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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. \*\*

Eldon Hopkins, M.D.

**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.

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#### 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.

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#### 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.**

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#### 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.

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#### 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.

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#### 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!**



# Medical City

## Hip & Knee Specialists | Frisco

- 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: \_\_\_\_\_

**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 INFORMATION**

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: \_\_\_\_\_

**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: \_\_\_\_\_

**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         | Guarantor                    |
| Parent         | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify) _____ |

**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**

\_\_\_\_\_

**Printed Name of Patient or Personal Representative**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Relationship to Patient**

\_\_\_\_\_

**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.

Comments: \_\_\_\_\_

- [ ] **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 your job cause this problem? \_\_\_\_\_

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: \_\_\_\_\_



**Medications:** Please list all current medications including over the counter:

<u>Current Medication</u>	<u>Dosage</u>

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

<u>Medication</u>	<u>Reaction</u>

**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 \_\_\_\_\_

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**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



**Medical City**  
**Hip & Knee Specialists | Frisco**

**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:** \_\_\_\_\_