Medical City
Hip & Knee Specialists | Frisco

Eldon Hopkins, MD

Medical City Hip & Knee Specialist |Frisco

Dear New Patient,

We are pleased that you have selected Hip & Knee | Frisco to provide 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 30 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 your insurance requires an authorization or referral, please contact your insurance company directly.
- ✓ Please allow 1-2 hours for your appointment.

If you have any questions or concerns prior to your appointment, please don't hesitate to contact us at 469/ 310-4400

We look forward to meeting you soon.

The Physicians and Staff of Hip & Knee Specialist | Frisco.

Appointment confirmation: _____

** 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, **not just the report, 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.

PRESCRIPTION REFILL GUIDELINES

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

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- 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: _____

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

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

DOB: (MM)____/(DD)____/(YYYY)_____ Sex: (M/F/T)_____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Legally Separated [ ] Partner

Social Security Number: _____-_____-_____

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: _____

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: _____

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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: _____

ADDITIONAL INFORMATION

Street Address (if different from mailing address): _____

City, State: _____ Zip: _____

Email Address: _____

Race: [ ] American/Indian/Alaska Native [ ] Asian [ ] Native Hawaiian/Pacific Islander [ ] Black/African American
[ ] White [ ] Other [ ] Declined to Report

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined to Report

Language: [ ] English [ ] Spanish [ ] French [ ] Other: _____ [ ] Declined to Report

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 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/Patient Representative Signature:

X_____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?

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*? _____

Have you had any of these treatments for *this problem*? [ ] Injection [ ] Brace [ ] Physical 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: _____

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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 ever 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 Packs/day Alcohol Use? [ ]None [ ]Social [ ]Daily [ ] Frequently
Illegal Drug Use? [ ] Yes [ ] No If yes, what type? _____

Review of Systems:
Current Symptoms: [ ] None

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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 (Parathesia) [ ] 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 (Petechiae)

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: _____