



To: Orthopedic Performance

From: _____

Fax: (210) 545-7176

Phone: _____

E-Mail Address: _____

Thank you for choosing Orthopedic Performance Institute, PLLC. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

- 1). New Patient Forms
- 2). Insurance Card(s)
- 3). Any and all recent X-rays and MRI's
- 4). Change of Clothing (shorts and sleeveless tops depending on injury)

Office Information:

Orthopedic Performance Institute
1139 E Sonterra, Suite 500
San Antonio, Texas 78258
Ph: (210) 545-7171 Fax: (210) 545-7176

Location:

North on Hwy 281 past Loop 1604
West on Sonterra Blvd next to
Stone Oak Methodist Hospital

Again, Thank you for choosing Orthopedic Performance Institute. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize Orthopedic Performance Institute, PLLC to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with Orthopedic Performance Institute, PLLC with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to Orthopedic Performance Institute, PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the health care providers at Orthopedic Performance Institute, PLLC to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, x-rays, and/or medical/ surgical procedures.

NOTICE OF PRIVACY PRACTICES:

Orthopedic Performance Institute, PLLC is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office’s Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and completed the requested information to the best of my ability.

Patient Name (Please Print) Date Patient Signature

Sign and date below for a patient that is a minor:

Parent / Guardian Name Date Signature of Parent or Legal Guardian

Guardian Information: (If Patient is a Minor)

Name: _____ Relationship to Patient: _____

SS#: _____ - _____ - _____ Birth date: ____/____/____ Gender: Male Female

Address: _____

Home #: _____ Cell #: _____ Work#: _____



FINANCIAL POLICY

Thank you for choosing Orthopedic Performance Institute as your healthcare provider. Our group is committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our billing department can be available to discuss our fees and policies with you. We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy, it is our policy to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE INITIAL EACH OF THE FOLLOWING)

_____ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, or our standard fee schedule.

_____ 2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees including bank service charges.

_____ 3. All charges are your responsibility whether your insurance company pays or does not pay.

_____ 4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Orthopedic Performance Institute, PLLC, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

_____ 5. The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claim is controverted.

_____ 6. Patients without insurance will be required to pay for each office appointment prior to seeing the physician. Any additional services or charges will be applied to your account and billed to you on your next visit. Surgeries will require payment arrangements prior to the surgery being scheduled. Our billing department will be available to provide payment plan options.

We encourage you to communicate any financial problems with our billing department, so that we may assist you in keeping your account in good standing. If you have any questions, please call the Billing Department at (210) 525-1668.

ASSIGNMENT OF BENEFITS AND MEDICAL RECORDS RELEASE

I hereby authorize my insurance benefits to be paid directly to the above group, Orthopedic Performance Institute, PLLC realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers. I have read and understand the above information and will be responsible for the patient listed below.

Printed Name of Patient: _____

Signature of Patient or Responsible Party

Date

Medical Questionnaire Form

Date: _____ / _____ / _____

Patient Name: _____
 First MI Last

Preferred Name: _____

DOB: ____/____/____ Age: ____ Occupation: _____ Employer: _____

Referring Physician: _____ City: _____ Send Note? Y / N

Primary Care Physician: _____ City: _____ Y / N

Coach / Trainer / Team Doctor: _____ School: _____ Y / N

Chief Complaint: _____

Body Part Being Seeing For: _____

Side of Body: (Circle) Right Left Both

Date Symptoms Began: ____ / ____ / ____

Was there an injury: (Circle) Yes No

Workers Comp? (Circle) Yes No

If so, how did it happen?

Current Symptoms:

If there is pain, where is it located? _____

Are your symptoms: (Circle) Improving Worsening Stable

Are your symptoms: (Circle) Mild Mild / Mod. Moderate Mod. / Severe Severe

What activities or body positions make your symptoms worse?

(Ex. Walking, Running, Reaching Overhead)

Have you had prior treatment? (Ex. Injections, Surgery, Physical Therapy)

Medical History:

Check if you have had any of these Medical Problems in the Past:

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Anemia			Kidney Disease		
Arthritis			Liver Disease		
Asthma			Loss of Vision		
Bleeding Problems			Mitral Valve Prolapse		
Blood Clots			Neuropathy		
Cancer: Type:			Paralysis		
Chest Pain			Peripheral Vascular Disease		
Diabetes			Pneumonia		
Gall Bladder Disease			Psychiatric Illness		
Gastric Ulcers			Pulmonary Embolism		
Glaucoma			Reflux		
Heart Arrhythmia / Palpitations			Skin Ulcer Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis – TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (Heart)		
HIV / AIDS			Wound healing Problems		
Immune Deficiency			OTHER:		

Please list any **Operations / Surgeries** you have had:

SURGERY / REASON	YEAR	SURGERY / REASON	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any **Medications** you are taking:

MEDICATION	DOSE	DOCTOR	MEDICATION	DOSE	DOCTOR
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Do you have any **Allergies** to medications / substances? (Please Circle) Yes No

Please List **Any** Allergies:

Family Medical History:

Please list all Major Illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Social History:**Marital Status:** Single Married Widowed Divorced

DESCRIPTION	USE	TYPE	FREQUENCY	AMOUNT	YEARS
Alcohol	Y / N				
Cigarette Use	Y / N				
Illicit Drug Use	Y / N				
Smokeless Tobacco Use	Y / N				

Review of Symptoms:

Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Abdominal Pain			Muscle Pain or Swelling		
Anxiety			Numbness or Tingling		
Chest Pain			Painful Urination		
Cough			Rapid Heart Beat		
Cuts that don't stop Bleeding			Rash		
Depression			Shortness of Breath		
Fever / Chills			Swelling of Legs		
Frequent / Easy Bruising			Tarry Stools		
Frequent Urination			Urgent Urination		
Irregular Heart Beat			Vomiting		
Joint Pain or Swelling			Wound Healing Problem		
Muscular Weakness			OTHER:		

How were you referred to our practice? (Please Circle)

Friend / Relative: _____ Physician Newspaper Radio Website

Other: _____

Agreement of Accuracy:

The information provided in this history form is true and complete to the best of my knowledge.

Patient Signature: _____ **Date:** _____ / _____ / _____



Matthew Dwyer, M.D. Craig Glauser, M.D. Christopher Phelps, M.D.

Orthopedic Performance Institute

Medication Policy Agreement

In order to safely manage refill requests we are implementing a medication policy agreement. We understand the need for your pain medication and this policy will aide in expediting your refill request in a timely manner. We look forward to working together to provide high quality medical care, thank you for your cooperation.

Please initial each of the following:

- _____ 1. All prescription medication requests must be made **Monday – Thursday 8 am – 4 pm.**
- _____ 2. New prescription request can take up to 24 hours to process.
- _____ 3. New prescriptions and/or refills requests cannot be completed after hours or on weekends.
- _____ 4. It is imperative that you call your pharmacy first for refill requests. If no refills remain on the original prescription, the pharmacy will fax a refill request form to your doctor. That form can take 24 hours to complete.
- _____ 5. Patients should be responsible and submit their request for refills prior to running out of their medication. Fulfilling refill request can take up to 24 hours to process so please plan ahead.
- _____ 6. If you have an appointment with your doctor and need refills, please request them at the time of your visit.

Important!! Pharmacy Information: No prescriptions can be written or refilled without the following information:

Pharmacy Name:

Address/Location:

Phone number:

Fax number, if available:

I have read the Orthopedic Performance Institute Medication Refill Policy Form and by initialing above and signing below, I agree to abide by them in full.

Patient Name (print)

Patient Signature

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *JANUARY 1, 2010* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Chris Mathis. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on January 1, 2010. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2010, the disclosure period would start on January 1, 2010 up to May 15, 2010. Disclosures prior to January 1, 2010 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: ORTHOPEDIC PERFORMANCE INSTITUTE PLLC

Privacy Officer: Chris Mathis

Telephone: 210.545.7171

Fax: 210.545.7176

Address: 1139 E SONTERRA SUITE 500, SAN ANTONIO, TEXAS 78258