



NEW PATIENT QUESTIONNAIRE

(Please Print)

Today's date:

Primary Care Physician:

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one): Single / Mar / Div / Sep / Wid	
				Email:			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:		Social Security no.:		Home phone no.: ()	Cell Phone no.: ()		
P.O. box:	City:		State:		ZIP Code:		
Occupation:		Employer:		Employer phone no.: ()			
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION

(Please give your insurance card and driver's license to the receptionist.)

Person responsible for bill (if not Patient):		Birth date: / /	Address (if different from above):		Home phone no.: ()		
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Occupation:	Employer:	Employer address:			Employer phone no.: ()		
Are you covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Aetna	<input type="checkbox"/> BCBS	<input type="checkbox"/> Great West	<input type="checkbox"/> Medicare	<input type="checkbox"/> PHCS	
<input type="checkbox"/> Unicare	<input type="checkbox"/> United Healthcare	<input type="checkbox"/> MHHNP	<input type="checkbox"/> Other				
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Other phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elite Orthopedics / Sports Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): M F DOB:

Chief Complaint:

Date of onset of injury: Previous or referring doctor:

Side of injury: Right Left Both Dominant Hand: Right Left Both

PERSONAL HEALTH HISTORY

What symptoms are you having? (Check all that apply)

Pain Popping Locking Catching Stiffness Weakness
 Numbness Tingling Swelling Mass Deformity

List other symptoms:

Have you ever been treated for this problem before:

If yes, by whom and what treatments were performed:

Past Medical History: Have you ever been diagnosed with any of the following? (Check all that apply)

High Blood Pressure Heart Attack/Disease Diabetes Kidney Stones/Problems Stroke Lung disease Blood Clots Seizures
 Cancer Thyroid Problems Stomach Problems/Ulcer Arthritis Depression
 Tuberculosis AIDS/HIV+ Other(please list):

Past Surgical History:

Year Reason Hospital

List your Medications (please include dosage and frequency):

List ALL your Allergies (please include the side affect):

FAMILY HISTORY

Heart Disease Stroke Diabetes Arthritis Cancer Anesthetic Issues

List family member(s) for above:

SOCIAL HISTORY

Smoking? If so, how much? IV Drug Use? If so, what drug? Alcohol use: None Social Moderate Heavy

Special Interests or Hobbies:

OTHER PROBLEMS

Fainting/Headaches Shortness of breath Sudden weight loss Chest Pain Blood in stools Painful Urination
 Fevers Heartburn Easy bleeding Balance problems
 Other joint pain (please list): Other (please list):

Patient/Guardian signature

Date



CONSENT FOR MEDICAL TREATMENT

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

KNOWING THAT I AM SEEKING MEDICAL CARE IN AN AMBULATORY SETTING, I HEREBY VOLUNTARILY CONSENT TO SUCH CARE ENCOMPASSING DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT BY MY PHYSICIAN, HIS/HER ASSISTANTS OR HIS/HER CONSIGNEES AS MAY BE NECESSARY IN HIS/HER JUDGMENT. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE AS TO THE RESULT OF TREATMENTS OR THE EXAMINATION DONE.

CARE

THE PATIENT IS UNDER THE CARE AND SUPERVISION OF THE PATIENT'S PHYSICIAN OR PHYSICIANS AND CONSULTANTS SELECTED BY THIS PHYSICIAN. IT IS THE RESPONSIBILITY OF ELITE ORTHOPEDICS/SPORTS MEDICINE AND ITS STAFF TO CARRY OUT THE INSTRUCTIONS OF THE PHYSICIAN.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

EITHER "A" OR "B" BELOW MUST BE COMPLETED AND THIS DOCUMENT MUST BE SIGNED AT THE BOTTOM

SECTION A:

Patient/Guardian signature

Date

Print name

Witness signature

Date

SECTION B:

Patient (name) _____ is a minor or _____ unable to consent because _____.

I hereby consent on his/her behalf and in his/her stead this _____ day of _____, 20____.

SIGNATURE OF PERSON RESPONSIBLE FOR PATIENT OR LEGAL GUARDIAN

Patient/Guardian signature

Date

Print name

Witness signature

Date

Witness name printed



NOTICE OF PRIVACY PRACTICES

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE VIEWED A COPY OF THE 'NOTICE OF PRIVACY PRACTICES' AS YOU SIGNED IN FOR YOUR APPOINTMENT. THIS NOTICE EXPLAINS HOW YOUR HEALTH INFORMATION WILL BE HANDLED. HIPAA, THE NEW FEDERAL LAW CONCERNING MEDICAL PRIVACY, REQUIRES THIS NOTICE.

ELITE ORTHOPEDICS/SPORTS MEDICINE HAS GIVEN ME THE OPPORTUNITY TO ASK ANY QUESTIONS ABOUT THIS NOTICE AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

SIGNATURE OF PATIENT, PERSON RESPONSIBLE FOR PATIENT, OR LEGAL GUARDIAN

Patient name (print)

Patient/Guardian Signature

Date

Patient/Guardian name (print)

Date

If guardian, relationship to patient



EOSM FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

Prior to your service, EOSM will typically collect fees from the patient per the following guidelines:

1. Patients must submit accurate and up-to-date insurance information, including other personal data prior to the scheduled visit date to ensure EOSM has all information required for payment/collections.
2. EOSM participates in most major insurance provider plans, Medicare, and workers comp; however, EOSM does not accept Medicaid or 3rd party payor arrangements.
3. EOSM will collect co-pays/coinsurance/deductibles per the fee schedule and benefits of your particular plan during your visit to the clinic unless arrangements have been made in advance.
4. EOSM accepts American Express, Discover, Visa, MasterCard, Cash, or Check. There is a \$25 charge for any returned checks.
5. If a patient can not pay at the time of service, EOSM may choose not to see the patient or may arrange other payment plans *prior* to the service.
6. An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency.
7. Patients with an outstanding balance of 30 days overdue must make arrangements for payment prior to scheduling appointments.
8. We bill your insurance company as a courtesy to you. If we have not received payment from your insurance company within 60 days of the filed claim, you will be expected to pay the balance in full.
9. If EOSM is forced to turn your account over to collections, we may choose to terminate the physician-patient relationship.

Note: To better serve our patients, EOSM verifies your insurance benefits prior to your visit. To accomplish this, it is important that you provide EOSM with your most current insurance information prior to your appointment. While we provide this service in good faith, it is ultimately the patient's responsibility to understand their particular benefits.

We bill your insurance company for you, but the balance in full is the patient's responsibility. This includes any balances not collected at the time of service but processed as 'patient responsibility' per your insurance provider or any claims not paid by your insurance provider within 60 days of a filed claim. Please remember that you are financially responsible for any balance due per your insurance benefits as this reflects your contract with your insurance carrier.

If you have no insurance and need financial help, our business office personnel will help you to work out an agreeable payment program or direct you to the appropriate source for medical treatment.

(CONTINUED ON NEXT PAGE)



EOSM FINANCIAL POLICY CONTINUED

CANCELLATION AND MISSED APPOINTMENTS

Our goal is to provide quality orthopedic and sports medicine care in a timely and professional manner. In order to accomplish this, we implemented a cancellation and missed appointment policy. This policy enables us to more efficiently utilize our resources to better serve our patients, provide you with the very best medical care, and accommodate all appointment requests.

As all medical services are provided by appointment only and this time is reserved for your exclusive use, we request 24-hours notice via a phone call to 281-997-3717 to cancel an appointment. You may **not** cancel appointments via email.

There is a fee of \$25 for missed appointments and/or cancellations made less than 24 hours in advance.

Your cooperation and understanding in this matter are greatly appreciated.

I HAVE READ AND UNDERSTAND THE EOSM FINANCIAL POLICY. I AGREE TO ASSIGN INSURANCE BENEFITS TO EOSM WHENEVER NECESSARY. I ALSO AGREE THAT IF IT BECOME NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, IN ADDITION TO THE AMOUNT OWED, I ALSO WILL BE RESPONSIBLE FOR THE FEE CHARGED BY THE COLLECTION AGENCY FOR COSTS OF COLLECTIONS. THESE POLICIES ARE SUBJECT TO CHANGE WITHOUT NOTICE.

Patient name (print)

Patient/Guardian Signature

Date

Patient/Guardian name (print)

Date

If guardian, relationship to patient