



**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: _____

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:** _____



Patient Name: _____

DOB: _____

Past Medical History

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: _____



Patient Name: _____

DOB: _____

Medications

Medication Name	Dosage	Times taken per day

Medication Allergies

Allergic to	Type of Reaction

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: _____

MRI/CT Pre Screening Form

Patient Name: _____ DOB: _____
 Height: _____ Weight: _____

Please be informed, to properly treat and diagnose your condition, our providers may order farther diagnostic imaging at an outside facility. For you protection and safety, we need to know the answers to these important questions as we care about your needs, wellbeing and preferences.

Preferred Imaging Facility	<input type="checkbox"/> Christus Good Shepherd (Open MRI Option) <input type="checkbox"/> Open Imaging (Not an Open MRI) <input type="checkbox"/> LPMC Center (Open MRI Option) <input type="checkbox"/> Other _____
Do you have an implanted pacemaker, cardiac defibrillator or stent?	Yes / No
Do you have a stimulator (neuro, spinal, bladder, etc.)?	Yes / No
Do you have a loop recorder?	Yes / No
Do you have an internal infusion pump?	Yes / No
Do you have aneurysm clips in your head/neck?	Yes / No
Any other implanted medical device (bladder, stent, spinal stim, etc.)	Yes / No
I am claustrophobic	Yes / No

*****If YES to any implants, please provide a copy of your card, so that we can properly schedule your diagnostic imaging. Failure to do so will cause delays in scheduling your procedure.*****

Thank you.

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

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: _____
Patient or Guardian Signature

Relationship to Patient: _____

Print Patient's Name

Date: _____

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: _____

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: _____

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!