Eldon Hopkins, MD
255 W. Lebanon Rd., Suite 132 Frisco, TX 75036
MedicalCityHipandKneeFrisco.com
Phone: 469-310-4400
Fax: 214-494-6328

Welcome and *thank you* for choosing Medical City Hip & Knee Frisco to serve your orthopedic care! It is our mission to provide an exceptional patient experience. Your health and well-being are our number one priority. Below are a few instructions that will help you prepare for your first appointment:

- ✓ Please arrive 20 minutes prior to your appointment.
- ✓ Please complete the enclosed forms prior to your visit and bring them with you.
- ✓ Please bring all medication(s) in the original bottles, or a list of all your current medications (please include dosage amounts and the number of times taken each day). This includes both Over the Counter and Prescription medications.
- ✓ Bring your current insurance card(s), photo ID, and copayment (if applicable).
- ✓ Bring a CD(s) of your imaging (X-Rays, MRIs, and CT Scans).
- ✓ If your insurance plan requires an authorization, please be certain that your primary care physician has sent an authorization/referral for your appointment. Please ensure all authorization and/or referral numbers have been transmitted to our office **prior** to your appointment. If you have questions regarding your insurance and whether you're insurance requires an authorization or referral, please contact your insurance company directly.
- ✓ Please allow 1-2 hours for your appointment.

Lastly, we'd love to hear how you learned about us so we can be sure to thank your family, friend or provider for entrusting us with your care.

Friend or family member: _____
Primary Care Physician (PCP): _____
Other Specialist: _____
Insurance Company: _____
Other: _____

If you have any additional questions or concerns please don't hesitate to contact us at (469) 310-4400.

We look forward to meeting you!

The Physicians and Staff of Hip & Knee Specialist | Frisco

***** For All HMO Plans it is the Patient's Responsibility to obtain a Current Referral, If no referral is obtained the patient will be billed in full for all services provided or services postponed until the proper referral is obtained.*****

*****If you do not bring your X-Ray/MRI/CT CD or Films we may have to reschedule your appointment. *****

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Welcome to our Practice! Our goal is to provide an exceptional healthcare experience. We believe that in the interest of best healthcare practices, it is necessary to establish practice guidelines/policies between our patients and ourselves in order to avoid misunderstandings. **Please read and initial each line**; by initialing and signing you are acknowledging that you understand our guidelines/policies.

WAIT TIMES

_____ We know that your time is valuable and that every patient has unique needs which may require more time than planned. We will make every effort to provide you with exceptional care and to minimize your waiting time. There may be times when an emergency arises or a surgery that takes longer than expected which may cause a delay or rescheduling of your appointment. We will make every effort to accommodate for this, and in the event of a delay or emergency, we will do our best to notify you as soon as possible.

LATE ARRIVAL

_____ We make every effort to stay on schedule; therefore, it is our policy that if you are more than 10 minutes LATE arriving to your scheduled appointment, you may encounter longer wait times. We will make our best effort to see you in a timely fashion but tardiness may result in longer wait times and or the need to reschedule your appointment. **If you are going to be late, please call our office**.

PHYSICIAN REFERRALS

_____ It is **YOUR** responsibility to obtain referrals from your primary care physician (PCP) and to ensure that we have received them. If the referral is NOT obtained before your visit, the patient will be liable for payment of services rendered.

TELEPHONE CALLS AND MEDICAL QUESTIONS

_____ Each provider has a dedicated clinical team to assist in providing your care. Except in emergencies, our physicians and/or clinical staff do not accept calls while they are in clinic with patients. If you call during those times, the front office staff will gladly take a message. The clinical team will respond to your calls within 24 hours. If your call is after 3pm, the clinical team will return your call the following business day.

FORM COMPLETION

_____ There will be a $25 charge per occurrence for the completion of the following forms:

- Disability
- FMLA
- ALFAC
- Supplemental Insurance
- Medical Hardships
- Dictated Work Excuse

Payment is due when forms are presented. Forms will not be processed without payment.
Please allow 5 to 7 business days for completion of forms.

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PRESCRIPTION REFILL GUIDELINES

Our office requires **48 hour notice for prescription refills. NO EXCEPTIONS!**

- Medications will be refilled between 8 AM and 4 PM Monday-Friday. No refills on weekends or holidays. The "on-call" physician will NOT refill medications.
- The safety of your prescription is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Secure your medications and keep them away from children.
- Our physicians may not refill medication if you are receiving similar medications from another physician.
- Please contact your doctor or pharmacist before taking any other medication while taking pain medication.
- Do not drink alcohol while taking pain medication. Obey warnings regarding the sedation effect of certain medications.
- Follow the prescribed dose of your medication. Do not share medications with other people and do not take other people's medications.

Patient/Guardian Signature: _____ Date: _____

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Patient Registration Form (Please Print)

PATIENT INFORMATION

☐Dr. ☐Miss ☐Mr. ☐Mrs. ☐Ms. Patient's Last Name: _____ Suffix: _____

Patient's First Name: _____ (MI): _____ goes by/Previous Name: _____

Address: _____ City, State: _____ Zip: _____

Phone Number: Home: _____ Cell: _____ Work: _____

Email Address: _____

Primary Care Provider (PCP): _____ Phone Number: _____

Referring Provider (if different from PCP): _____ Phone Number: _____

DOB: (MM) _____/ (DD) _____/ (YYYY) _____ Sex: (M/F/T) _____ Social Security Number: _____-_____-_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Partner

Race: ☐American Indian / Alaska Native ☐Asian ☐Black or African American ☐Decline to specify ☐Hispanic
☐Native Hawaiian or Other Pacific Islander ☐Other Race ☐White

Ethnicity: ☐Decline to Specify ☐Hispanic or Latino ☐Not Hispanic or Latino

Preferred Language: ☐English ☐Spanish ☐Other: _____

Employer Name: _____ Phone Number: _____

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Self Employed ☐Retired ☐Military

Student Status: ☐Full-Time Student ☐Part-Time Student ☐Not a Student

Emergency Contact Name: _____ Guardian ☐Yes ☐No

Emergency Contact Phone Number: _____ Relationship to Patient: _____

Emergency Contact Address: _____ City, State: _____ Zip: _____

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RESPONSIBLE PARTY INFORMAITON

Responsible Party: ☐ Self ☐ Guarantor (Only fill out if other than self)

Responsible Party Name (Last): _____ (First): _____ (MI): _____

DOB: (MM) _____/ (DD) _____/ (YYYY) _____ Sex: (M/F) _____ Social Security Number: _____-_____-_____

Address: _____ City, State: _____ Zip: _____

Employer Name: _____ Phone Number: _____

PRIMARY INSURANCE INFORMATION [ ] SEE CARD

Insurance Company: _____ Insurance Phone Number: _____

Name of Insured: _____ DOB: _____/_____/_____ Relationship to Insured: _____

Subscriber ID/Member ID Number: _____ Group ID Number: _____

SECONDARY INSURANCE INFORMATION – IF APPLICABLE [ ] SEE CARD

Insurance Company: _____ Insurance Phone Number: _____

Name of Insured: _____ DOB: _____/_____/_____ Relationship to Insured: _____

Subscriber ID/Member ID Number: _____ Group ID Number: _____

Do you need a translator for your appointment: ☐ Yes ☐ No, I'll bring my own interpreter

Preferred Pharmacy: _____

Address/Cross Street: _____ Phone Number: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (Or Responsible Party) Signature: _____ Date: _____

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PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____ (Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

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Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ (Patient/Representative Initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

_____ (Patient/Representative Initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I understand that once I have consented to receive communication via text or email, I still have the right to revoke that consent at any time.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____ (Patient/Representative initials) I **consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The e-mail that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

OR

_____ (Patient/Representative Initials) I decline to receive communication via text.
_____ (Patient/Representative Initials) I decline to receive communication via email.

******Below is ONLY if you have previously consented to receive communication via text/email and wish to remove the consent***

Revocation *(I do not consent to use my cell or email* ***any longer)***
I hereby revoke my request for future communications via email and/or text.
__*I hereby revoke my request to receive any future appointment reminders, feedback, and general health via* ***text.***
__*I hereby revoke my request to receive any future appointment reminders, feedback, and general health via* ***email.***

Patient Name: _____

Patient/Patient Representative Signature: _____
Date: _____ *Time:* _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:
Name: _____ Date:_____
Name: _____ Date:_____

_____ (Patient/Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature_____ Date: _____
Patient/Parent/Guardian/Patient Representative Name (Printed) _____
Patient Name (Printed): _____Date of Birth: _____

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PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ **(Patient or Guardian Initials) Financial Agreement.**
   - I acknowledge, that as a courtesy, **Hip & Knee Specialist | Frisco** may bill my insurance company for services provided to me.
   - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
   - I understand that there is a fee for returned checks.

2. _____ **(Patient or Guardian Initials)**
   Third Party Collection. I acknowledge that **Hip & Knee Specialist |Frisco** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ **(Patient or Guardian Initials)**
   Assignment of Benefits. I hereby assign to **Hip & Knee Specialist |Frisco** any insurance or other third-party benefits available for health care services provided to me. I understand **Hip & Knee Specialist |Frisco** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Hip & Knee Specialist |Frisco,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ **(Patient or Guardian Initials)**
   Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Hip & Knee Specialist |Frisco** by the Medicare or Medicaid program.

5. _____ **(Patient or Guardian Initials)**
   Consent to Telephone Calls for Financial Communications. I agree that, in order for **Hip & Knee Specialist |Frisco**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Hip & Knee specialist |Frisco** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Hip & Knee Specialist |Frisco** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ **(Patient or Guardian Initials)**
   A photocopy of this consent shall be considered as valid as the original.

Patient Name: _____ Date of Birth: _____

Patient/Patient Representative Signature: _____Date:_____

If you are not the Patient, please identify your Relationship to the Patient.
(Circle or mark relationship(s) from list below):

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify) _____

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**

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Health History

Patient Name: _____ Age: _____ ☐Female ☐Male Dominant Hand: ☐Right ☐Left

- What is the main reason for your visit today:

☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other: _____

- Did you bring imaging: ☐ Yes ☐ No
- What Body Part is involved? Please mark in the table below: ****We will evaluate one body part per visit****

Shoulder ☐ R ☐ L	Knee ☐ R ☐ L
Pelvis ☐ R ☐ L	Hip ☐ R ☐ L

- How long ago did your symptoms start? _____Days _____Weeks _____Months _____Years
- Have you had a problem like this before? ☐ Yes ☐ No

In this section, check the **ONE BOX** which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ **No Injury** (Onset was: ☐ Gradual ☐ Sudden)
Why do you think it started?

☐ **Injury** ☐ Sport ☐ Accident-**Not Auto or Work** ☐**Auto**
Date: _____ (Where and how did it happen?)
What Sport? _____

☐ **Injury at Work**: Date: _____
From a ☐Lift ☐Twist ☐Fall ☐Bend ☐Pull ☐Reach

☐ **Work Related-No Injury**
Date: _____ how did you job cause this problem?

*****Please be advised that we do not bill or work with Third Party insurances if you have been involved in an auto or work injury. *****

Comments:
_____
_____
_____
_____
_____
_____
_____
_____

- On a Scale of 0-10 (10 is the worst), how ***severe*** is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10
- What is the quality of the pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning
- The pain is: ☐Constant ☐Comes and Goes
- Does your pain wake you from sleep? ☐Yes ☐No
- Do you have any of the following? ☐Swelling ☐Bruising ☐Numbness ☐Tingling ☐Weakness
- Since my problem started, it is: ☐Getting Better ☐Getting Worse ☐Unchanged
- What makes your symptoms ***worse***? ☐Standing ☐Walking ☐Lifting ☐Exercise ☐Twisting ☐Lying in bed ☐Bending ☐Squatting ☐Kneeling ☐Stairs ☐Sitting ☐Reaching overhead ☐Reaching behind your back
- What makes your symptoms ***better***? ☐Rest ☐Elevation ☐Ice ☐Heat ☐Other: _____
- What Medications are you currently taking for *this problem*? _____

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- Have you had any of these treatments for *this problem*? ☐Injection ☐Brace ☐Phys. Therapy ☐Cane/Crutches
- What Scans/Tests have you had for *this problem*? ☐X-Rays ☐MRI ☐CT Scan ☐Bone Scan ☐Nerve Test(EMG)

  If so, where were these done: _____
- **Medications:** Please list all current medications including over the counter:

Current Medication	Dosage

- **Allergies:** Do you have any ***Allergies*** to any medications? ☐ Yes ☐ No If Yes, please list below:

Medication	Reaction

- **Past Medical History:** Have you been diagnosed with any of the following conditions? Check all that apply.

☐ None
☐ Asthma ☐ Stroke ☐ Heart Attack (when? _____) ☐ High Cholesterol
☐ Kidney Failure ☐ Heart Failure ☐ Cancer (location? _____) ☐ High Blood Pressure
☐ Ulcers ☐ Hepatitis ☐ Seizures ☐ HIV ☐ Emphysema/COPD
☐ Diabetes ☐ Blood Clots (DVT) or PE ☐ Thyroid Problem ☐ Mental Illness
☐ Liver Disease *Notes/Other:* _____

- **Past Surgical History:** Please list all prior surgeries including dates. ☐ **None**

_____

_____

- **Family History:** Have any direct relatives had any of the following disorders? If so, which relative?

☐ None
☐ Heart Disease _____ ☐ Lung Cancer _____ ☐ Breast Cancer _____
☐ Diabetes _____ ☐ Rheumatoid arthritis_____ ☐ Kidney Disease _____ ☐ Other _____

- **Social History:**
  - Do you use tobacco? ☐ Yes ☐ No If yes, how many packs a day? _____
  - Alcohol Use? ☐ None ☐ Social ☐Daily ☐Frequently
  - Illegal Drug Use? ☐ Yes ☐ No If yes, what type? _____

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Immunizations:

- Have you had the **Flu Shot** this Flu Season? ☐ Yes ☐ No If Yes, list month & year: _____
- Have you had the **Pneumococcal Vaccine**? ☐ Yes ☐ No If Yes, list month & year: _____

Review of Systems:
Current Symptoms: ☐ None

CONST: ☐ Fevers ☐ Chills

SKIN: ☐ Bruising ☐ Pale Skin ☐ Skin Color Changes

ENT: ☐ Headaches ☐ Hoarseness ☐ Nasal Congestion

C-VASC: ☐ Fainting/Blacking Out ☐ Rapid Heart Rate ☐ Chest Pain

RESP: ☐ Cough ☐ Shortness of Breath ☐ Bloody Cough

GI: ☐ Abdominal Pain ☐ Abdominal Swelling ☐ Nausea ☐ Diarrhea ☐ Vomiting

GU: ☐ Discharge ☐ Change in Force When Urinating ☐ Blood in Urine

M/S: ☐ Decreased Range of Motion ☐ Joint Pain ☐ Swollen Joints ☐ Stiffness ☐ Difficulty Walking

NEURO: ☐ Numbness ☐ Tingling ☐ Headaches ☐ Pins and Needles (Paresthesia)
☐ Sensitive to Touch (Dysesthesia) ☐ Weakness in Extremities

PSYCH: ☐ Delirium ☐ Delusions ☐ Personality Changes ☐ Hallucinations

ENDO: ☐ Growth Abnormalities ☐ Heat/Cold Intolerance

LYMPH: ☐ Abnormal Bleeding ☐ Purple/Red Spots On the Skin (Petechial)

ALLERGIC: ☐ Hives ☐ Persistent Itching

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (Or Responsible Party) Signature: _____

Date: _____