UT★PHYSICIANS

ORTHOPAEDICS

NORTHWEST : 1800 WEST 26TH ST #200

(P) 713-486-4900 (F) 713-880-8754

MIDTOWN: 548 WAUGH DRIVE

(P) 713-524-0400 (F) 713-524-0411

Office Hours: Our clinics are open Monday through Friday from 8:00 a.m. to 5:00 p.m., except for major holidays and closed for lunch from 12:00 to 1:00 PM

Keeping Your Appointment: You will receive an automated call prior to your appointment to remind you of your appointment. Please plan to check-in at the registration desk 20 minutes before your appointment time. If you arrive past your appointment time, you may be asked to reschedule your appointment.
If you are unable to keep your appointment, please call the office at least 24 hours before your appointment.

Please Bring With You:

- Insurance card and photo identification.
- A means to pay for your visit. We accept major credit cards, checks, and cash.
- Your medical information such as x-rays, MRI films, radiology , laboratory and surgical reports, summary of medical history, etc. Or you may contact your referring physician to transfer your medical records.
- A complete list of your medications, including herbal supplements, vitamins and over the counter medications including the dosage and number of times taken daily.
- A list of questions you want to ask the doctor, this will maximize your time with the doctor.
- Your referring physician's name, mailing address, and phone and fax numbers.
- A referral or authorization from your primary care physician. It is ***your responsibility*** to ensure that we have the referral prior to your visit. If we do not have the referral, you will be asked to sign a waiver and to pay for your visit at the time of service. Or you can reschedule the visit.
- Please complete all forms in this packet and bring the completed forms with you to your first appointment.

Nobody Likes to Wait: We know that your time is important and we will do everything we can to be on time. However, we need your assistance to minimize wait times as well.

- Arrive 20 minutes prior to your appointment time to process paper work and take x-rays if necessary.
- If we are running behind, please understand that some problems are more complicated and require additional time. We want patients to have quality visits and to have their needs met. Also keep in mind we schedule appointments every 15 minutes and remember to be considerate of the patient who is scheduled after you.
- In most cases, we cannot accommodate walk-in patients. The best way to see a doctor is by scheduling an appointment

Return Phone Messages: Please leave a detailed message, spell your first and last name; leave your date of birth and a brief message. Please do not leave multiple messages as this may delay return phone calls. Phone calls are returned within 24 hours. If you have an urgent issue you may press zero and ask to speak with Dr's assistant. Please remember urgent medical issues only, prescription refills and completing forms are not considered urgent issues.

Medication Refills: Please call your pharmacy to have a refill request faxed to our office at 713-880-8754. Even if your prescription bottle does not have refills remaining, please follow this procedure.

- Refills require 24 hours to process; contact your pharmacy a minimum of 2-3 days before your medication runs out.
- No refills will be called in over the weekend or at nighttime by the on-call physician.
- No refills are called in if you are not compliant with your physicians' instructions.
- Please make sure you keep your scheduled visits and ask for prescriptions while you are in the office

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ORTHOPAEDICS

You may be referred to a pain management specialist if your physician feels your pain is not being managed with conservative measures. If you are referred to a pain management specialist, we will not prescribe any further pain medications to you. Please keep your pain management appointments to avoid being without pain medications.

Disability Forms: Many of our disabled patients ask our office to assist them in completion of special forms which cover credit cards, car payments, mortgage payments, and short or long term disability income. Below is our policy on completion of such forms:

- Allow 7-10 business days for completion of these forms.
- The patient portion must be completed and signed prior to dropping the form off for us to complete.
- Your payment of $35.00 per form is due in advance of our completing any forms

Test Results: Unless otherwise specified by your physician you will need to schedule a follow up appointment to discuss test results. Please schedule your follow up appointment approximately 5 days after the test is completed. Please make sure you tell the operator you are coming in for test results so that we can make sure we have the results available.

Medical Records: You may request a copy of your medical records by mailing or faxing a signed release of information to UTP medical records department.
Mail: 6410 Fannin, Suite LL100.3 Houston Texas 77030
Contact Numbers: Direct: 832-325-6543 Fax: 713-512-2252

Copies of X-rays: Please fax or mail a signed release to the clinic location where the x-ray was performed. Processing times may vary so you will need to contact the clinic to verify when they will be ready for pick up. We charge $8.00 per sheet to copy x-rays.

Questions and Concerns: If you have any questions or concerns prior to your appointment, please do not hesitate to call us or let us know at any time. We want to keep you informed and reassured. We're here to serve you.

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ORTHOPAEDICS

NEW PATIENT HISTORY

Patient Name ______________________ **Age**________ **Date**__________

Occupation ______________________ **Circle: Male or Female** **Left or Right handed**

Who may we thank for your referral:______________________

Current Problem:______________________**Date problem began:**__________

Are you experiencing any of the following: (circle)

Pain Swelling Redness Limited Motion Weakness Atrophy Cramps

Popping Locking/Catch Stiffness Numbness Tingling Mass Deformity

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Have you been treated for this problem before?________ **What kind of treatment: Medication Injection**

Splint/Brace Therapy Surgery X-rays MRI Nerve Test Other:__________

Are you Allergic to any medications? ______________________

Have you ever had an adverse reaction to a blood transfusion? __________

Do you have an allergy to tape or adhesives? ______ Have you ever had problems with anesthesia __________

Have you ever been hospitalized or had surgery?________ Surgeries:______________________

CURRENT MEDICATIONS

Please list all medications you are currently taking, including aspirin, herbal remedies, and any over-the-counter medications. (If you are taking more than 6 medications, continue on reverse side.)

Medication	Strength	How Often Taken

Have you ever used steroid medications (cortisone, prednisone, etc.)? No [ ] Yes [ ]

HABITS

Tobacco Use	☐ No	☐ Yes	Type and Amount per Day ______________
Alcohol Use	☐ No	☐ Yes	Type and Frequency ______________
Drug Use	☐ No	☐ Yes	Type and Frequency ______________
Caffeine Use	☐ No	☐ Yes	Type and Frequency ______________
Exercise	☐ No	☐ Yes	Type and Frequency ______________

HEALTH

Do you have, or have you ever had, any of the following? Check all that apply.

- ☐ AIDS/HIV +
- ☐ Arthritis, bursitis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood clots
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes (Sugar)
- ☐ Epilepsy or seizures
- ☐ Excessive bleeding
- ☐ Gallbladder trouble
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hemorrhoids
- ☐ Hepatitis or jaundice
- ☐ Hernia
- ☐ Hypertension/High blood pressure
- ☐ Kidney disease
- ☐ Kidney stone
- ☐ Leukemia
- ☐ Loss of any part of arm/leg
- ☐ Lung disease
- ☐ Osteoporosis
- ☐ Palsy
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Psychiatric treatment
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid arthritis
- ☐ Scarlet Fever
- ☐ Strokes
- ☐ TB
- ☐ Thyroid disease
- ☐ T.I.A.
- ☐ Tumor/growth/cyst
- ☐ Ulcer – gastric
- ☐ Ulcer – peptic
- ☐ Venereal disease
- ☐
- ☐ other__________
- ☐__________
- ☐__________

Who is your primary care physician:________________________________Phone:

REVIEW OF SYSTEMS: (Check all that you have experienced recently)

General

- ☐ Weight loss
- ☐ Weight gain
- ☐ Poor appetite
- ☐ Chills
- ☐ Fever
- ☐ Night sweats

Skin

- ☐ Rash
- ☐ Hives
- ☐ Lesions

Head/Eyes/Ears/Nose/Throat

- ☐ Hay fever
- ☐ Postnasal drip
- ☐ Hoarseness
- ☐ Visual problems
- ☐ Nose bleeds
- ☐ Neck stiffness/pain

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Other ____________________

____

____

Pulmonary

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing
- ☐ Coughing up blood

Genitourinary

- ☐ Frequent urination (frequency)
- ☐ Urgent urination (urgency)
- ☐ Painful urination (dysuria)
- ☐ Need to awaken to urinate
- ☐ Blood in urine
- ☐ Penile or vaginal discharge
- ☐ Kidney stone pain

Gastrointestinal

- ☐ Indigestion
- ☐ Gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Yellow skin
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal bleeding

Musculoskeletal

- ☐ Pain
- ☐ Swelling
- ☐ Redness
- ☐ Limited motion
- ☐ Weakness
- ☐ Atrophy
- ☐ Cramps
- ☐ Popping
- ☐ Locking/catching
- ☐ Stiffness
- ☐ Numbness
- ☐ Tingling
- ☐ Mass
- ☐ Deformity

Lymphatics

- ☐ Lymph node swelling
- ☐ Node tenderness

Endocrine

- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Excessive appetite
- ☐ Hot intolerance
- ☐ Cold intolerance
- ☐ Easy bleeding

Cardiovascular

- ☐ Chest pain (angina)
- ☐ Palpitations (rapid heartbeat)
- ☐ Irregular heartbeat (arrhythmia)
- ☐ Rheumatic fever
- ☐ Swollen ankles (pedal edema)
- ☐ Shortness of breath on exertion
- ☐ Shortness of breath at night

Neurological

- ☐ Loss of consciousness
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures (fits)
- ☐ Fainting spells

Height ____________________

Weight ____________________

Dominance

- ☐ Right Hand
- ☐ Left Hand

FAMILY HEALTH Have blood relatives ever had any of the following? If so, indicate their relationship to you (e.g. Diabetes – maternal grandmother)

- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart Trouble
- ☐ Liver Trouble
- ☐ High Blood Pressure
- ☐ Any Unusual Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Blood Disease
- ☐ Psychiatric Disease
- ☐ Unusual Reaction to Anesthesia
- ☐ Stroke

If your mother, father or any of your brothers and/or sisters have died, what was the cause of their death and what was the age at the time of death?____

____

____

I certify that the information provided above is true.

________________________________ ________________________________

Signature Date

Relationship: __Self

__Parent or Legal Guardian

__Other:________________________

(Please Specify)

Physician Notes:____

____

Signature:________________________________**Date:**________________________

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PATIENT INFORMATION

Patient Name ____________________
Date ____________________
Street ____________________
City ____________________
State ____________________
Zip Code ____________________
Home Phone ____________________
Work Phone ____________________
Email Address ____________________
Other Name/Phone ____________________
Social Security Number ____________________
Sex [ ] M [ ] F Date of Birth ____________________
Age ____________________
Marital Status ____________________
Date of Injury ____________________
Was the injury work related? [ ] Yes [ ] No
Auto Accident? [ ] Yes [ ] No
Employer ____________________
Address ____________________
Name of Spouse ____________________
Spouse Work Phone ____________________
Relative or Friend Name ____________________
Phone ____________________
Primary Care Provider (PCP) Name ____________________
Phone ____________________
Referred By ____________________
Phone ____________________
Responsible Party Name ____________________
Phone ____________________

INSURANCE INFORMATION

Primary Insurance ____________________
Phone ____________________
Member ID Number ____________________
Group Number ____________________
Insured's Name ____________________
Insured's Date of Birth ____________________
Relationship to Patient ____________________
Insured's SSN ____________________

Secondary Insurance ____________________
Phone ____________________
Member ID Number ____________________
Group Number ____________________
Insured's Name ____________________
Insured's Date of Birth ____________________
Relationship to Patient ____________________
Insured's SSN ____________________

AUTHORIZATION I authorize UT Physicians to secure medical information from other providers and to release medical information to insurers (including Medicare if appropriate) and other physicians. I authorize these to be faxed. I also authorize UT Physicians to release medical and insurance information to outside agents used to assist diagnosis and treatment. I understand these may be faxed. I further authorize the physicians treating me to perform basic office procedures such as manipulations, casting, taking x-rays and performing injections as they are discussed with me. I authorize the use of my verbal consent in lieu of a written consent for these procedures, which have been explained to me. I also authorize benefits to be paid directly to UT Physicians on my behalf. I understand I am financially responsible for any balance not covered by my insurance. A copy of this signature is as valid as the original. I also understand that is my responsibility to make sure that my referral is accurate, and denial of payment because of my not obtaining this will result in my being personally responsible for the charges incurred. I also understand that is my responsibility to make that insurance information provided is accurate and up to date. If it is not, I will assume responsibility for charges that are denied because of not filing to the right carrier in a timely fashion.

____
Signature

____
Date

Relationship:
__**Self**
__**Parent or Legal Guardian**
__**Other:** ____________________
(Please Specify)

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AUTHORIZATION TO LEAVE RECORDED VOICE MESSAGES

Patient's Name: ____
(Please Print)

I hereby give permission for UT Physicians to leave messages regarding office visits, surgery information and appointment confirmations, as well as any other medical information related to my treatment at the following phone number(s) and/or with the following individual(s):

(Please check all that apply)

__Home Answering Machine Phone Number: ____________________

__Family Members (*Please list below*)

Name: ____________________ Phone Number: ____________________
Name: ____________________ Phone Number: ____________________
Name: ____________________ Phone Number: ____________________

__Housekeeper (*Please list below*)

Name: ____________________ Phone Number: ____________________

__Work Voicemail Phone Number: ____________________

__Assistant (*Please list below*)

Name: ____________________ Phone Number: ____________________

__ Other (*Please list below*) Phone Number: ____________________

__ I DO NOT give my permission to UT Physicians to leave any medical information related to my condition to anyone other than myself in a direct manner. Please call me at the following phone number: ____.

______________________________ ____________________
Signature **Date**

Relationship: __**Self**
__**Parent or Legal Guardian**
__**Other:**____________________

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, ______________________________ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: ____________________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

Place Label Here or Enter Info:

Patient Name: ______________

____

MRN or DOB: ______________

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that you have received a copy of the Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. UTHealth and UTP have given me the opportunity to ask questions about this notice and all of my questions have been answered.

____

Patient or Guardian Signature

____

If Guardian, Relationship to Patient

____

Date Signed

UT★PHYSICIANS

CONSENT FOR USE OF EMAIL ADDRESS

AUTHORIZATION FOR THE USE OF PATIENT'S EMAIL ADDRESS BY UT PHYSICIANS, ITS AFFILIATED ENTITIES AND BUSINESS ASSSOCIATES

UT Physicians is committed to protecting information you provide us. UT Physicians creates a record of the information you provide us for use in your care and treatment and for communicating with you. These records are maintained in a confidential manner, as required by law. UT Physicians, its professional staff, employees, volunteers, affiliated entities and business associates follow the privacy practices described in this consent and our Joint Notice of Privacy Practices.

You are requested to provide your email address to UT Physicians. The provision of your email address is entirely voluntary. Your email address may be used by UT Physicians, its affiliated entities and business associates for the following purposes:

- For appointment reminders.
- To inform you of benefits and services related to your health.
- Through the use of online surveys emailed to you by UT Physicians, its affiliated entities and business associates, to allow you to communicate your opinion of our staff, facilities and services received.
- As required by law and for certain law enforcement activities.
- As otherwise described in our Joint Notice of Privacy Practices.

Except as described above, we will not use or disclose your email address unless you authorize (permit) UT Physicians in writing to disclose your email address. If you initially give permission, you may revoke that permission, which will be effective only after the date of your written revocation.

As the patient email addresses UT Physicians collects will be assembled into a mailing list, group mailings will not be sent in a manner in which recipients are visible to one another.

To the extent permitted by law, the undersigned agrees to indemnify and hold harmless UT Physicians, its affiliated entities and business associates from and against all claims, demands, liabilities, judgments or causes of action of any nature for any relief, elements of recovery or damages recognized by law (including, without limitation, attorney's fees, defense costs, and equitable relief), for any damage or loss incurred by the undersigned arising out of, resulting from, or attributable to any acts or omissions or other conduct of UT Physicians, its affiliated entities or business associates. These indemnities shall survive the revocation of this consent.

DECLARATION I have read and understand the above agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement other than the rendition of services. All of my questions have been fully answered.

Patient's or Patient's Legal Representative's Email Address: ______________________ @ ______________

Signature of Patient or
Patient's Legal Representative: ______________________________ Date: ______________

Printed Name of Patient: ______________________________

Printed Name of Legal Representative (if any): ______________________________

Representative's Authority to Act for Patient: ______________________________

PATIENT CONCERNS

Our entire staff strives to provide excellent care and service, and we hold ourselves to high personal and professional standards. If we fail to meet your expectations in any way, please do not hesitate to let us know as soon as possible. Rest assured that voicing a concern will never adversely affect the care and service we provide. If there is a problem, we sincerely want to correct it. Usually, a word to your nurse is all that is needed, but if you prefer, call Patient Relations to speak confidentially with a patient representative. Your question or concern will be promptly addressed. We appreciate the opportunity to assist you and to make your visit as pleasant as possible. You also have the right to register a complaint with Health Care Financing Administration, Texas Medical Board and/or Texas Department of Insurance.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize UTP and the Patient's physician(s) to disclose the Patient's health care information to any person, Social Security Administration, insurance or benefit payer, health benefit plan, worker's compensation carrier or other entity specified in UTP's Joint Notice of Privacy Practices, and to the extent specified in said Notice, which is or may be liable for all or a portion of the treating physician's charges, and to complete claim forms on behalf of the Patient.

I understand that special written authorization from me (the Patient or legal guardian of the Patient) will be requested by UTP prior to releasing health care information if the Patient is receiving mental health services or care in an alcohol or drug treatment program or facility.

DECLARATION

I have read and understand the above agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement other than the rendition of services. All of my questions have been fully answered.

______________________________ ____________

PATIENT SIGNATURE (Patients over 18 years of age) **DATE**

____

PRINT NAME (All Patients)

______________________________ ____________

GUARANTOR/INSURED SIGNATURE **DATE**

______________________________ ______________________________

PRINT NAME **RELATIONSHIP TO PATIENT**

______________________________ ____________

LEGAL GUARDIAN SIGNATURE **DATE**

______________________________ ______________________________

PRINT NAME **RELATIONSHIP TO PATIENT**

______________________________ ____________

WITNESS SIGNATURE **DATE**

____

PRINT NAME