

Name:
DOB:
Chart:
Age:
Date:

**NORTHEAST ORTHOPAEDICS
& SPORTS MEDICINE, LLP**

12709 Toepperwein Rd #101
San Antonio, TX 78233
210-477-5151
Fax: 477-5152

18707 Hardy Oak Blvd, Suite 415
San Antonio, TX 78258
210-477-5151
Fax: 210-477-5152

8715 Village Dr #120
San Antonio, TX 78217
210-477-5151
Fax: 210-477-5152

PLEASE PRINT ALL INFORMATION BELOW, THANK YOU.

Today's Date: _____

Patient's Name: _____ Gender: _____
Last First MI

Patient Mailing Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Home e-mail: _____

Date of Birth: _____ Driver's License #: _____

Social Security #: _____

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip

Marital Status: Single Married Divorced Widowed Spouse's Name: _____

DEMOGRAPHICS (choose the best description)			SMOKING STATUS
Race Choices <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Type-Unknown <input type="checkbox"/> White	Ethnicity Choices <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Type-Unknown	Language Choices <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Japanese <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish	<input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Never smoker <input type="checkbox"/> Smoker, current status unknown <input type="checkbox"/> Unknown if ever smoked

ACCOUNT GUARANTOR / SPOUSE INFORMATION

Name: _____ Phone #: _____
Last First MI

Date of Birth: _____ Social Security #: _____

If patient is under 18 years of age or full-time student, please complete the following:

Parent or Guardian Name: _____ Social Security #: _____

WORKER'S COMPENSATION INJURY: Yes No (if yes, please see receptionist)

MOTOR VEHICLE ACCIDENT: Yes No (if yes, please see receptionist)

Assignment / Authorization

I hereby authorize payment of insurance benefits to be made to Northeast Orthopaedics & Sports Medicine, LLP for services provided to me or members of my family. I understand that I am financially responsible for all charges not covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I agree to release pertinent demographic and insurance information to a specialist and/or health services in the event that is necessary in my course of treatment.

I certify the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under general or special instructions of the physician.

Signature: _____ Date: _____

If you are referred to Sendero Imaging or Christus Santa Rosa Physicians Ambulatory Surgery Center, we are required by law to inform you that Northeast Orthopaedics & Sports Medicine physicians may have ownership interest in those facilities and may receive remunerations indirectly for services rendered.

Name:
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Date:

**NORTHEAST ORTHOPAEDICS
& SPORTS MEDICINE, LLP**

PRIMARY - INSURANCE COVERAGE INFORMATION

Today's Date: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Street / P.O. Box

City

State

Zip

Policy ID#: _____ Effective Date of Coverage: _____

Group #: _____ Group / Co. Name: _____

Policy Holder's Name: _____

Last

First

MI

Date of Birth: _____

Relationship to Patient: SELF SPOUSE CHILD OTHER: _____

SECONDARY - INSURANCE COVERAGE INFORMATION

Insurance Co. Name: _____

Insurance Co. Address: _____

Street / P.O. Box

City

State

Zip

Policy ID#: _____ Effective Date of Coverage: _____

Group #: _____

Policy Holder's Name: _____

Last

First

MI

Date of Birth: _____

Relationship to Patient: SELF SPOUSE CHILD OTHER: _____

ACCIDENT INFORMATION

Are you being seen as a result of an accident? YES NO Date of Injury: _____

If yes, where did the accident occur? _____

Describe your injury (including body part involved): _____

**Acknowledgement of Review of
Notice of Privacy Practices**

I have reviewed the office's Notice of Privacy Practices of Northeast Orthopaedics & Sports Medicine, L.L.P., which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Print name of Patient or Personal Representative

Description of Personal Representative's Relationship/Authority

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

Patient Medical History

Patient Name: _____ Birth Date: _____ Today's Date: _____
Age: _____ Sex: _____ Occupation: _____ Dominant hand: R L
Date of Injury: _____ Is this work related? Yes No Was it reported? Yes No
Primary Care Physician: _____ City: _____
Referring Physician's Name: _____ City: _____

HISTORY OF PRESENT ILLNESS: Problem with: Right extremity Left extremity

Chief Complaint / Why are you here today? _____

Location: _____
(Where is the pain/problem? Does it travel to other areas?)

Quality: _____
(Is the pain dull, throbbing, or sharp? If lump, is it warm, tender, red?)

Severity: _____ **Duration:** _____
(On a scale of 1-10 with 10 being the most severe?) (How long have you had the problem?)

Timing: _____ **Context:** _____
(Is the pain rare, intermittent, or constant? Occur at a specific time?) (What were you doing at the onset of the pain / problem?)

Associated signs/symptoms: _____
(Popping, grinding, clicking, swelling, stiffness, instability, night pain, numbness, weakness?)

Modifying factors: _____
(What makes the pain or problem better or worse?)

Have you seen any other physicians regarding **this** condition prior to coming to our office? Yes No

<u>Doctor</u>	<u>When</u>	<u>Tests</u>	<u>Results</u>	<u>Treatment</u>

Please list any hobbies / sports you enjoy: _____

Which of the above activities are you **unable** to perform due to your pain? _____

PAST MEDICAL HISTORY: Have you ever had any of the following? *Please check all pertinent boxes:*

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> AIDS or HIV + | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pacemaker / Defibrillator |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Fractures _____ | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> I <input type="checkbox"/> II | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Blood Clot (DVT) | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Infectious Mono | <input type="checkbox"/> Staph Infections (MRSA) |
| <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Reflux | | | |

Name:
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PAST SURGICAL HISTORY:

Date	Surgery	Surgeon	Date	Surgery	Surgeon
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies to Medications:	Drug Name:	Reaction	Mild	Moderate	Severere
1.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS: Include prescription & non-prescription medications & herbal supplements (or please attach a list)

Social History:

<u>Alcohol use</u>	<u>Tobacco use</u>	<u>Living status</u>
<input type="checkbox"/> no <input type="checkbox"/> moderate <input type="checkbox"/> rare <input type="checkbox"/> daily	<input type="checkbox"/> never <input type="checkbox"/> yes _____ packs / day x _____ years <input type="checkbox"/> quit <input type="checkbox"/> smokeless	<input type="checkbox"/> with family <input type="checkbox"/> alone <input type="checkbox"/> with friends <input type="checkbox"/> other

Family Medical History: Any family history of the following problems? *Please check all pertinent boxes:*

<input type="checkbox"/> Adverse reaction to anesthesia	<input type="checkbox"/> Bleeding tendency (hemophilia)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Scoliosis

Review of Systems: Please indicate *current* symptoms that you are having: *Please check all pertinent boxes:*

General, Constitutional <input type="checkbox"/> good general health lately <input type="checkbox"/> recent weight change <input type="checkbox"/> fever	Respiratory <input type="checkbox"/> shortness of breath <input type="checkbox"/> asthma or wheezing Gastrointestinal <input type="checkbox"/> indigestion <input type="checkbox"/> blood in stool <input type="checkbox"/> nausea or vomiting	Musculoskeletal <input type="checkbox"/> joint pain <input type="checkbox"/> joint stiffness or swelling <input type="checkbox"/> back pain <input type="checkbox"/> muscle pain or cramps <input type="checkbox"/> difficulty walking <input type="checkbox"/> cold extremities	Psychiatric <input type="checkbox"/> depression <input type="checkbox"/> sleep disturbance Endocrine <input type="checkbox"/> excessive thirst <input type="checkbox"/> excessive urination
Eyes <input type="checkbox"/> visual changes	Genitourinary <input type="checkbox"/> incontinence <input type="checkbox"/> frequent urination <input type="checkbox"/> burning or painful urination <input type="checkbox"/> difficulty with urination	Neurological <input type="checkbox"/> numbness <input type="checkbox"/> weakness <input type="checkbox"/> tremor <input type="checkbox"/> light headed or dizzy	Hematologic <input type="checkbox"/> bleeding tendency <input type="checkbox"/> anemia Skin <input type="checkbox"/> rash <input type="checkbox"/> itching
Ears, Nose, Throat <input type="checkbox"/> hearing loss <input type="checkbox"/> bleeding gums <input type="checkbox"/> teeth pain / cavities	Cardiovascular <input type="checkbox"/> chest pain		

Height: _____ Weight: _____

To the best of my knowledge, the questions on this form have been answered correctly. I understand that it is my responsibility to inform the doctor of any changes in my medical condition.

Signature of Patient, or Parent of Minor

Date

Physician Initials

Date

Name:
DOB:
Chart:
Age:
Date:

Orthopaedic Surgery - Arthroscopic Surgery - Joint Replacement - Sports Medicine - Fracture Care

John R. Chance, M.D., David L. Fox, M.D., Jamie L. Lynch, M.D., Brian E. Schulze, M.D., Patrick M. Simon, M.D., Rex E. Wilcox, M.D.
Diplomates, American Board of Orthopaedic Surgery
Kelly A. Cooper, PA-C

Contact Information Authorization

(PLEASE PRINT ALL INFORMATION)

All information in our office is kept confidential. Please list names of anyone that you would like our office to speak with about your condition, treatment, lab results, appointments and any billing or insurance questions. *Please indicate by writing "NONE" if you prefer all information to be kept confidential.

Name	Relationship & Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

Is there anyone that we may discuss your condition with in the event of an emergency?
_____ (Name & Phone Number)

Which phone number do you prefer us to contact you during our regular office hours?
_____ (Home, Work, Cell)

Do you have an answering machine or voice mail that we may leave confidential messages concerning your appointment, lab results or your condition?

If yes, what number? _____

It is your responsibility to notify our office if this information changes.

I agree that Northeast Orthopaedics & Sports Medicine, L.L.P. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I also agree that Northeast Orthopaedics & sports Medicine, L.L.P. may share my health information with medical providers outside of this practice in order to facilitate my care.

Patient Signature: _____ Date _____

12709 Toepperwein Road, Suite 101 San Antonio, Texas 78233
Phone: (210) 477-5151 Facsimile: (210) 477-5152

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PATIENT FINANCIAL POLICY STATEMENT

The physicians and staff of Northeast Orthopaedics & Sports Medicine, LLP (NEOSM) are here to serve your needs as our patient. It is our goal to create an experience for our patients that hopefully will limit the amount of stress patients may encounter. Our PATIENT FINANCIAL POLICY is intended to describe our expectations regarding the payment for services we provide. Unless otherwise noted, payment is due at the time of service.

Our staff is prepared to provide patients with any assistance or resources possible in making payment arrangements for services. We can help patients contact the appropriate entities to obtain the documents needed to insure proper payment such as referrals and pre-authorizations for procedures. We ask that patients recognize their responsibility to understand what services their insurance covers as well as what documents are required to assure that payment is made.

The FINANCIAL POLICY details the expectations of our medical group as they relate to patients making payment for provided services. Patients should acknowledge the following policy requirements:

1. The patient, or their designated guarantor, is responsible for payment of services.
2. All office charges, co-payments, and applicable deductible amounts are due at the time of service.
3. The provision of an insurance card for payment of services will be accepted and filed on behalf of the patient; however, the patient is still responsible for payment if their insurance coverage fails to adequately provide payment in a timely or appropriate manner. If you do not have your insurance card, you will be considered a self-pay patient.
4. Submitting an expired insurance card or someone else's insurance card is insurance fraud.
5. It is the obligation of the patient to obtain and provide any referral notifications required by the patient's insurance carrier. Without the appropriate referral the patient's appointment may be rescheduled.
6. Arrangements for co-insurance payment estimates must be made prior to the scheduled surgery date in order to prevent possible delays in providing the service.
7. Patient account balances are due within 30 days of the receipt of the billing statement unless otherwise specified.
8. Patients may contact our patient accounts representative to make payment arrangements. After 90 days, if no arrangements have been made for payment, or if no payments have been received, then collection proceedings will begin.
9. Delinquent accounts may be assigned to a collection agency. All collection costs will be added to your outstanding balance and will become an additional cost to you. We will not be held responsible for any collection agency fees.
10. From time to time, various forms including but not limited to disability and FMLA forms need to be filled out. There is a \$25 fee to complete each form.
11. We accept MasterCard, Visa, Discover and American Express. Checks returned for closed accounts or non-sufficient funds will be charged a \$25 service fee and sent to the Bexar County DA's office.
12. There will be a \$25 fee assessed for failure to provide at least 24 hours notice of appointment cancellation.

We ask that each patient/guarantor sign this document as part of his or her registration at Northeast Orthopaedics & Sports Medicine, L.L.P. in accordance with the following statement:

"I _____, (patient/guarantor), acknowledge that I have received and read this financial policy statement."

(Patient/Guarantor Signature)

Date