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

1100 S. Coulter • Amarillo, Texas 79106
806-468-9700 • Fax: 806-468-9771 • 1-800-668-9645
www.amarilloboneandjoint.com

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

Past Surgies/Dates: ____

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

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

FEMALES ONLY: Could you be pregnant? ☐ Yes ☐ No

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

Tobacco	Alcohol	Caffeine	Illicit Drugs	☐ I DON'T USE ANY OF THESE
☐ Yes	☐ Yes	☐ Yes	☐ Yes	
☐ No	☐ No	☐ No	☐ No	
☐ Former				

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: ________________

Authorization for the Disclosure of Health Information

Patient Name:____ Date of Birth: ___________________
Social Security Number: ______________________________ Telephone Number: _________________________________
Address: ____ City, State: ______________________ Zip: _____________

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

____
____

Specify date(s) of Encounter(s)/Hospitalization(s):

____
____
____

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

_____ Complete Medical Record
_____ Physician's Office Progress Notes
_____ Photographs, Videotapes, Digital or other images
_____ History & Physical
_____ X-Ray Film(s)
_____ Operative Report
_____ Problem List Discharge Summary
_____ Other: ___________________________

with regard to ____ medical/hospital records for the purpose of:
(Patient Name)

☐ 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 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.

____ ______________________
Patient or Authorized Representative Signature Date

If signed by Legal Representative, Relationship to Patient ---

____ ______________________
Witness Signature Date

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) ______________________________

____
Signature of Interpreter 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

E-mail Form Print Form