
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.

Signature of Patient or Personal Representative

Date

Print-Name of Patient or Personal Representative

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): _____

Date: _____

Waco Orthopedic & Sports Medicine Clinic Medical History Form

Name: _____

Age: _____

Occupation: _____

Sex: Male Female

Dominant Hand: right left

Weight: _____

Height: _____

Medical Problems: (check the box yes or no for each illness you have)

Diabetes	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Heart disease	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
High blood pressure	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Seizures	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Asthma	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Stomach ulcers	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Hepatitis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
HIV / AIDS	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Parkinson's	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Cancer	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
where:	_____			
Gout	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Kidney disease	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Thyroid disease	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
DVT	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Pulmonary embolism	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
pacemaker/defibrillator	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Family History: Any family history of the following problems?

Heart disease	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Arthritis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Diabetes	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Free bleeding	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Scoliosis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Cancer	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Social History:

Marital status:	single	<input type="checkbox"/>	married	<input type="checkbox"/>
Tobacco use:	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Alcohol use:	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

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Amount: _____
Amount: _____

Review of Systems: Do you have any of the following problems?

Constitutional:

Fever	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Weight loss	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Weight gain	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Eyes:

Blindness	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
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ENT:

Deafness	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
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CV:

Chest pain	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
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Respiratory:

Short of breath	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Cough	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

GI:

Indigestion	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Intestinal bleeding	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

GU:

Bladder infections	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Incontinence	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Difficulty with urination	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Skin:

Rashes	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
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Musculoskeletal:

Previous fractures	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
where:	_____			

Sprains	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
where:	_____			

Joint swelling	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Arthritis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Stiffness	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Joint pain	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Neurology:

Weakness	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Seizures	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Numbness (arm or leg)	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Psychology:

Depression	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Sleep disturbances	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Endocrine:

Thirsty often	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Urinate often	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Hematology:

Bleeding tendencies	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Anemia	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Nurse initials: _____

Physician initials: _____

Date: _____

**Waco Orthopedic & Sports Medicine Clinic
Medical History Form**

Current Medications (prescription & non-prescription):

Previous surgeries: (include month/year of surgery)

_____ appendectomy _____ tonsillectomy _____ hysterectomy _____ C-section
_____ breast surgery _____ cholecystectomy (gallbladder removal)
_____ vascular surgery arms / legs _____ heart surgery _____ back surgery _____ neck surgery
_____ surgery for fracture of arms or legs _____ carpal tunnel _____ knee replacement
_____ hip replacement _____ shoulder replacement _____ knee arthroscopy

Other: _____

Allergies (include allergies to *medications, latex, IV dye or shrimp*): _____

Have you had previous imaging studies (x-rays, MRI scans) for the problem that you are being seen for today? If so, where? _____

Preferred Pharmacy:

Name: _____

Location: _____

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."

(Patient/Guarantor Signature)

(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
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