Comprehensive Orthopaedics & Rehabilitation

Sacheen H. Mehta, M.D.
Orthopaedic Surgery, Board-Certified
Sports Medicine, Board-Certified

Virendra C. Patel, M.D.
Orthopaedic Surgery, Board-Certified

HOW DID YOU HEAR ABOUT US?

Patient Name: _____ **Date:** _____

- ☐ **Referred by Primary Care Physician - PCP's Name:** _____
- ☐ **Referred by other physician - Name:** _____
- ☐ **Referred by friend or another patient - Name:** _____
- ☐ **Referred by Emergency Room - Name of Hospital:** _____
- ☐ **Referred by Urgent Care Clinic - Name of Clinic:** _____
- ☐ **Insurance company provider list: (Please circle one)**
  Insurane Website Printed Book or by Phone
- ☐ **Yellow pages Ad: (Please circle one)**
  AT&T Verizon Unknown or Other _____
- ☐ **Saw the doctor while in the hospital.**
- ☐ **Saw an advertisement - Name of publication:** _____
- ☐ **Dr. Mehta's Website**
- ☐ **Online or telephone physician referral service - Name of service:** _____
- ☐ **Attended lecture by Dr. Mehta or Dr. Patel - Date & location:** _____
- ☐ **Personal Friend of Dr. Mehta or Dr. Patel**
- ☐ **Internet – Please specify website:** _____
- ☐ **Other** _____

1120 W. Campbell Road, Suite #109
Richardson, Texas 75080-2978

Phone: (214) 575-BONE (2663)
Fax: (214) 575-2664

www.comprehensiveortho.com

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HIPAA CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician's certification

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand 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: _____ Date: _____

Signature: _____

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NOTICE OF PRIVACY PRACTICE

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- ❖ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- ❖ The right to inspect and copy your protected health information.
- ❖ The right to amend your protected health information.
- ❖ The right to receive an accounting of disclosures of protected health information.
- ❖ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Sacheen H. Mehta, M.D.

PRIVACY OFFICER
(214) 575-2663

Notice of Organized Health Care Arrangement
Between Hospital and Medical Staff

Methodist Richardson Regional Medical Center, Baylor Scott & White Medical Center - Plano, Baylor Surgicare of North Texas, Preferred Imaging Centers, Methodist McKinney Hospital, Texas Health Hospital, Medical City McKinney, the independent contractor members of their Medical Staff (including your physician), and other health care providers affiliated with the hospitals, imaging centers and surgery center have agreed as permitted by law to share your health information among themselves for purposes of treatment, payment, or health care operations. This enables us to better address your health care needs. This notice is being provided to you as a supplement to the Notices of Privacy Practices already given to you by the Hospitals/Surgery Center and by your health care provider.

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PATIENT'S LAST NAME: _____ **FIRST NAME:** _____ **SEX:**___

Date of Birth: _____/____/_____ Address: _____

Social Security: _____ - ____ - _____ _____

CONTACT INFORMATION AND PERMISSIONS:

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Mobile Phone: (_____) _____-_____ Email Address: _____

How may we contact you with confidential medical information? (Circle all that apply)

HOME PHONE / WORK PHONE / MOBILE PHONE / EMAIL

Where may we leave a message with confidential medical information? (Circle all that apply)

HOME PHONE / WORK PHONE / MOBILE PHONE / EMAIL

Who else may we speak to regarding confidential medical information?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MARITAL STATUS: (circle one) Married / Single / Divorced / Separated / Widowed / Partner

INJURY INFORMATION: Car Accident: YES / NO On the Job Injury: YES / NO

OTHER CONTACTS:

Emergency Contact:

Name: _____ Relationship: _____ Phone: (____) _____-_____

Financial Guarantor: (Write 'Self' if applicable)

Name: _____

Date of Birth: _____/____/_____ Address: _____

Social Security: _____ - ____ - _____ _____

INSURANCE INFORMATION:

Primary Insurance: _____ID#_____ Group #: _____

Policy Holder's Name:_____ DOB:___/_____/_____SS#____-_____-_____

Policy Holder's Relationship to Patient: SPOUSE / PARENT / SELF / OTHER (Specify:_____)

Secondary Insurance:_____ ID#: _____Group #:_____

Policy Holder's Name: _____ DOB: ____/____/_____ SS#____-_____-_____

Policy Holder's Relationship to Patient: SPOUSE / PARENT / SELF / OTHER (Specify:_____)

PREFERRED PHARMACY:

Pharmacy Name: _____ **Address:** _____ **Phone:** _____

Payment is required at the time services are rendered We wish to notify you that Dr. Mehta has ownership/interest in Preferred Imaging of Plano, Preferred Imaging of Frisco, Baylor Surgicare at North Dallas, Methodist McKinney Hospital and shares in the profits in part from payments made by patients who maybe referred to these facilities. You are under no obligation to use these facilities.

I authorize payment of medical benefits by my insurance policy to Comprehensive Orthopaedics & Rehabilitation, P.A. I understand that I am responsible for the balance on the account regardless of my insurance policy. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as original. I hereby authorize said assignee to release all information necessary to secure payment. I authorize Comprehensive Orthopaedics & Rehabilitation, P.A. and its affiliated healthcare providers to treat me.

Patient Signature: X_____**DATE:** _____

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PATIENT'S LAST NAME: _____ FIRST NAME:_____ AGE:____

Primary Care Physician:_____ Who Referred You to Us: _____

MAIN PROBLEM: Circle One – **RIGHT / LEFT / BOTH / Not Applicable**

List Body Area:_____

HISTORY OF PRESENT ILLNESS:

Date of Injury or Onset: _____ Car Accident: YES / NO On the Job Injury: YES / NO

Describe how the problem began: _____

_____

Describe the current pain/problem as specifically as possible (**Character of pain** – burning, aching, sharp, dull, **Timing** – constant, intermittent, sudden, gradual, etc, **Associated symptoms** – numbness, spasm, swelling, etc):

_____

_____

Please grade the severity of the pain from 1 to 10 (10 is the worst pain you have ever felt) _____

What makes the problem worse: _____

_____

What makes it better: _____

List all previous treatments: (i.e. Braces, Casts, Physical Therapy, Medications, Injections, Surgery, etc.)

_____

_____

List any previous treating physicians and their specialties: _____

Have you ever had this problem before (Please describe the circumstances): _____

_____

WORK HISTORY:

Are You Currently Employed: YES / NO Are you Currently Able to Work: YES / NO / LIGHT DUTY

Job Title: _____Employer:_____

Specific Job Duties: _____

How Much Work Have You Missed As a Result of this Problem: _____

Patient Signature: X_____**DATE:** _____

PHYSICIAN'S NOTES: LEAVE BLANK:

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Do not leave any blanks – write "None" for each question if applicable.

PAST MEDICAL HISTORY: (List all acute and chronic medical conditions/problems)

PAST SURGICAL HISTORY: (List all surgeries and procedures, dates, and the physician who performed it)

Surgery/Procedure	Date	Physician	Surgery/Procedure	Date	Physician

ALLERGIES: (List all medication allergies and the type of reaction - i.e. rash, swelling, itching, etc.)

Medication	Reaction	Medication	Reaction

MEDICATIONS: (List all medications you are currently taking and dosages)

Medication	Dose	Frequency	Medication	Dose	Frequency

SOCIAL HISTORY:

Have you used tobacco products: YES / NO Type: _____ Quantity: _____
Do you consume alcohol: YES / NO Amount: _____ Frequency: _____
Have you used illegal drugs: YES / NO Type: _____ Quantity: _____
Could you be pregnant: YES / NO If no, how do you know: _____

FAMILY HISTORY: (List any medical problems that run in your family and how he/she is related to you)

_____

REVIEW OF SYSTEMS: (Do YOU have any *OTHER* medical problems (Do not leave blank, write none)

☐General:	Diabetes	Hypertension	Cancer	DVT	Other: _____
☐Head:	Glaucoma	Cataracts	Hearing Loss	Vision Loss	Other: _____
☐Heart:	High Cholesterol	Heart Attack	Heart Failure	Irregular rhythm	Other: _____
☐Lungs:	Asthma	COPD	Emphysema	Bronchitis	Other: _____
☐GI:	Stomach Ulcers	Bleeding	Liver Disease	Colon Cancer	Other: _____
☐Genitourinary:	Urinary Infection	Kidney Stones	Kidney Disease	Pregnancy	Other: _____
☐Neurological:	Parkinson's dz	Alzheimer's dz	Stroke	Seizures	Other: _____
☐Infectious:	Tuberculosis	HIV/AIDS	Hepatitis B or C	Tooth infections	Other: _____
☐Vascular:	Poor Circulation	Blood Clots	Venous Stasis	Varicose Veins	Other: _____
☐Lymphatic:	Lymphoma	Lymphedema	Tonsillitis	Lymphangitis	Other: _____
☐Skin:	Rash	Skin Infection	Open Sores	Psoriasis	Other: _____
☐Hematologic:	Sickle Cell Dz	Leukemia	Clotting Disorder	Bleeding Disorder	Other: _____
☐Immunologic:	AIDS	MultipleMyeloma	Severe Allergies	Reiter's Disease	Other: _____
☐Rheumatologic:	Lupus	Rheumatoid arthritis	Gout	Fibromyalgia	Other: _____
☐Cancer:	Lung	Breast	Prostate	Kidney	Thyroid
	Bone	Colon	Ovarian	Uterine	Testicular
	Skin	Brain	Esophagus	Blood	Other: _____

Patient Signature: X _____ **DATE:** _____