



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: _____ last name first name initial Spouse's Work Phone: (____) _____

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

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):

Right:	<input type="checkbox"/> Buttock	<input type="checkbox"/> Thigh-front	<input type="checkbox"/> Thigh-back	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
Left:	<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):

Right:	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Big toe
Left:	<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):

Right:	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
Left:	<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

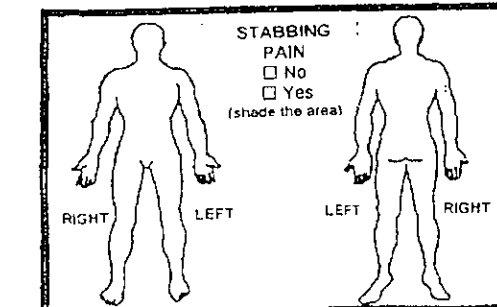
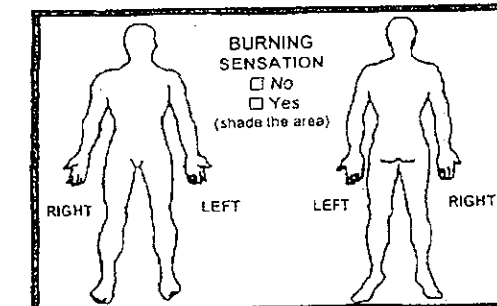
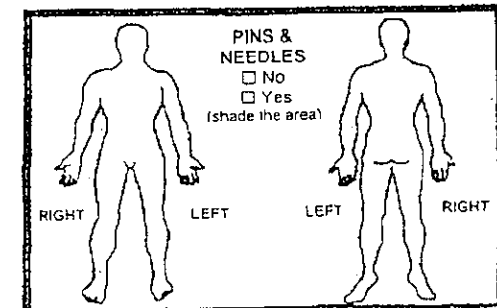
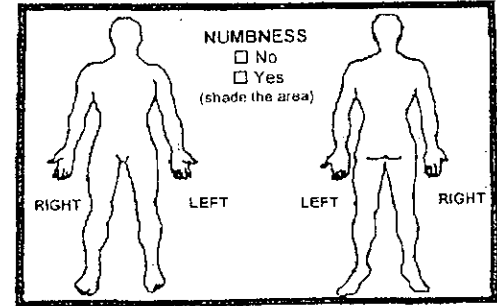
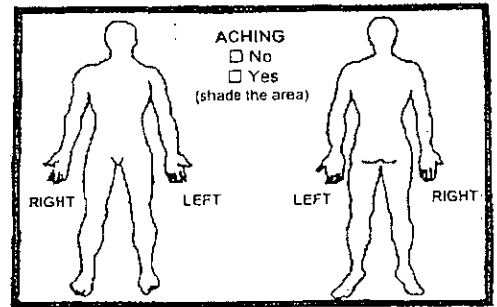
H. FAMILY HISTORY: Check all that apply.

- | | | | |
|--|---|---|---------------------------------------|
| <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

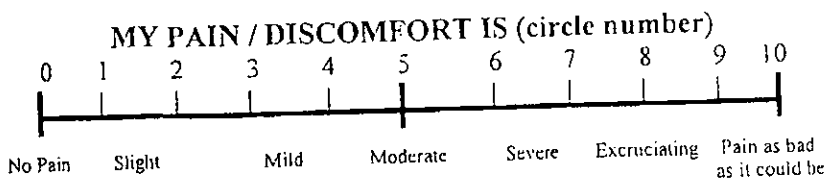
4. I live: Alone With: _____

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 Blvd., Suite 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.
Yong T. Pak, M.D.
Venkat Sethuraman, 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)

CONSENT TO MEDICAL TREATMENT OF A MINOR

The undersigned hereby consents on behalf of the below named minor less than eighteen (18) years of age to the medical diagnosis or treatment described below to be performed by Dr. _____ and/or by any person(s) he may designate as assistants.

1. Name of minor (please print) _____

Name of Parents/Managing Conservator/Guardian (please print) _____

2. Relationship of the undersigned to the minor:

- _____ Parent
- _____ Managing Conservator
- _____ Possessory Conservator
- _____ Guardian of the person
- _____ Grandparent
- _____ Brother or sister, eighteen (18) years or older
- _____ Aunt or Uncle, eighteen (18) years or older
- _____ Judge of the Court having jurisdiction of the child
- _____ Person over 18 years of age, responsible for the care and treatment of a minor under the jurisdiction of a juvenile court.
- _____ Texas Youth Commission
- _____ Educational institution in which the minor is enrolled that has received written authorization from a person authorized by law to give such consent to medical care (written authorization must be attached).
- _____ A person 18 years or older who has care and control of the minor and has written authorization to consent to medical care for the minor from a person authorized to give such consent (written authorization must be attached).
- _____ The person having power to consent cannot be contacted and actual notice to the contrary has not been given by that person.

3. Grounds upon which the minor has capacity to consent to his/her own medical treatment:

- _____ Active armed services
- _____ Sixteen (16) years old and living independently
- _____ for reportable communicable disease
- _____ Unmarried and pregnant
- _____ for blood donation
- _____ for chemical dependency

4. Statement of nature of the medical treatment, including any emergency involving an immediate danger to the health and safety of the child and foreseeable risks:

5. I authorize for any different diagnosis or additional treatment, which the physician may deem necessary, for this minor.

6. Date on which the diagnosis or treatment is to begin: _____

7. I certify that I have read and fully understand the foregoing consent, and that the explanations therein referred to were made and that all blanks were filled in before I signed.

Signature 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.
Yong T. Pak, M.D.
Venkat Sethuraman, M.D.



Orthopedic Surgery
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Arthroscopy
Joint Replacement
Fracture Care
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Comprehensive Back & Neck Care
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Important Information About Provider/Patient Email

As a patient of a Irving Orthopedics & Sports Medicine (IOSM), Southwest Spine Institute, and Southlake Orthopedics & Sports Medicine you have the right to request we communicate with you by electronic mail (email). It is also your right to be informed in sufficient detail about the risks of communicating via email with your health care provider or office, and how IOSM will use and disclose provider/patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition. If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you – and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and/or your PDA have inherent privacy risks – especially when your email access is provided through your employer or when access to your email messages is not password protected. Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the post office.

Email messages may be inadvertently missed. To minimize this risk, IOSM or any of the DBA's will require that you respond appropriately to a test email message before we will allow health information about you to be communicated with you via email. You can also help minimize this risk by using only the email address that you are provided at the successful conclusion of the testing period to communicate with IOSM.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. In order to forward or to process and respond to your email, individuals at IOSM other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider. Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

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Orthopedic Surgery
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Patient Request for Email Communications

Communications over the Internet and/or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way. Nevertheless, you may request that we communicate with you via email. To do so, you must complete this form and return it to Irving Orthopedics & Sports Medicine (IOSM).

Please be advised that:

- (1) **This Request applies only to the health care provider or office that you indicate below. If you would like to request to communicate via email with another health care provider or office, you must complete a separate Request for that office.**
- (2) IOSM will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS information, substance abuse treatment records information, mental health information) via email even if we agree to communicate with you via email.
- (3) Your Request will not be effective until you receive and respond appropriately to a test email message from IOSM.

Please select the test question you want to use below, and provide us with your answer.

Please provide the following information:

Patient Name: _____ Date of Birth: _____
Phone number: _____
Address: _____

Please specify the email address to which communications should be addressed:

Please select the question you want to use (by checking the one of the boxes below) for your test email and provide your answer.

- The last four digits of my Social Security Number: _____
- My mother's maiden name: _____
- My middle name: _____
- The street number of my residence: _____

Please initial each blank and sign below:

____ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.

____ I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL form, and I have read and understand it.

____ I understand and acknowledge that communications over the Internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.

____ I understand that all email communications in which I engage may be forwarded to other providers, including providers not associated with IOSM, for purposes of providing treatment to me.

____ I agree to hold IOSM and individuals associated with it harmless from any and all claims and liabilities arising from or related to this Request to communicate via email.

Signature of patient or personal representative

Date _____

If personal representative, authority to act on behalf of patient