯ Both
- ☐ Knee Arthroplasty
  ◯ Right ◯ Left ◯ Both
- ☐ Kyphoplasty/Vertebroplasty
  ◯ Right ◯ Left ◯ Both
- ☐ Lumbar Spine Surgery: Decompression
  ◯ Right ◯ Left ◯ Both
- ☐ Lumbar Spine Surgery: Decompression &Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Rotary Cuff Repair
  ◯ Right ◯ Left ◯ Both
- ☐ Other:______________________
- ☐ **NONE**

SOCIAL HISTORY

Alcohol Use

- ☐ Does not drink alcohol
- ☐ Drink less than 1 drink per day
- ☐ Drink 1-2 drinks per day
- ☐ Drink 3 or more drinks per day

Exercise Frequency

- ☐ Exercise several times per day
- ☐ Exercise once per day
- ☐ Exercise a few times per week
- ☐ Exercise a few times per month
- ☐ Other:

TOMBALL: 13603 Michel Road Tomball, TX 77375
THE WOODLANDS: 9319 Pinecroft Drive, Suite 200 The Woodlands, TX 77380
Tel 281.351.7261 Fax 281.351.2515
www.tosm.org

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PLEASE CHECK YES OR NO IF YOU ARE EXPERIENCING THE FOLLOWING SYMPTOMS:

☐ Yes ☐ No Joint pains
☐ Yes ☐ No Joint swelling
☐ Yes ☐ No Joint stiffness
☐ Yes ☐ No Unsteady gait
☐ Yes ☐ No Numbness
☐ Yes ☐ No Tingling
☐ Yes ☐ No Unexpected weight loss
☐ Yes ☐ No Fever
☐ Yes ☐ No Chills
☐ Yes ☐ No Poor healing wounds
☐ Yes ☐ No Scarring/ Keloids
☐ Yes ☐ No Easy bleeding
☐ Yes ☐ No Anxiety
☐ Yes ☐ No Depression

PLEASE CHECK YES OR NO IF ANY OF THE FOLLOWING CONDITIONS APPLY:

☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Blood thinner
☐ Yes ☐ No Defibrillator
☐ Yes ☐ No Premedication prior to procedures
☐ Yes ☐ No Rheumatoid Arthritis Yes D No RSD
☐ Yes ☐ No Allergy to latex
☐ Yes ☐ No Allergy to Adhesive
☐ Yes ☐ No Allergy to shellfish/ iodine
☐ Yes ☐ No Under pain management
☐ Yes ☐ No Fall risk

PLEASE INFORM THE PHYSICIAN OR MEDICAL STAFF OF ANY OTHER MEDICAL CONDITIONS OR CONCERNS

SMOKING STATUS:

☐ Never a smoker
☐ Quit: former smoker
☐ Smokes less than daily
☐ Smokes daily # of packs per day___________

PLEASE CHECK YES OR NO FOR THE FOLLOWING:

☐ Yes ☐ No Received the pneumococcal vaccination- Date:______________
☐ Yes ☐ No Received the TDap vaccination- Date:______________
☐ Yes ☐ No Received the Flu vaccination- Date:______________

65 years and Older

Do you have a health Proxy or living will? ___ Yes ___ No
Name ________________________________ Phone Number ___________________________
Doctor Signature:______________________ Date:_______________

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Tel 281.351.7261 Fax 281.351.2515
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