



Welcome to Amarillo Bone & Joint Clinic,

Our physician group is comprised of Drs. Brian Sims, Brad Veazey, T.M. “Toby” Risko, Joshua North, Todd Bradshaw, and Creed Paris. 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

PATIENT HISTORY

First: _____ Last: _____ Hand Dominance: Right Left

Height: _____ Weight: _____ Primary Care Physician:

Who referred you to our clinic? _____

Do you see any other medical specialists (i.e., cardiologist, etc.)? If yes, please list: _____

Pharmacy name and address: _____

Date of Injury: _____ **How did the injury occur?** _____

Where did the injury occur? _____

Injury result of: Sports Auto Accident *On the Job **If on the job, is it Workers' Comp?** Yes No

Signature: _____
 Right Left

Injury Location:

- Shoulder Elbow Hand Hip Knee Foot
- Arm Wrist Finger Leg Ankle Toe

What symptoms are you experiencing?

- Locking Grinding Catching Weakness Popping
- Numbness Stiffness Other _____

Pain Level (0-10; 10 being severe pain): _____

What increases your pain? _____

Have you ever had Physical Therapy for this issue? Y/N

Have you had Chiropractic Treatment? Y/N

Have you had any studies or testing for this injury?

- X-ray MRI CT EMG/NCV Other _____

Place and date of these studies: _____

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

- AIDS/HIV Cancer - Breast Gout
- Alcoholism Cancer - Colon Heart Attack
- Alzheimer's Cancer - Lung Hypertension
- Anemia Cancer - Prostate Hepatitis
- Rheumatoid Arthritis COPD Kidney Disease
- Asthma Depression Osteoarthritis
- Blood Clot Leg Diabetes Seizures
- Blood Clot Lung Drug Abuse Ulcers, Bleeding
- Stroke Sleep Apnea Blood Thinners (Plavix, aspirin, etc.)
- Osteogenesis Imperfecta
- Other Disease(s) _____

Past Surgeries/Dates: _____

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

- AIDS/HIV Diabetes Kidney Disease
- Anemia Gout Liver Disease
- Blood Clots Heart Attack Muscle Disease
- Cancer Hemophilia Osteoporosis
- Coronary Artery Disease Hypertension Osteoarthritis
- Rheumatoid Arthritis Other _____

FEMALES ONLY: Could you be pregnant? Yes No

Social History: (Please indicate use/former use of the following substances)

Tobacco

- Yes
- No
- Former

Alcohol

- Yes
- No

Caffeine

- Yes
- No

Illicit Drugs

- Yes
- No

I DON'T USE

ANY OF THESE

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

None

List Attached

Do you have any allergies to any medications or substances?

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

Constitutional

- Weight Loss/Gain
- Weakness
- Fatigue
- Fever

Eyes

- Glasses or Contacts
- Blurred Vision
- Glaucoma
- Cataracts
- Excessive Tearing

Ear/Nose/Mouth/Throat

- Ears Ringing
- Earaches
- Hearing Aid
- Frequent Colds
- Nasal Discharge
- Hay Fever
- Nosebleeds
- Dentures
- Bleeding gums
- Frequent Sore Throats

Cardiovascular

- High Blood Pressure
- Chest Pain
- Rheumatic Fever
- Palpitations
- Have Pacemaker

Respiratory

- Shortness of Breath
- Cough
- Wheezing
- Asthma
- Bronchitis

Gastrointestinal

- Heartburn
- Rectal Bleeding
- Abdominal Pain
- Gallbladder trouble
- Hepatitis

Genitourinary

- Blood in Urine
- Urinary Infections
- Kidney Stones
- Burning Urination
- STDs

Musculoskeletal

- Joint Pain
- Arthritis
- Muscular Weakness
- Stiffness
- Muscular Pain

Skin

- Rashes
- Sores
- Lumps
- Dryness
- Itching

Neurologic

- Headache
- Dizziness
- Seizures
- Loss of Sensation
- Vertigo

Psychiatric

- Nervousness
- Depression
- Mood Change

Endocrine

- Thyroid Trouble
- Excessive Sweating
- Excessive Thirst

Hematolymphatic

- Anemia
- Easy Bruising
- Easy Bleeding
- Swollen Glands

Immunologic

- Reactions to Drugs
- Skin Rashes
- Reactions to Foods

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



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

Legal Name: _____ Relationship to Patient: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Employer Name & Phone: _____

EMERGENCY CONTACT

Legal Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile: _____

FAMILY ACCOUNTS

Do you have other family members in your household being treated at ABJC? Yes No

Name and Birthdate(s): _____

INSURANCE INFORMATION

Insurance Company: _____

Policy Holder's Name/Relationship: _____ Date of Birth: _____

Policy #: _____ Group #: _____

Name as it appears on insurance card: _____

Secondary Insurance: _____

Policy Holder's Name/Relationship: _____ Date of Birth: _____

Policy #: _____ Group #: _____

Name as it appears on insurance card: _____

I authorize release of any medical or other information necessary to process this claim, including the appeal of claims for payment on my behalf.

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: Amarillo Bone & Joint Clinic, J. Brian Sims, MD, PA, Brad Veazey, MD, PA, Toby Risko, MD, PA, Joshua North, MD, PA, Todd Bradshaw, MD, PA, and/or Creed Paris, MD, PA.

Signature: _____ Relationship: _____



RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Please list the names of any family members, friends or any other person that we may release information to, such as: general medical condition including treatment, prescriptions to be picked up at our office if you were unable to come by, medical records, school notes, etc. Please note: for children under the age of 18- to the parent filling out patient paperwork, please list the second parent on this form if they will need access to the patient's information.

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Signature: _____

Date: _____

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

We are committed to providing you excellent care. Since payment of your bill is part of your treatment, we want to be sure that our financial policies are clearly understood.

Payment is due at the time of service. Services not covered by insurance, including surgical assistants, deductibles, and co-insurance amounts, are due at the time of service. As a courtesy, we will submit your claim to your insurance company. 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. Payment of your account is your responsibility regardless of your insurance coverage. Your insurance is a contract between yourself and the insurance carrier. We are not a party to that contract. We do our best to verify your insurance coverage and benefits at the time of your visit, but it is your responsibility to check with your insurance provider to know what they cover and what providers are in your network.

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. Notification of any change in your insurance status must be provided to the office forty-eight (48) hours in advance of next visit, or payment in full will be required.

Surgery: Amarillo Bone & Joint Clinic strives to give you the most accurate surgery estimate based off the surgeon's anticipated procedure codes, your insurance benefits, and your insurance allowable. At times, due to findings during surgery, these procedure codes could change. These modifications could result in an additional balance. Final determination will be made by your insurance company.

Assistant Surgeon: To give you the level of care needed; your surgeon deems it necessary to have an Assistant Surgeon during your surgery. Insurance companies cover some of these charges, however some are deemed as non-covered services under your policy. If your insurance company denies the Assistant Surgeon charges, you will be responsible for the balance at a courtesy reduced rate.

Liability of Auto Accident Claims: We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the necessary information to be reimbursed. You may contact the Billing Department for an itemization of your statement.

Workers' Compensation: We do not participate in Workers' Compensation and are unable to file claims on your behalf. We do not see patients for any work-related injuries.

Refunds: Refunds will be assessed once all claims have processed on your account, and after you have been released from treatment from both the surgeon and Physical Therapy, if you are having physical therapy at ABJC.

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

- Extended Payment Plans: may be available upon application acceptance through Care Credit.
- Short Term Payment Plans: may be available on balances and cannot exceed three months.

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.

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 my behalf as outlined above.

Signature

Date