LONGVIEW ORTHOPAEDIC
CLINIC ASSOCIATION
Personalized Medicine. Quality Care.

Patient Name: ________________________________ **Date of Birth**: ________________

Age: _______ Gender: _____________ Social Security Number: ___________________

Race: ❑African-American ❑Hispanic ❑Asian ❑White ❑Other: _______________

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Physical Address: ____

Mailing Address: ____

Preferred Phone: _________________________ ❑Home ❑Mobile ❑Work

Email: ____________________________ Employer: _____________________________

Emergency Contact, Relationship & Phone: ____

Primary Care Physician: _____________________ Physician who referred you: _____________

**** Is this problem the result of a ❑work-related accident ❑car accident ❑sports injury**

RESPONSIBLE PARTY IF PATIENT IS A MINOR OR STUDENT

Father's Name & Address: ____

Father's DOB & SSN: ____

Father's Phone & Employer: ____

Mother's Name & Address: ____

Mother's DOB & SSN: ____

Mother's Phone & Employer: ____

How did you hear about Longview Orthopedic Clinic:
❑Physician Referral ❑Google ❑Facebook ❑Family/Friends ❑Other: ______________

Authorization

I hereby assign to my physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. I hereby authorize my physician to furnish information to my insurance carrier concerning my illness and treatments.

The physicians of Longview Orthopaedic Clinic Association disclose that we do have financial interests in the following rehabilitation providers from which you may receive care: Highland Pines Skilled Nursing Facility, Choice Home Health, Premier Home Health, Texas Home Health, The Willows, Longview Orthopedic Clinic Physical Therapy, and KER Rock Island.

Patient Signature: __________________________________ Date: ______________________

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Patient Health History Form

Patient Name: ____________________ **DOB**: _________________

Height: ____ ft ___ inches **Weight**: ____ lbs. ❑Right-handed ❑Left-handed

Preferred Pharmacy: ____________________________________

Occupation: ______________________ ❑Full-time ❑Part-time ❑Seasonal ❑Unemployed

Reason for visit today: ____

How long have you had this problem? _____ Days _____ Weeks ____ Months ____ Years

How did this problem happen? ____
____
____

If this problem is the result of a work-related accident or a car accident:

Date of accident: __________________ Place of accident: _________________

Are you currently working? ❑ Yes, full duty ❑Yes, light duty ❑No

Have you received care from another healthcare provider for this problem? ❑ Yes ❑No

If yes, whom & when: ____

Social History

Use tobacco: ❑Yes ❑No

If yes, type: _____________ How many per day _______ How long (years) ________

If you have quit tobacco, how long ago did you quit? _____________

Use alcohol: ❑Yes ❑No

If yes, type:__________________ Amount per day or week: _________________

Use recreational drugs: ❑Yes ❑No

If yes, type: __________________ Amount per day or week: _________________

Have you ever been treated for a drug, alcohol or opioid addiction? ❑Yes ❑No

If yes, substance: _________________________ Dates: ____________________________

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Patient Name: ____________________ **DOB**: _________________

Past Medical History

Diabetes	❑Yes	❑No	High blood pressure	❑Yes	❑No
Heart disease	❑Yes	❑No	High cholesterol	❑Yes	❑No
Blood clots	❑Yes	❑No	Stroke	❑Yes	❑No
Depression	❑Yes	❑No	Kidney disease	❑Yes	❑No
COPD	❑Yes	❑No	Asthma	❑Yes	❑No
Arthritis	❑Yes	❑No	Osteoporosis	❑Yes	❑No
Cancer	❑Yes	❑No			

If yes, what type and when? ____

____

Other conditions: ____

Past Surgical History & Dates

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

Are you allergic to Latex: ❑Yes ❑No

Are you currently classified as disabled through Social Security? ❑Yes ❑No

If yes, please list the condition for which you are disabled: ____________________________

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Patient Name: ____________________ **DOB**: _________________

Medications

Medication Name	Dosage	Times taken per day

Medication Allergies

Allergic to	Type of Reaction

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Patient Name: ____________________   **DOB**: _________________

Review of Systems

*Please check if you have had any of the following **in the past 12 months**:*

Constitutional

❑ Weight gain ❑Weight loss ❑Night sweats ❑Chills ❑Fever

Skin

❑Easy bleeding ❑Easy bruising ❑Any rashes

Ear, Nose, Throat & Eyes

❑Vision changes ❑Change in smells ❑Dizziness ❑Hearing changes

Respiratory

❑Shortness of breath ❑Wheezing ❑Cough ❑Increased mucus

Cardiovascular

❑Chest pain ❑Palpitations ❑Heart murmur ❑Feet swelling

Gastrointestinal

❑Nausea ❑Vomiting ❑Diarrhea ❑Dark/bloody stools

Musculoskeletal

❑Cramps ❑Joint pain ❑Joint swelling ❑Stiffness in the morning ❑Weakness

Nervous System

❑Numbness/tingling in feet ❑Numbness/tingling in hands ❑Problems sleeping

Genitourinary

❑Blood in urine ❑Incontinence (bowel or bladder) ❑Urinary tract infection

For Females: ❑Abnormal vaginal bleeding ❑Breast biopsy ❑Nipple discharge
Last menstrual period: __________________________

For Males: ❑Prostatitis ❑Difficulty urinating
Date of last prostate exam/PSA: _____________ Results: _____________________

I hereby acknowledge that the above information is complete and accurate to the best of my knowledge.

Patient Signature: ______________________________ Date: _______________________

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General Consent for Care and Consent to Treatment

TO OUR PATIENTS: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that **(1)** you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and **(2)** you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right to discuss the treatment plan with your health care provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request a physician, and/or advanced practice provider (nurse practitioner or physician assistant) and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	______________
Signature of Patient or Personal Representative	Date
______________________________	______________
Printed Name of Patient/Personal Representative	Relationship to Patient
______________________________	______________
Signature of Witness	Employee Job Title
______________________________	______________
Printed Name of Witness	Date

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Longview Orthopaedic Clinic to use and/or disclose certain protected health information (PHI) about me to __________________________ (spouse, child, caregiver, etc.).

** **FOR STUDENT-ATHLETES**: I ❑AUTHORIZE ❑DO NOT AUTHORIZE release of injury and treatment information to school representatives including coaches and athletic trainers.

This authorization permits Longview Orthopaedic Clinic to use and/or disclose individually identifiable PHI about me, including but not limited to dates of service, types of services, and the origin of the information. This information may be used or disclosed so that I and my approved delegates may make informed decisions about my care.

This authorization will expire on ________________________.

Longview Orthopaedic Clinic will not receive payment or other remuneration from a third party in exchange for using or disclosing any PHI.

I do not have to sign this authorization in order to receive treatment from Longview Orthopaedic Clinic. In fact, I have the right to refuse to sign this authorization. When my PHI is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at rshort@longvieworthopedic.com.

Longview Orthopaedic Clinic will notify any patient of a potential breach of HIPAA privacy information as soon as the breach is identified.

Signed by: _____________________________ Relationship to Patient: ____________________
Patient or Guardian Signature

_____________________________ Date: __________________
Print Patient's Name

____
Print Name of Parent or Guardian

- *Patient/guardian must be provided a signed copy of this authorization*

Acknowledgment of Receipt of Notice of Privacy Practices

I, ____________________________, acknowledge that I have received a copy of the Longview Orthopaedic Clinic Association (LOCA) Notice of Privacy Practices.

______________________________ ______________________
Patient Signature Date

____________________________________ ________________________
Patient Legal Representative (if applicable) Date

____________________________________ ________________________
Printed name of Legal Representative Relationship to Patient

For LOCA Use Only

LOCA has made the good following good faith efforts to obtain the above-referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices:

(identify the efforts taken to obtain acknowledgment including reasons why it was not obtained)

____
____
____
____

Name of LOCA Representative: ________________________________

Date placed in patient chart: ______________________

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Consent to Contact

You agree, in order for us to service your account, collect any amounts you may owe or to survey your satisfaction with our services, that we may contact you by telephone at any telephone number associated with your account, including mobile phone numbers, which could result in charges to you. We may also contact you by sending messages or emails using any email address you provide to us. Methods of contact may include pre-recorded/artificial voice messages, use of automated dialing devices or third-party applications.

I have read this disclosure and agree that the Lender/Creditor may contact me as described above.

Signature: ___________________________ Date: ___________________

I grant Longview Orthopedic permission to speak with the following people concerning my financial account:

Name: ______________________________ DOB: ___________________

Name: ______________________________ DOB: ___________________

Name: ______________________________ DOB: ___________________

Name: ______________________________ DOB: ___________________

Signature: ___________________________ Date: ___________________

LONGVIEW ORTHOPAEDIC
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For Our Patients: Authorization Times for Imaging & Surgical Procedures

Once your doctor, nurse practitioner or physician assistant has ordered an imaging or surgical procedure, there is a period of time during which we will seek authorization for the procedure by your insurance company. The time between us requesting authorization for your procedure and your insurance company deciding to approve or deny it can be a time of stress and uncertainty for you. Our goal is to help reduce this stress and uncertainty.

The table below outlines the typical time for insurance companies to approve or deny your procedure. The information in this tool is based on our experience working closely with many insurance companies and is in no way a guarantee or criticism of your insurance coverage. This tool is only a guide to clarify expectations for when a decision about your procedure may be provided by the insurance company.

Insurance Company	Uses 3rd Party	Estimated Time to Approve
Blue Cross Blue Shield Texas	Yes	3-7 days
Cigna – Commercial	Yes	3-10 days
Cigna Healthspring	Yes	5-14 days
Medicare – Traditional	Yes	2-4 days
Superior Medicaid	Yes	3-14 days
Medicaid - Traditional	Yes	3-10 days
AETNA	Yes	3-10 days
Blue Cross Blue Shield HMO, TN, IL, KY, NY	Yes	3-7 days
Molina	No	3-10 days
Boon Chapman	No	3-10 days
CHRISTUS Health Plan	No	3-10 days
EBSO	No	3-10 days
American Benefits	No	3-10 days
TML	No	3-10 days
UMR	No	3-10 days
Blue Cross Blue Shield CHRISTUS Employees	No	No auth required
Blue Cross Blue Shield LRMC Employees	No	No auth required
United Healthcare – Commercial, MCR & MCD	Yes	3-7 days
Humana - Commercial	Yes	3-7 days
Humana – Military/Tricare	Yes	3-7 days

It is our goal to get your procedure approved and scheduled as quickly as possible. We want you on the road to recovery. Thank you in advance for your patience as we work efficiently through the process with your insurance company. And thank you for choosing Longview Orthopedic!