Welcome to Amarillo Bone & Joint Clinic,

Our physician group is comprised of Drs. Keith Bjork, Brian Sims, Brad Veazey, T.M. “Toby” Risko, Joshua North, Brian Haseloff, Todd Bradshaw, and Lisa Longhofer, M.D. The mission of Amarillo Bone & Joint is the restoration of musculoskeletal functions in a caring and compassionate manner. We strive to accomplish this in the highest respect of a patient’s right to receive exceptional orthopedic care provided at the hands of skilled physicians respecting the dignity of the patient. It is our desire to accomplish this through excellent technology with our radiology and MRI services combined with excellent office staff, orthopedic physician assistants, nursing and surgical care. We pride ourselves in trying to do the right thing with kindness and mercy. We value you as our patient and we hope we meet your goals in restoring your orthopedic health needs.

Enclosed is the new patient paperwork that will need to be completed prior to your arrival at Amarillo Bone & Joint Clinic. You may also elect to complete the forms entirely online on our website, www.amarilloboneandjoint.com. This process allows you to easily complete all of the required paperwork online at your convenience. You may also print the forms from our website and complete them prior to arriving to your appointment. Please bring these forms and the following required documentation with you to your appointment:

- Bring your insurance cards.
- Bring a picture ID.
- If your insurance requires a referral, bring the referral form with you.
- If you have had X-rays, MRIs, Bone Scans, Arthrograms, etc., please bring the actual films and reports with you on your appointment date.
- If you had radiology studies at NWTHS, BSA or Open Air MRI, we can view them through our radiology system; you are not required to bring these.
- If you had radiology studies at Texas Diagnostic Imaging Center, you do not need to bring the films or reports of an MRI study, but do bring any other studies with you.

If you are unable to complete the new patient paperwork before your appointment time, it may result in further delay of your appointment and possible rescheduling of your appointment to a future date.

We appreciate your assistance in this admission process and we look forward to providing you quality orthopedic medical care. If you have any questions or concerns about your care or billing, please do not hesitate to contact our office.

Our kindest regards,

Amarillo Bone & Joint Clinic
Date: ________________________________  Age: ___________  M / F

Patient Name: _______________________________________________________________________________________________

Address: __________________________ City: __________ State: ________ ZIP: __________
Home Phone: ______________________ Mobile: __________________ Email: ________________

Social Security Number: __________________________  Date of Birth: __________________
Race: ________  Ethnicity: ____________  Primary Language: ______________________
Employer/School: ______________________  Occupation: __________________________
Employer/School Address & Phone: ______________________________________________________________________________

Marital Status: ☐ Single  ☐ Married  ☐ Widowed  ☐ Divorced

RESPONSIBLE PARTY/INSURED

Legal Name: ____________________________________________  Relationship: ______________________
Social Security Number: __________________________  Date of Birth: __________________
Employer: __________________________________________________________________________________________
Employer Address & Phone: ______________________________________________________________________________

EMERGENCY CONTACT, OTHER THAN SPOUSE (NOT IN SAME HOUSEHOLD)

Legal Name: ____________________________________________  Relationship: ______________________
Address: __________________________ City: __________ State: ________ ZIP: __________
Alternate Mailing Address: ______________________________________________________________________________
Home Phone: ______________________ Mobile: __________________
Employer: __________________________________________________________________________________________
Employer Address & Phone: ______________________________________________________________________________

INSURANCE INFORMATION

Insurance Company: __________________________________________________________________________________________
Policy Holder’s Name/Relationship: ________________________________________________________________
Policy #: __________________________  Group #: __________________________
Name as it appears on insurance card: __________________________
Secondary Insurance:
Policy Holder’s Name/Relationship: ________________________________________________________________
Policy #: __________________________  Group #: __________________________

I authorize release of any medical or other information necessary to process this claim.
I understand that services rendered today are my financial responsibility. Insurance is filed as a courtesy to you; there may be a difference between your benefits and fees.
I assign payment of medical benefits to: Keith D. Bjork, MD (Amarillo Bone & Joint Clinic, PA), J. Brian Sims, MD, PA, Brad Veazey, MD, PA, Toby Risko, MD, PA, Brian Haseloff, MD, PA, Joshua North, MD, PA, Todd Bradshaw, MD, PA, or Lisa Longhofer, MD, PA.

Signature: ____________________________________________  Relationship: ______________________

Keith Bjork, MD  J. Brian Sims, MD  T.M. “Toby” Risko, MD  Brad Veazey, MD
Brian Haseloff, MD  Joshua North, MD  Todd Bradshaw, MD  Lisa Longhofer, MD
1100 S. Coulter Dr. • Amarillo, Texas 79106 • (806) 468-9700 Office • (806) 468-9711 Fax
PATIENT HISTORY

<table>
<thead>
<tr>
<th>First: ______________________________</th>
<th>Last: ______________________________</th>
<th>Hand Dominance: ☐ Right ☐ Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height: ___________________________</td>
<td>Weight: ___________________________</td>
<td></td>
</tr>
<tr>
<td>Who referred you to our clinic? _______________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy name and address: ___________________________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of Injury: ___________________________________________  Result of: ☐ Sports ☐ On the job ☐ Auto accident

How did the injury occur? ____________________________________________________________

<table>
<thead>
<tr>
<th>Injury Location:</th>
<th>☐ Right</th>
<th>☐ Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What symptoms are you experiencing? ________________________________________________

<table>
<thead>
<tr>
<th>☐ Locking</th>
<th>☐ Grinding</th>
<th>☐ Catching</th>
<th>☐ Weakness</th>
<th>☐ Popping</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Numbness</td>
<td>☐ Stiffness</td>
<td>☐ Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you had any studies or testing for this injury?

<table>
<thead>
<tr>
<th>☐ X-ray</th>
<th>☐ MRI</th>
<th>☐ CT</th>
<th>☐ EMG/NCV</th>
<th>☐ Other</th>
<th></th>
</tr>
</thead>
</table>

Place and date of these studies: ______________________________________________________

Medical History: (Please include any medical conditions you have been treated for)

<table>
<thead>
<tr>
<th>☐ AIDS/HIV</th>
<th>☐ Cancer - Breast</th>
<th>☐ Gout</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alcoholism</td>
<td>☐ Cancer - Colon</td>
<td>☐ Heart Attack</td>
</tr>
<tr>
<td>☐ Alzheimer’s</td>
<td>☐ Cancer - Lung</td>
<td>☐ Hypertension</td>
</tr>
<tr>
<td>☐ Anemia</td>
<td>☐ Cancer - Prostate</td>
<td>☐ Hepatitis</td>
</tr>
<tr>
<td>☐ Rheumatoid Arthritis</td>
<td>☐ COPD</td>
<td>☐ Kidney Disease</td>
</tr>
<tr>
<td>☐ Asthma</td>
<td>☐ Depression</td>
<td>☐ Osteoarthritis</td>
</tr>
<tr>
<td>☐ Blood Clot Leg</td>
<td>☐ Diabetes</td>
<td>☐ Seizures</td>
</tr>
<tr>
<td>☐ Blood Clot Lung</td>
<td>☐ Drug Abuse</td>
<td>☐ Ulcers, Bleeding</td>
</tr>
<tr>
<td>☐ Stroke</td>
<td>☐ Sleep Apnea</td>
<td>☐ Blood Thinners (Plavix, aspirin, etc.)</td>
</tr>
<tr>
<td>☐ Other Disease(s)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Past Surgeries/Dates:

Family History: (If family condition exists, please write “father”, “mother”, or “sibling” after condition)

<table>
<thead>
<tr>
<th>☐ AIDS/HIV</th>
<th>☐ Diabetes</th>
<th>☐ Kidney Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Anemia</td>
<td>☐ Gout</td>
<td>☐ Liver Disease</td>
</tr>
<tr>
<td>☐ Blood Clots</td>
<td>☐ Heart Attack</td>
<td>☐ Muscle Disease</td>
</tr>
<tr>
<td>☐ Cancer</td>
<td>☐ Hemophilia</td>
<td>☐ Osteoporosis</td>
</tr>
<tr>
<td>☐ Coronary Artery Disease</td>
<td>☐ Hypertension</td>
<td>☐ Osteoarthritis</td>
</tr>
<tr>
<td>☐ Rheumatoid Arthritis</td>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

FEMALES ONLY: Could you be pregnant? ☐ Yes ☐ No
### Social History: (Please indicate use/former use of the following substances)

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Alcohol</th>
<th>Caffeine</th>
<th>Illicit Drugs</th>
<th>I DON'T USE ANY OF THESE</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ Yes</td>
<td>□ Yes</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>□ No</td>
<td>□ No</td>
<td>□ No</td>
<td>□ No</td>
<td></td>
</tr>
<tr>
<td>□ Former</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### List all current medications and dose (include non-prescription and herbal supplements)

- □ None
- □ List Attached

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### Do you have any allergies to any medications or substances?

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### Review of Systems: (Please indicate if you experience any of the following)

#### Constitutional
- □ Weight Loss/Gain
- □ Weakness
- □ Fatigue
- □ Fever

#### Cardiovascular
- □ High Blood Pressure
- □ Chest Pain
- □ Rheumatic Fever
- □ Palpitations
- □ Have Pacemaker

#### Musculoskeletal
- □ Joint Pain
- □ Arthritis
- □ Muscular Weakness
- □ Stiffness
- □ Muscular Pain

#### Endocrine
- □ Thyroid Trouble
- □ Excessive Sweating
- □ Excessive Thirst

#### Hematolymphatic
- □ Anemia
- □ Easy Bruising
- □ Easy Bleeding
- □ Swollen Glands

#### Immunologic
- □ Reactions to Drugs
- □ Skin Rashes
- □ Reactions to Foods

#### Eyes
- □ Glasses or Contacts
- □ Blurred Vision
- □ Glaucoma
- □ Cataracts
- □ Excessive Tearing

#### Respiratory
- □ Shortness of Breath
- □ Cough
- □ Wheezing
- □ Asthma
- □ Bronchitis

#### Skin
- □ Rashes
- □ Sores
- □ Lumps
- □ Dryness
- □ Itching

#### Gastrointestinal
- □ Heartburn
- □ Rectal Bleeding
- □ Abdominal Pain
- □ Gallbladder trouble
- □ Hepatitis

#### Neurologic
- □ Headache
- □ Dizziness
- □ Seizures
- □ Loss of Sensation
- □ Vertigo

#### Genitourinary
- □ Blood in Urine
- □ Urinary Infections
- □ Kidney Stones
- □ Burning Urination
- □ STDs

#### Psychiatric
- □ Nervousness
- □ Depression
- □ Mood Change

---

**CONSENT FOR TREATMENT:** To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

---

**Signature of Patient or Parent of Minor**  Date
Authorization for the Disclosure of Health Information

Patient Name __________________________ Date of Birth __________________________
Social Security # __________________________ Telephone Number __________________________
Address _____________________________________________________________
City, State, Zip ___________________________________________________________

I hereby authorize and request Amarillo Bone & Joint Clinic, LLP to □ provide to or □ receive from:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The type and amount of information to be used or disclosed is as follows:

□ Complete Medical Record □ History & Physical □ Operative Report
□ Physician’s Office Progress Notes □ Lab Reports □ Problem List
□ X-Ray Reports □ X-Ray Film(s) □ Discharge Summary
□ Photographs, Videotapes, digital or other images □ Other __________________________
with regard to __________________________ medical/hospital records for the purpose of:
________________________________________________________________________

□ Continuity of Care □ Billing and Payment of Bill □ Other (explain) __________________________

I understand that this authorization can be revoked, in writing, at any time except to the extent that disclosure made in good faith has already occurred in reliance upon this authorization. This authorization shall expire one year after the date appearing below except for payment of all claims at which time this authorization may be in force greater than one year.

This authorization is for full disclosure of all health data which may include any information related to care for my impairment(s) information about how my impairment(s) affects my ability to complete tasks and activities of daily living, information about how my impairment(s) affect my ability to work; and/or related to drug, alcohol, mental health, psychiatric conditions, and/or sexually transmitted disease, Sickle Cell anemia, including AIDS/HIV information [42 CFR part 2]. Such records will be disclosed unless you specify information that you wish to be excluded.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. If I have questions about disclosure of my health information, I can contact Amarillo Bone & Joint Clinic, LLP.

Facsimile transmission of this form will be deemed as having the same force and effect as an original. The risks associated with the use of facsimile transmission are understood.

This form (  ) was read BY me (  ) was read TO me. I have been offered the opportunity to ask questions about this form, and I fully understand its contents and meaning. All blanks were filled in before the form was signed by me.

______________________________ Date ________________________________
Patient or Authorized Representative Signature

If signed by Legal Representative, Relationship to Patient ________________________________

______________________________ Date ________________________________
Witness Signature

Interpreter’s Statement (if interpreter assisted):
I have translated the information presented orally to the patient by: (Employee’s Name) ________________________________

I have also read the Authorization for Disclosure of Health Information Form to: (Patient Name) ________________________________
in (language) __________________________________________

______________________________ Date ________________________________
Signature of Interpreter
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ________________________________, acknowledge that I have received a copy of the Amarillo Bone & Joint Clinic, LLP (AB&JC) Notice of Privacy Practices.

Patient Signature ________________________________ Date _________________

Patient Legal Representative (if applicable) ________________________________ Date _________________

Print name of Legal Representative ________________________________ Relationship to patient ________________________________

FOR AB&JC USE ONLY:

AB&JC has made the following good faith efforts to obtain the above-referenced individual’s written acknowledgement of receipt 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.)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Name of Office Representative: ________________________________

Date Placed in Patient Chart: ________________________________
FINANCIAL RESPONSIBILITIES

How the Payment Process works at Amarillo Bone and Joint Clinic

INSURANCE: The doctor’s service is provided directly to you and you are responsible for payment of services rendered. As a courtesy, we will submit your claim to the insurance company you have provided us.

Your co-pay amount is due at the time of service. Services not covered by insurance, including deductibles and co-insurance amounts, are also due at the time of service. Surgery deposits are required on all non-emergent procedures. Our deposits are based on estimates and patient responsibility may vary depending on the actual surgery/procedure and what your insurance pays.

If claims for services provided by ABJC Clinic are denied by your insurance company, you are responsible for payment. Responsibility for payment begins on the date that services are provided.

Workers’ Compensation: If your claim has been accepted and services approved, your claim will be handled directly with your Workers’ Comp carrier and no charges will be incurred by you. Your recovery and return to work takes a partnership with you, your case manager and us. If your claim is denied, charges will be your responsibility.

Balance: If you have a balance remaining after your insurance carrier has paid, and for our patients without insurance, we offer the following options:

- Payments are accepted by cash, check or most credit cards.
- Short Term Payment Plans: may be available on balances and will not exceed three months.
- Extended Payment Plans: may be available upon application acceptance through Care Credit.
- Financial Constraints: Patients who have other financial considerations should speak with our financial counselor for assistance. Our goal is to ensure that everyone in need receive appropriate care. Please call 806-468-9700 ext. 2005 if you have any questions.

Accounts with a remaining balance where no resolution has been made in a timely fashion may be turned over to a collection agency.

I understand that I am financially responsible for payment of medical charges incurred on by behalf as outlined above.

_________________________  _________________________
Signature                                      Date

1100 S. Coulter  Amarillo, Texas 79106
Phone 806-468-9700   Fax 806-468-9700