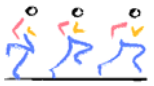
Fondren Orthopedic Group L.L.P.



Patient Information	Provider #:		Account Number:	
Patient's Name (First MI Last)	Gender ☐ Male ☐ Female	DOB Age	DL#	SSN
Address	City and State		Zip Code	Home Phone
Email Address	Race		Ethnicity	Preferred Language
Patient's Employer	Business Phone	Emergency Phone	Marital Status ☐ M ☐ S ☐ D ☐ W	Referring Doctor

Guarantor Information			
Guarantor's Name	Relationship to Patient	DOB	SSN
Billing Address	City and State	Zip Code	Phone

Insurance Information				
Insurance Carrier Name – Primary	Identification Number	Group Number	Insurance Phone Number	
Name of Policy Holder	Employer	SSN	DOB	Relationship
Insurance Carrier Name - Secondary	Identification Number	Group Number	Insurance Phone Number	
Name of Policy Holder	Employer	SSN	DOB	Relationship

Please check one of the following: ☐ This IS a work-related injury. ☐ This is NOT a work related injury

Reason for Today's Visit: _____

_____

_____

MEDICARE / MEDICAID – PATIENT'S ONLY

I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS' COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office. I have read and understand the above statement regarding MEDICARE coverage.

☐ Medicare is my primary coverage.
☐ Medicare is my secondary coverage.
☐ I am not covered by Medicare or a Medicare HMO.
☐ Medicaid is my primary coverage.
☐ Medicaid is my secondary coverage.
☐ I am not covered by Medicaid or a Medicaid HMO.

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the Fondren Orthopedic Group, L.L.P. of the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all personal balances incurred as a result of services rendered to me during the course of my medical treatment.

☐ Payment is required today for all copays, deductibles, or co-insurance amounts that may be due by the patient.

X _____ _____
Signature of Patient/Parent/ or Guardian — Date

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and/or treatment. I understand this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

X _____ _____
Signature of Patient/Parent/ or Guardian — Date

CONSENT TO CARE: I authorize and direct Fondren Orthopedic Group, L.L.P. to perform upon me injections, draw blood and / or any other procedure or treatments the doctor may in his best judgment determine advisable for my well being.

X _____ _____
Signature of Patient/Parent/ or Guardian — Date

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP), and other doctors/specialists) with whom we may share your information:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What is the best phone number for us to contact you?
Phone Number: _____

What is this number (Home, Work, Cell, Other)? _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such message to include details (such as diagnosis and medication information) at this number**? _____

What other ways may we contact you? Please list any that are acceptable ways to reach you.
Home Phone Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Work Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Cell Phone Number: _____

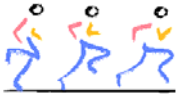
Is it OK to leave a **detailed** message at this number in your absence? _____

Other: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Print name of Patient or Legal Representative **Relationship to Patient**



Fondren Orthopedic Group L.L.P.
7401 South Main Street
Houston, TX 77030-4509
713-799-2300

Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.**, your medical provider, to : (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

Patient's Name _____ Fondren Account Number _____

Patient's Signature _____ Date _____

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

Legal Representative's Name _____

Legal Representative's Signature _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

FONDREN ORTHOPEDIC GROUP L.L.P.

I, **[name of patient]** _____, acknowledge and agree that I have reviewed a copy of **Fondren Orthopedic Group's Notice of Privacy Practices**.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to patient

Clinic Use Only:

Fondren Orthopedic Group, LLP made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]:**

_____

_____

_____

_____ _____
Signature of Employee Date

_____ _____
Print Name of Employee Title

FONDREN ORTHOPEDIC GROUP L.L.P.

Name: _____ DOB: _____ Today's Date _____

Weight _____ Height _____ Occupation _____ Who Referred You _____

MEDICAL HISTORY: PLEASE READ AND RESPOND TO ALL QUESTIONS

Please check any of the following medical conditions that you have or have had in the past:

☐ Anxiety/depression	☐ Insulin Dependent (Diabetes Type I)	☐ Heart Disease	☐ Osteoporosis
☐ Arrhythmia	☐ Non-Insulin Dependent (Diabetes Type II)	☐ High Blood Pressure (Hypertension)	☐ Rheumatoid Arthritis
☐ Asthma	☐ Gout	☐ Kidney Disease	☐ Scoliosis
☐ Cancer	☐ Hemophilia	☐ Liver Disease	☐ Stroke
☐ Chronic Obstructive Pulmonary Dis	☐ Hepatitis	☐ Lupus	☐ Thyroid Problems
☐ Congestive Heart Failure	☐ HIV	☐ Obesity	☐ Tuberculosis

List any significant medical family history: _____

List past surgeries: _____

Social History: Use of Tobacco: **YES** **NO** If Yes, ho much and how long?_____

Use of Alcohol: **YES** **NO** If Yes, how much?_____

Use of Recreational Drugs: **YES** **NO**

Current Medications: _____

Allergies to Medicine: _____

Are you under a physicians care? **YES** **NO** If yes, name & phone #:_____

What will we be treating you for today? _____

When did your symptoms first appear? _____

Was this an injury? **YES** **NO** If yes, date of injury: _____ **How** did injury occur? _____

I hereby grant permission to the physicians of Fondren Orthopedic Group LLP to perform such medical treatment they deem necessary. I understand that I am responsible for disclosing any changes in the above answers that I have provided at all times. I understand that I will need to complete a similar form when treatment consists of a medical problem other than the problem listed above or to update the form on file.

_____ _____

Signature: Date: