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

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Signature of Patient or Personal Representative

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Date

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Print-Name of Patient or Personal Representative

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Description of Personal Representative's Authority

# Waco Orthopedic & Sports Medicine Clinic

## 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

Policy Holder's Address: \_\_\_\_\_  
Street City State Zip

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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 #: \_\_\_\_\_ Group / Co. Name: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
Last First MI

Policy Holder's Address: \_\_\_\_\_  
Street City State Zip

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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): \_\_\_\_\_

**WORKER'S COMPENSATION INJURY:**  YES  NO Date of Injury: \_\_\_\_\_

Employer at Time of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street / P.O. Box City State Zip

Employer Phone: ( ) \_\_\_\_\_ Employer Fax: ( ) \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Insurance Co. Phone: ( ) \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street / P.O. Box City State Zip Fax#: ( ) \_\_\_\_\_

Describe your injury (including body part involved): \_\_\_\_\_



### Patient Medical History

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  M  F 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

Doctor When Tests Results Treatment

**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 I <input type="checkbox"/> or II <input type="checkbox"/> | <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 or Reflux   | <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 _____               |

**PAST SURGICAL HISTORY:**

<u>Date</u>	<u>Surgery</u>	<u>Date</u>	<u>Surgery</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGIES:** (medication & reaction) \_\_\_\_\_

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

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Social History:**

<u>Marital status:</u>	<u>Alcohol use</u>	<u>Tobacco use</u>	<u>Living status</u>
<input type="checkbox"/> single <input type="checkbox"/> divorced	<input type="checkbox"/> no <input type="checkbox"/> moderate	<input type="checkbox"/> never <input type="checkbox"/> yes ___ packs / day	<input type="checkbox"/> with family <input type="checkbox"/> alone
<input type="checkbox"/> married <input type="checkbox"/> widowed	<input type="checkbox"/> rare <input type="checkbox"/> daily	<input type="checkbox"/> quit    ___ smokeless	<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:*

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

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

**Stop Here**

**Vital Signs:**      Weight: \_\_\_\_\_ lbs      Height: \_\_\_\_\_ ft \_\_\_\_\_ in      Temp: \_\_\_\_\_

_____	_____	_____	_____
Nurse Initials	Date	Physician Initials	Date

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**WACO ORTHOPEDIC GROUP**  
**PATIENT FINANCIAL POLICY STATEMENT**

The physicians and staff of Waco Orthopedic Clinic (WOC) 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 \$10.00 fee to complete each form.
11. We accept MasterCard and Visa Cards. Checks returned for closed accounts or non-sufficient funds will be charged a \$30.00 service fee and sent to the McLennan County DA's office.

We ask that each patient/guarantor sign this document as part of his or her registration at WOC in accordance with the following statement:

"I \_\_\_\_\_, (patient/guarantor), acknowledge that I have received and read this  
(Print Name) financial policy statement."

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(Patient/Guarantor Signature)

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(Date)



**Contact Information Authorization**

**WACO ORTHOPEDIC  
& Sports Medicine Clinic**

Gary L. Becker, M.D.  
J. Kendall Ethridge, M.D.  
Jerry A. Benham, M.D.  
Jon Marc Goodnight, M.D.  
Jacob R. Battle, M.D.

Diplomates of the American Board of  
Orthopaedic Surgery

**(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, lab results, or appointments. **(Please note to leave this section blank if you prefer all information to be kept confidential.)**

Name	Relation & Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

Is there anyone that we may discuss your condition with in the event of an emergency?  
\_\_\_\_\_ (name & phone number)

At which phone number do you prefer us to contact you during our regular office hours?  
\_\_\_\_\_

Do you have an answering machine or voice mail that we may leave confidential messages concerning your appointment, lab results, or your condition? (yes or no)  
If yes, what number? \_\_\_\_\_

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

I agree that Waco Orthopedic & Sports Medicine Clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. (yes or no)

\_\_\_\_\_  
Patient Signature Date