Comprehensive Orthopaedics & Rehabilitation

Sacheen H. Mehta, M.D.
Orthopaedic Surgery, Board-Certified
Sports Medicine, Board-Certified

Virendra Patel, M.D.
Orthopaedic Surgery, Board-Certified

Sai Madhavapeddi, M.D.
Primary Care Sports Medicine
Board-Certified

PATIENT'S LAST NAME: _____ **FIRST:** _____ **SEX:** _____
Date of Birth: ____/____/____ Address: _____
Social Security: _____ - _____ - _____ _____

CONTACT INFORMATION AND PERMISSIONS:

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____
Mobile Phone: (_____) _____ - _____ Email: _____

How may we contact you with confidential medical information (Circle all that apply)?
HOME PHONE / WORK PHONE / MOBILE PHONE / EMAIL

Where may we leave a message with confidential medical information (Circle all that apply)?
HOME PHONE / WORK PHONE / MOBILE PHONE / EMAIL

Who else may we speak with regarding confidential medical information?
Name: _____ Relationship _____
Name: _____ Relationship _____

MARITAL STATUS (circle one) Married / Single / Divorced / Separated / Widowed / Partner

INJURY INFORMATION: Car Accident YES / NO On the job injury YES / NO

OTHER CONTACTS:
Emergency Contact:
Name: _____ Relationship: _____ Phone (_____) _____ - _____
Financial Guarantor: (Write "self" if applicable)
Name: _____ Date of Birth: _____ / _____ / _____
Address: _____
Social Security _____ - _____ - _____

INSURANCE INFORMATION:
Primary Insurance: _____ ID#: _____ Group#: _____
Policy Holder's Name: _____ DOB: ____/____/____ SS#: _____ - _____ - _____
Policy Holders Relationship to Patient: SPOUSE / PARENT / SELF / OTHER (Specify: _____)

Secondary Insurance: _____ ID#: _____ Group#: _____
Policy Holder's Name: _____ DOB: ____/____/____ SS#: _____ - _____ - _____
Policy Holders Relationship to Patient: SPOUSE / PARENT / SELF / OTHER (Specify: _____)

PREFERRED PHARMACY
Pharmacy Name: _____ Address: _____ Phone: _____

Payment is required at the time services are rendered. We wish to notify you that Dr. Mehta has ownership/interest in Preferred Imaging of Plano, Precision Imaging of Frisco, Baylor Surgicare at North Dallas, Methodist McKinney Hospital and shares the profits in part from payments made by patients who may be referred to these facilities. You are under no obligation to use these facilities

I authorize payment of medical benefits by my insurance policy to Comprehensive Orthopaedics & Rehabilitation, P.A. I understand that I am responsible for the balance on the account regardless of my insurance policy. This agreement will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as original. I hereby authorize said assignee to release all information necessary to secure payment I authorize Comprehensive Orthopaedics & Rehabilitation, P.A. and is affiliated healthcare providers to treat me.

Patients Signature: _____ **Date:** _____

1120 W. Campbell Road, Suite #109
Richardson, Texas 75080-2978
Phone: (214) 575-2663
Fax: (214) 575-2664
www.comprehensiveortho.com

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PATIENTS LAST NAME: _____ **FIRST:** _____ **AGE:**____

Primary Care Physician: _____ Who Referred you to us: _____

MAIN PROBLEM: Circle one – **RIGHT / LEFT / BOTH / Not Applicable**
List Body Are: _____

HISTORY OF PRESENT ILLNESS:

Date of Injury or Onset: _____ Car Accident: YES / NO On the job injury: YES / NO
Describe how the problem began: _____
_____

Describe the current pain/problem as specifically as possible (Character of pain – burning, aching, sharp, dull)

Timing – constant, intermittent, sudden, gradual, etc. **Associated symptoms** – numbness, spasm, swelling)
_____
_____

Please grade the severity of the pain from 1 to 10 (10 is the worst pain you have ever felt) _____
What makes the problem worse: _____
_____

What makes it better: _____
List all previous treatments: (i.e Braces, Casts, Physical Therapy, Medication, Injections, Surgery, etc)
_____
_____
List any previous treating physicians and their specialties: _____
Have you ever had this problem before (Please describe the circumstances)? _____
_____

WORK HISTORY:

Are you currently employed: YES / NO Are you Currently able to work: YES / NO / LIGHT DUTY
Job Title: _____ Employer: _____
Specific Job Duties: _____
How much work have you missed as a result of this problem? _____

Patient Signature: _____ **DATE:** _____

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PAST MEDICAL HISTORY: (list all acute and chronic medical conditions / problems)

PAST SURGICAL HISTORY: (list all surgeries and procedures, dates, and the physician who performed it)

Surgery/Procedure	Date	Physician	Surgery/Procedure	Date	Physician

ALLERGIES: (List all medication allergies and they type of reaction – i.e rash, swelling, itching, etc)

Medication	Reaction	Medication	Reaction

MEDICATIONS: (list all medication you are currently taking and dosages)

Medication	Dose	Frequency	Medication	Dose	Frequency

SOCIAL HISTORY:

Have you used tobacco products: YES / NO Type: _____ Quantity:_____
Do you consume alcohol: YES / NO Amount: _____ Frequency: _____
Have you used illegal drugs: YES / NO Type: _____ Quantity:_____
Could you be pregnant: YES / NO If No, how do you know: _____

FAMILY HISTORY: (list any medical problems that run in your family and how he/she is related to you)

REVIEW OF SYSTEMS: (Do YOU have any *OTHER* medical problems (DO NOT LEAVE BLANK, write none)

AIDS/HIV	DVT	Kidney	Psoriasis	Vascular	Other _____
Alzheimer's	Emphysema	Kidney Disease	Rash	Venous Stasis	Other _____
Anemia	Fibromyalgia	Kidney Stones	Reiter's Dz	Vision Loss	Other _____
Anxiety disorder	Gastric Sleeve	Lapband	Rheumatoid A.		Other _____
Arthritis	Genitourinary	Leukemia	Seizures		Other _____
Asthma	GERD / Reflux	Liver Disease	Sever Allergies		Other _____
Bleeding Disorder	GI	Lungs	Sickle Cell		Other _____
Blood Clots	Glaucoma	Lupus	Skin		Other _____
Bone	GOUT	Lymphangitis	Stomach Ulcer		Other _____
Breast	Head	Lymphatic	Stroke		Other _____
Bronchitis	Hearing Loss	Lymphedema	Testicular		Other _____
Cancer	Hear	Migraines	Thyroid		Other _____
Cataracts	Hematologic	Neurological	Tonsilitis		Other _____
Clotting Disorder	Hepatitis	Open Sores	Tooth Infection		Other _____
Colon	Hernia	Osteoporosis	Tuberculosis		Other _____
Colon Cancer	Hight Cholesterol	Pacemaker	Ulcers		Other _____
COPD	Hypertension	Parkinson's DZ	Urinary Infection		Other _____
Depression	Hyperthyroidism	Pregnancy	Uterine		Other _____
Diabetes	Irregular Rhythm	Prostate	Varicose Veins		Other _____

Patient Signature: _____ **Date:** _____

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HIPPA CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this form can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments an physician's certification

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ **Date:** _____

Signature: _____

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Patients Name: _____ **Date:** _____

Medication Policy

1. Our doctor must see you prior to writing any new prescription.
2. No controlled medication will be prescribed over the phone, out of state, after hours or over the weekend.
3. If you have not seen the doctor in the last 3 months and need a refill, you will need to make an appointment first.
4. Prescriptions are sent electronically so it is very important we have the correct pharmacy for you. It is your responsibility to update your pharmacy with our office prior to prescriptions being sent.
5. All medication refills require 48 hours' notice.
6. Written prescriptions are given only when necessary. We are not responsible if you lose your paper prescription and we will not write a replacement prescription.

Initials: _____

Disability Forms and Medical Records

Please note there is a $25.00 charge for completing disability forms and $10.00 for medical records. Please allow at least 48 hours for disability form requested and 2 weeks for medical records request.

Initials: _____

Physical Therapy Patients: No Show and Late Appointment Policy

Our office requires a **24 HOUR NOTICE** for cancelled appointments. If you are more than 15 minutes late, your appointment will be rescheduled. Please note there is a $25.00 "no show" fee. This charge is billed to the patient, not the insurance company.

Initial _____

_____ _____

Guarantor / Patient Signature **Date**

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NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- ❖ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- ❖ The right to inspect and copy your protected health information.
- ❖ The right to amend your protected health information.
- ❖ The right to receive an accounting of disclosures of protected health information.
- ❖ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Sacheen H. Mehta, M.D.

PRIVACY OFFICER
(214) 575-2663

Notice of Organized Health Care Arrangement
Between Hospital and Medical Staff

Methodist Richardson Regional Medical Center, Baylor Scott & White Medical Center - Plano, Baylor Surgicare of North Texas, Preferred Imaging Centers, Methodist McKinney Hospital, Texas Health Hospital, Medical City McKinney, the independent contractor members of their Medical Staff (including your physician), and other health care providers affiliated with the hospitals, imaging centers and surgery center have agreed as permitted by law to share your health information among themselves for purposes of treatment, payment, or health care operations. This enables us to better address your health care needs. This notice is being provided to you as a supplement to the Notices of Privacy Practices already given to you by the Hospitals/Surgery Center and by your health care provider.