



# IRVING ORTHOPEDICS & SPORTS MEDICINE SOUTHWEST SPINE INSTITUTE

Please PRINT AND complete All sections below!

Is your condition a result of work injury? YES NO An auto accident? YES NO Date of injury \_\_\_\_\_

### PATIENT'S INFORMATION

Marital Status:  Single  Married  Divorced  Widowed Sex:  Male  Female

Name: \_\_\_\_\_  
last name first name initial

Street Address: \_\_\_\_\_ (Apt# \_\_\_\_\_) City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Driver's Lic.: (state & #) \_\_\_\_\_ Social Security # \_\_\_\_\_  
month day year

Employer Name: \_\_\_\_\_  Full Time  Part Time

Spouse's Name: \_\_\_\_\_ Spouse's Work Phone: (\_\_\_\_) \_\_\_\_\_  
last name first name initial

### RESPONSIBLE PARTY INFORMATION

If different than patient.

Responsible Party: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

Relationship to Patient:  Self  Spouse  Other \_\_\_\_\_ Social Security # \_\_\_\_\_

Responsible Party's Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ (Apt# \_\_\_\_\_) City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Name: (\_\_\_\_) \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

### PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Company's Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Insured:  Self  Spouse

Other  Child

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

SECONDARY Insurance Company's Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Insured:  Self  Spouse

Other  Child

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### PATIENT'S REFERRAL INFORMATION

Name of Physician that referred you: \_\_\_\_\_

PCP Name (If different than Referring Physician): \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

How did you hear about us?  Physician Referral  Internet  Health Expo  Telephone Book  Other \_\_\_\_\_

Assignment of benefits \* Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to **Irving Orthopedics and Sports Medicine**, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: \_\_\_\_\_ Your Signature: \_\_\_\_\_

Method of Payment:  Cash  Check  Credit Card

AR 32103

Form Continued on Reverse Side

PATIENT REGISTRATION

Please PRINT AND complete ALL sections below !

**EMERGENCY CONTACT**

Name of Person not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_

**PHARMACY REFERENCE**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IOSM FACSIMILE AUTHORIZATION FORM**

I, the undersigned, authorizes IOSM to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories and other medical caregivers in the necessary coordination of care for the patient listed below.

I may revoke this authorization by giving IOSM five (5) days written notice. This revocation may be by facsimile transmission, however a **written copy of the revocation must be mailed to IOSM as well.**

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

**CONTACT AUTHORIZATION**

Circle where you can be reached during business hours:  Home  Work  Cell

May we contact you at home:  Yes  No

May we contact you at your place of business?  Yes  No

Leave message with:

Leave message with:

Yes  No Voicemail / Answer Machine

Yes  No Voicemail / Answer Machine

Yes  No Mobile Phone

Yes  No Mobile Phone

Yes  No Family Member

Yes  No Co-Worker

May we contact you via email?  Yes  No  E-mail Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

I hereby give permission to Irving Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following members (relatives, or close personal friends):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical conditions.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ HEIGHT: \_\_\_\_\_ FT. \_\_\_\_\_ IN. WEIGHT \_\_\_\_\_ LBS

**A.** 1. Referring doctor name and full address: \_\_\_\_\_

If not referred, how did you choose this office? \_\_\_\_\_

2. Internist or family doctor name and address: \_\_\_\_\_

3. Chief complaint     Neck pain    Arm:  Pain     Numbness     Weakness  
(check all that apply):  Back pain    Leg:  Pain     Numbness     Weakness    Other \_\_\_\_\_

4. Your age: \_\_\_\_\_ Years \_\_\_\_\_ Months

5. Your sex:  Male     Female

6. How long has the pain (or your problem) been present? \_\_\_\_\_

7. Has your problem worsened recently?  No     Yes – How recently? \_\_\_\_\_

8. What started the pain (or problem)? \_\_\_\_\_

**B. For patients with NECK OR ARM pain, numbness or weakness:**

(If you are seeing the doctor for back or leg pain, go to "C")

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)

- Neck 0%, Arm 100%     Neck 10%, Arm 90%     Neck 25%, Arm 75%     Neck 40%, Arm 60%  
 Neck 50%, Arm 50%     Neck 60%, Arm 40%     Neck 75%, Arm 25%     Neck 90%, Arm 10%  
 Neck 100%, Arm 0%

2. There is:     No arm pain     Arm pain is as follows (check the following):

- a.  Right 0%, Left 100%     Right 10%, Left 90%     Right 25%, Left 75%     Right 40%, Left 60%  
 Right 50%, Left 50%     Right 60%, Left 40%     Right 75%, Left 25%     Right 90%, Left 10%  
 Right 100%, Left 0%

b. The arm pain is present in the (check the following):

- Right:**  Upper back     Shoulder     Upper arm     Forearm     Hand/finger  
**Left:**  Upper back     Shoulder     Upper arm     Forearm     Hand/finger

3. Raising the arm:  Improves the pain     Worsens the pain     Does not affect the pain

4. Moving the neck:  Improves the pain     Worsens the pain     Does not affect the pain

5. There is:     No weakness of the arms and hands     Weakness of the (check the following):

- Right:**  Shoulder     Upper arm     Forearm     Hand/finger  
**Left:**  Shoulder     Upper arm     Forearm     Hand/finger

6. There is:  No numbness of the arms and hands     Numbness of the (check the following):

- Right:**  Upper arm     Forearm     Thumb     Index finger     Long finger     Ring finger     Small finger  
**Left:**  Upper arm     Forearm     Thumb     Index finger     Long finger     Ring finger     Small finger

7. There (  is     is no) difficulty picking up small objects like coins or buttoning buttons.

8. There (  is a     is no) problem with balance or tripping frequently.

9. There are: (  Frequent     Occasional     No) headaches in the back of the head.

END OF NECK QUESTIONS – PLEASE GO TO "D"

**C. For patients with BACK OR LEG PAIN, numbness or weakness.**

(If you are seeing the doctor for neck problems, please complete section "B")

1. What % of your pain is back pain and what % is leg or buttock pain? (check appropriate box):
 

<input type="checkbox"/> Back 0%, Leg 100%	<input type="checkbox"/> Back 10%, Leg 90%	<input type="checkbox"/> Back 25%, Leg 75%	<input type="checkbox"/> Back 40%, Leg 60%
<input type="checkbox"/> Back 50%, Leg 50%	<input type="checkbox"/> Back 60%, Leg 40%	<input type="checkbox"/> Back 75%, Leg 25%	<input type="checkbox"/> Back 90%, Leg 10%
<input type="checkbox"/> Back 100%, Leg 0%			
2. There is:  No leg pain     Leg pain as follows (check the following):
  - a.  Right 0%, Left 100%     Right 10%, Left 90%     Right 25%, Left 75%     Right 40%, Left 60%
  - Right 50%, Left 50%     Right 60%, Left 40%     Right 75%, Left 25%     Right 90%, Left 10%
  - Right 100%, Left 0%
- b. The pain is present in the (check the following):
 

<b>Right:</b>	<input type="checkbox"/> Buttock	<input type="checkbox"/> Thigh-front	<input type="checkbox"/> Thigh-back	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
<b>Left:</b>	<input type="checkbox"/> Buttock	<input type="checkbox"/> Thigh-front	<input type="checkbox"/> Thigh-back	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
3. There is:  No weakness of the legs     Weakness of the (check the following):
 

<b>Right:</b>	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Big toe
<b>Left:</b>	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Big toe
4. There is:  No numbness of the legs     Numbness of the (check the following):
 

<b>Right:</b>	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
<b>Left:</b>	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
5. The worst position for the pain is:  Sitting     Standing     Walking
6. How many minutes can you stand in one place without pain?     0-10     15-30     30-60     60+
7. How many minutes can you walk without pain?     0-10     15-30     30-60     60+
8. Lying down:     Eases the pain     Does not ease the pain     Sometimes eases the pain
9. Bending forward:  Increases the pain     Decreases the pain     Doesn't affect the pain

PLEASE GO TO "D"

**D. ★★★ ALL PATIENTS SHOULD ANSWER THE FOLLOWING ★★★**

1. Coughing or sneezing (  Increases     Sometimes increases     Does not increase) the pain.
2. There is:  No loss of bowel or bladder control     Loss of bowel or bladder control since \_\_\_\_\_
3. I have:     Not missed any work because of this problem     Missed (how much?) \_\_\_\_\_ work
4. Treatments have included:     No medicines, therapy, manipulations, injections, or braces

**Neck Back**

**Neck Back**

- |                          |                          |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Physical therapy, exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | Massage & ultrasound       |
| <input type="checkbox"/> | <input type="checkbox"/> | Traction                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Manipulation               |
| <input type="checkbox"/> | <input type="checkbox"/> | Tens Unit                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder injections        |
| <input type="checkbox"/> | <input type="checkbox"/> | Braces                     |

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-inflammatory medications   |
| <input type="checkbox"/> | <input type="checkbox"/> | Narcotic medication   |
| <input type="checkbox"/> | <input type="checkbox"/> | Epidural steroid injections _____ times which relieved the pain for (how long)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Trigger point injections _____ times which relieved the pain for (how long)? _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____  |

5. List pain medications and dose taken for your spine problem:     None

Medication	Dose

6. Previous doctors seen about this problem:  None

Doctor	Specialty	City (If not St. Louis)	Treatments

7. Tests done to evaluate your problem, the dates and the location they were done:  None

	Neck	Back	#1 DATE	WHERE	#2 DATE	WHERE	#3 DATE	WHERE
Plain x-rays	<input type="checkbox"/>	<input type="checkbox"/>						
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>						
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>						
MRI	<input type="checkbox"/>	<input type="checkbox"/>						
EMGs	<input type="checkbox"/>	<input type="checkbox"/>						
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>						

**E. REVIEW OF SYSTEMS:** Check all that apply.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Reading glasses       | <input type="checkbox"/> Abnormal heartbeat     | <input type="checkbox"/> None apply                                   | <input type="checkbox"/> Hot or cold spells   |
| <input type="checkbox"/> Change of vision      | <input type="checkbox"/> Swollen ankles         | <input type="checkbox"/> Frequent Constipation                        | <input type="checkbox"/> Recent weight change |
| <input type="checkbox"/> Loss of hearing       | <input type="checkbox"/> Calf cramps w/ walking | <input type="checkbox"/> Hemorrhoids                                  | <input type="checkbox"/> Nervous exhaustion   |
| <input type="checkbox"/> Ear pain              | <input type="checkbox"/> Poor appetite          | <input type="checkbox"/> Frequent urination                           | <i>Women only:</i>                            |
| <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Toothache              | <input type="checkbox"/> Burning on urination                         | <input type="checkbox"/> Irregular periods    |
| <input type="checkbox"/> Nosebleeds            | <input type="checkbox"/> Gum trouble            | <input type="checkbox"/> Difficulty starting urination                | <input type="checkbox"/> Vaginal discharge    |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Nausea or vomiting     | <input type="checkbox"/> Get up more than once every night to urinate | <input type="checkbox"/> Frequent spotting    |
| <input type="checkbox"/> Morning cough         | <input type="checkbox"/> Stomach pain           | <input type="checkbox"/> Frequent headaches                           | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Blackouts                                    | _____   |
| <input type="checkbox"/> Fever or chills       | <input type="checkbox"/> Frequent belching      | <input type="checkbox"/> Seizures                                     | _____   |
| <input type="checkbox"/> Heart or chest pain   | <input type="checkbox"/> Frequent diarrhea      | <input type="checkbox"/> Frequent rash                                | _____   |

**F. MEDICAL HISTORY:** Check all that apply.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Heart attack           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> None apply         | <input type="checkbox"/> Liver trouble              |
| <input type="checkbox"/> Heart failure          | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Lung disease       | <input type="checkbox"/> Hepatitis                  |
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Seizures       | <input type="checkbox"/> HIV                | <input type="checkbox"/> Thyroid trouble            |
| <input type="checkbox"/> Osteoarthritis         | <input type="checkbox"/> Mental illness | <input type="checkbox"/> AIDS               | <input type="checkbox"/> Bleeding disorders         |
| <input type="checkbox"/> Rheumatoid arthritis   | <input type="checkbox"/> Kidney stones  | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Anemia                     |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Serious injuries (explain) |
| <input type="checkbox"/> Gout                   | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Blood clot in leg  | _____   |
| <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Blood clot in lung | <input type="checkbox"/> Other: _____               |
|   |   | <input type="checkbox"/> Stomach ulcers     | _____   |

**G. SURGICAL HISTORY:** Previous surgeries - List procedures, surgeon and date.

None

OPERATION	SURGEON	DATE

**H. FAMILY HISTORY:** Check all that apply.

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis      | <input type="checkbox"/> None apply               | <input type="checkbox"/> Alcoholism   |
| <input type="checkbox"/> Heart trouble       | <input type="checkbox"/> Gout           | <input type="checkbox"/> Mental illness           | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Kidney trouble or stones | _____                                 |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Spine problems | <input type="checkbox"/> Cancer                   | _____                                 |
|  |   | <input type="checkbox"/> Bleeding disorders       | _____                                 |

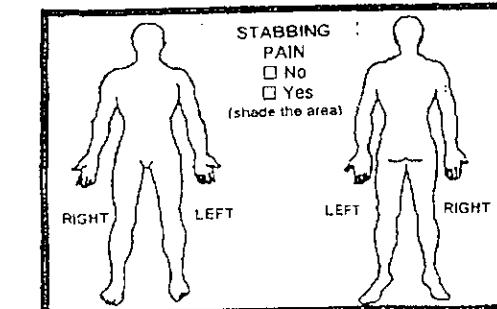
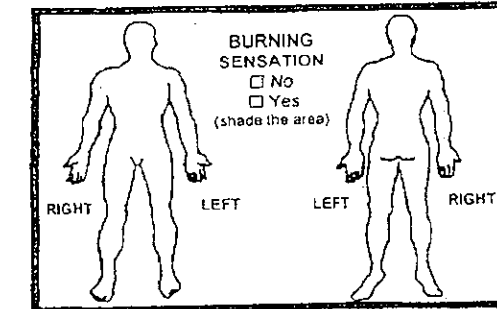
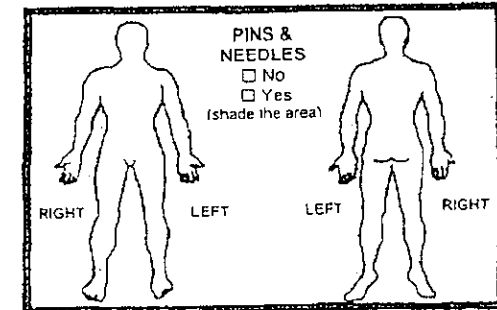
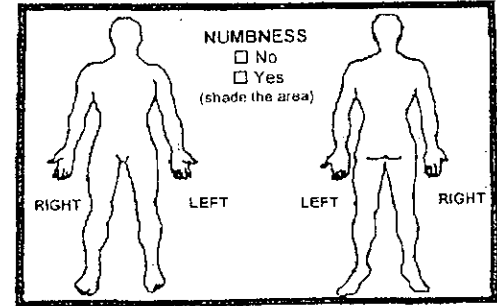
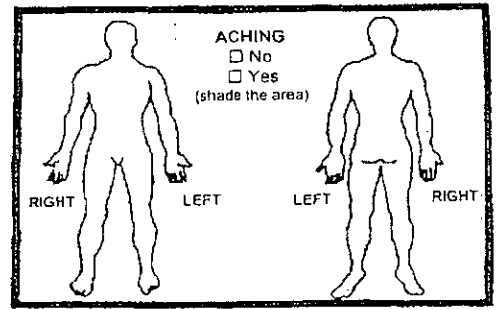
**I. MEDICATIONS YOU TAKE:**  None

\_\_\_\_\_

\_\_\_\_\_

**J. ALLERGIES TO MEDICATIONS:**  No known drug allergies

MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



**K. SOCIAL HISTORY:**

1. Work status:  Homemaker  Retired  Disabled  On leave  
 Unemployed  Working:      Full time      Part time  
 Occupation: \_\_\_\_\_

2. Marital status:  Married  Single  Co-habiting  
 Widowed  Divorced

3. Number of living children:  1  2  3  4  5  
 6  7  8  9  10

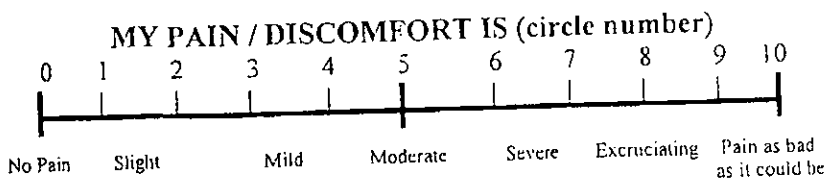
4. I live:  Alone  With: \_\_\_\_\_

5. Tobacco use:  Never (skip to #6)  
 Cigar  Chew  Pipe  Cigarettes  
 \_\_\_\_\_ packs per day for \_\_\_\_\_ years.  
 Quit - When? \_\_\_\_\_ after smoking  
 \_\_\_\_\_ packs per day for \_\_\_\_\_ years (total)

6. Alcohol:  Never or rare  
 Social  Frequently drunk (more than twice a week)  
 Alcoholic  Recovering alcoholic

7. Drug overuse/abuse:  Never  Currently  In the past

8. Because of this spine problem, I have filed or plan to file:  
 A lawsuit  A Worker's Compensation claim  
 Neither a lawsuit or Worker's Compensation claim



\_\_\_\_\_  
 Patient Signature Date

## ***IRVING ORTHOPEDICS & SPORTS MEDICINE***

Thank you for choosing Irving Orthopedics & Sports Medicine as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

**Full payment is due at the time of service**  
**We accept cash, checks, or Visa/ MasterCard/ American Express**  
**We offer an extended payment plan with prior approval**

### **INSURANCE**

We may accept assignments of insurance benefits upon your first visit; however, we do require your portion of the bill to be paid at the time of service (i.e. co pay, deductible, etc.). Because the bill is your responsibility, should your insurance company not pay – you will receive a bill for the remaining balance. We will do everything reasonably required to facilitate the filling of your insurance claim. This necessitates you providing us with your insurance information, along with all other relevant documents (i.e. accident reports, secondary insurance, workman’s compensation, etc.). Your insurance policy is a contract between you and your insurance company. Please be aware that your insurance may deny coverage that is usual, customary, and in our opinion medically necessary- declaring the treatment not necessary or not covered. Should this occur, you will be responsible for the entire bill. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency.

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to: **Irving Orthopedics & Sports Medicine** or if my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows: **2120 N. MacArthur Ste 100, Irving, TX 75061**

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize my doctor to initiate a complaint on my behalf to the Insurance Commissioner for any reason.

### **USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

### **PRIVATE PAY**

There is a minimum deposit of \$250.00 (cash or credit card only – no checks accepted) due upfront for all private pay patients on the initial visit. Due to the bill being your responsibility, should your charges add up to more than your deposit, you will be billed the remaining balance. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency.

### **MINOR PATIENTS**

The adult accompanying a minor and the parent (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, VISA / MasterCard, or payment by cash or check at the time of service. Minor patients must also have a signed consent form by their parent or guardian in order for our professionals to treat the minor.

### **MISSED APPOINTMENTS**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit (subject to extenuating circumstances). Please help us serve you better by keeping scheduled appointments.

### **RETURNED CHECKS**

There will be a \$30.00 service charge on returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

By signing below, I am stating I understand and agree to this Financial Policy.

---

Signature of Patient or Responsible Party

---

Date

Robert E. Bayless, M.D.  
Steven B. Sanders, M.D.  
R. Mills Roberts, M.D.  
John G. Westkaemper, M.D.  
Mark A. Kazewych, M.D.  
Douglas S. Won, M.D.  
Yong T. Pak, M.D.



Orthopedic Surgery  
Sports Medicine  
Arthroscopy  
Joint Replacement  
Fracture Care  
Hand & Upper Extremity Care  
Comprehensive Back & Neck Care  
Open MRI & Bone Densitometer

Member Authorization Form for a Designated Representative to Appeal a Determination

TO: \_\_\_\_\_  
[Your Insurance Carrier's Name]  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Member Name: \_\_\_\_\_

Member#: \_\_\_\_\_

I hereby authorize Irving Orthopedics & Sports Medicine/Southwest Spine Institute to appeal \_\_\_\_\_'s determination concerning my coverage for medical  
[Your Insurance Carrier's Name]

care provided on \_\_\_\_\_ on my behalf, as my Designated  
[Date(s) of Service]

Representative, and, as part of the appeal, I hereby authorize \_\_\_\_\_  
[Your Insurance Carrier's Name]

to send all decision letters in connection with the processing of my claim and to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain medical and financial information that relates to my appeal.

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

\_\_\_\_\_  
Members or Legal Guardian

\_\_\_\_\_  
Designated Representative Signature

\_\_\_\_\_  
Designated Representative (Print Name)

Robert E. Bayless, M.D.  
 Steven B. Sanders, M.D.  
 R. Mills Roberts, M.D.  
 John G. Westkaemper, M.D.  
 Mark A. Kazewych, M.D.  
 Douglas S. Won, M.D.  
 Yong T. Pak, M.D.



Orthopedic Surgery  
 Sports Medicine  
 Arthroscopy  
 Joint Replacement  
 Fracture Care  
 Hand & Upper Extremity Care  
 Comprehensive Back & Neck Care  
 Open MRI & Bone Densitometer

**Physician Assistant  
 Consent For Treatment**

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

“Supervision” does not required the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include, but are not limited to:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and understand that health care services may be provided by a physician assistant.

I understand that at any time I can request to see the physician.

Name:	Date:
Signature:	Witness (optional):