

# OUCH – Orthopedic Urgent Care Home

David S. Brown, M.D.

(800) 682-4220

## PATIENT INFORMATION

Patient's Name (First, Middle, Last): \_\_\_\_\_ Male  Female

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Main Contact Number: \_\_\_\_\_ Alternate: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (MM/DD/YYYY)

Pharmacy: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

Pharmacy Address/Intersection: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
(First and Last Name)

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
(First and Last Name)

## CONTACT INFORMATION

Mother's/Guardian's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Father's/Guardian's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## INSURANCE INFORMATION

1. Primary Insurance: \_\_\_\_\_

Member/Subscriber ID No: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ (MM/DD/YYYY)

Address (if different than patient): \_\_\_\_\_

2. Secondary Insurance: \_\_\_\_\_

Member/Subscriber ID No: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ (MM/DD/YYYY)

Address (if different than patient): \_\_\_\_\_

## GUARANTOR INFORMATION (Person responsible for billing/payments)

Check if Guarantor is same as Primary Insurance Policy Holder

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ (MM/DD/YYYY)

Phone Number: \_\_\_\_\_

Address (if different than patient): \_\_\_\_\_

## PAYING INSURANCE BENEFITS:

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to Orthopedic Urgent Care Home, PLLC. ("OUCH"). This assignment is for services rendered to me by "OUCH". This assignment will remain in effect until revoked by myself in writing. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify "OUCH" of any changes of insurance coverage will result in the financial obligation to rest fully on me regardless of any contract between the insurance company and "OUCH".

PATIENT NAME (Please Print): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE OF PATIENT/GUARDIAN: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

● **FINANCIAL POLICY PATIENT CONSENT FORM**

“OUCH” RECOGNIZES THE NEED FOR A CLEAR UNDERSTANDING BETWEEN PATIENT AND MEDICAL PROVIDERS REGARDING PROTECTED HEALTH INFORMATION AND FINANCIAL ARRANGEMENTS FOR HEALTHCARE. THE FOLLOWING INFORMATION IS PROVIDED TO AVOID ANY MISUNDERSTANDING CONCERNING PROTECTED HEALTH INFORMATION AND PAYMENT FOR PROFESSIONAL SERVICES.

**I. PAYMENT/REFUNDS/COLLECTIONS: PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**

The guarantor is responsible for copayment, deductible, coinsurance and/or any non-covered services. It is the responsibility of the parent/guardian to notify “OUCH” of any changes to the health insurance coverage. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a \$25.00 charge for returned checks. If not paid within sixty (60) days, “OUCH” will begin various collection activities including, but not limited by, submitting the past due account to a collection agency. Refunds will only be issued in the event of overpayment by the guarantor and will be issued within 30 days of the credit. Refunds will not be issued for returned DME unless it is unopened/unused & must have approval by the medical staff and/or business manager.

**II. SELF PAYMENT (PRIVATE, CASH PAYMENT):**

If you do not have insurance coverage, we ask that you coordinate your care with our business office prior to your surgery/procedure. We require an advance payment for professional service.

**III. MANAGED CARE:**

**ALL MANAGED CARE (HMO, PPM, etc) CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

By signing below, patient acknowledges that it is the patient’s responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by the plan.

**IV. CHILDREN OF DIVORCED PARENTS:**

Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of “OUCH”.

**V. SECONDARY INSURANCE:**

The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider, if applicable. You agree to provide such information as outlined below. You agree to notify the provider in the future immediately of any additions, changes or deletions in primary or secondary coverage.

Initial/Complete as applicable:

\_\_\_\_\_ I have NO SECONDARY INSURANCE COVERAGE.

\_\_\_\_\_ I have SECONDARY INSURANCE COVERAGE AS DESCRIBED ON THE ATTACHED PATIENT DEMOGRAPHIC FORM.

“OUCH” firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies, please call us at 1-800-682-4220.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
PATIENT NAME (PLEASE PRINT) (DATE OF BIRTH IN MM/DD/YYYY)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
PATIENT/PARENT SIGNATURE (DATE - MM/DD/YYYY)

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## Consent for Treatment

The following information is to be completed by the patient or by the patient's legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Orthopedic Urgent Care Home will share patient health information according to federal and state law for the treatment, payment, and operations.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider to pay Orthopedic Urgent Care Home for services rendered.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient (if 18 or older)      Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Legally Authorized Representative      Date

Relationship of Legally Authorized Representative: \_\_\_\_\_

• **HIPAA DISCLOSURE**

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. PROTECTED HEALTH INFORMATION (PHI) MAY ORIGINATE IN YOUR MEDICAL RECORD AT "OUCH", OR MAY BE RECEIVED FROM OUTSIDE HEALTH ENTITIES AND FILED IN YOUR MEDICAL RECORD. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED BY "OUCH" TO: A) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY OR INDIRECTLY, B) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS, C) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSURANCE THROUGH "OUCH" OR NETWORKING ORGANIZATIONS. I HAVE BEEN INFORMED BY YOU OR YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DISCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATIONS. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACE PRACTICES FROM M Y OFFICE OR BY CONTACTING THEM AT 431 E. STATE HWY 114., SUITE 120, SOUTHLAKE, TX 76092. I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
PATIENT NAME (PLEASE PRINT) (DATE OF BIRTH IN MM/DD/YYYY)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SIGNATURE OF PATIENT/PARENT/GUARDIAN (DATE IN MM/DD/YYYY)

\_\_\_\_\_ "OUCH" MAY NOT DISCUSS MY HEALTHCARE AND MAY NOT DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ANYONE.

\_\_\_\_\_ "OUCH" MAY DISCUSS MY HEALTHCARE AND MAY DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ONLY THE FOLLOWING INDIVIDUALS LISTED BELOW:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

OUCH MAY LEAVE A MESSAGE ON MY PHONE: \_\_\_\_\_

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## Patient History Form

\*This is a confidential record and information contained here will not be released without your consent.\*

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Name (First, Middle Last): \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Chief Complaint: What is the main reason for your visit today? Describe problem in detail. (Ex. What hurts?)

\_\_\_\_\_

Sports related? Yes  No  Motor vehicle accident? Yes  No

When did you first notice this problem? \_\_\_\_\_ Date if injured: \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

What makes the problem better? \_\_\_\_\_

How long does the problem usually last? Constant: \_\_\_\_\_ Occasional: \_\_\_\_\_

Does the pain interfere with your normal functions? (Explain) \_\_\_\_\_

Have you seen another physician for the problem? (Explain) \_\_\_\_\_

Have you had any diagnostic studies or treatments for this problem? (X-rays, MRI, EMG, Bone Scan, Bone Density)

If so, when and where? \_\_\_\_\_

Pain Level: \_\_\_\_ 0-3 (mild) \_\_\_\_ 4-6 (moderate) \_\_\_\_ 7-10 (severe)

### Developmental History

Full Term  Premature at \_\_\_\_\_ wks. gestation. Complications/Developmental Delays? \_\_\_\_\_

If premature, was patient in the NICU? \_\_\_\_\_ Age when first walked? \_\_\_\_\_

Female Patients: Date when menses began (mo/yr): \_\_\_\_\_ Regular or Irregular? \_\_\_\_\_

**Medical Diagnoses:** \_\_\_\_\_

\_\_\_\_\_

**Previous Surgeries:** \_\_\_\_\_

\_\_\_\_\_

**Family History:** \_\_\_\_\_

**Social History (who does the patient live with?):** \_\_\_\_\_

**Patient History of:** Smoking: Yes  No  Alcohol Use: Yes  No  Drug Use: Yes  No

**Current Medications:** \_\_\_\_\_

\_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

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Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

PLEASE ANSWER EACH QUESTION

	Yes	No	Comments
Constitutional:			
A. Recent weight change?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Weakness, fatigue, or chills?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes:			
A. Difficulty seeing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Temporary loss of vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat:			
A. Problems with hearing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Hoarseness, sore throat?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular:			
A. Chest pain/discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Palpitations?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory:			
A. Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Cough?	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. Wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal:			
A. Constipation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Frequent Heartburn or indigestion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. Abdominal Pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
D. Blood in stool?	<input type="checkbox"/>	<input type="checkbox"/>	_____
E. Difficulty swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gentourinary:			
A. Blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Urinary frequency/urgency?	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. Pain when urinating?	<input type="checkbox"/>	<input type="checkbox"/>	_____
D. Urethral discharge?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine:			
A. History of high or low blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal:			
A. Joint pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Joint swelling?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological:			
A. Fainting?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Problems with concentration?	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. Sense of smell and taste?	<input type="checkbox"/>	<input type="checkbox"/>	_____
D. Coordination?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric:			
A. Depression?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. Other psychiatric problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin:			
A. Rashes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Skin cancers?	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. Other major skin problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heme/lymph:			
A. Bleeding tendencies/bruising?	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Any history of anemia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. Do you have sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient signature/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_