Orthopedic & Sports Medicine Institute of New Braunfels

MEDICAL SCREENING QUESTIONNAIRE

Name: _____ **DOB:** _____

Date: _____

Do you have any medication allergies? _____

Other allergies- latex, eggs? _____

Please list all current medications: _____

_____

What Pharmacy do you prefer to use? _____

PAST MEDICAL HISTORY – Please circle any that you have (or had in the past)

Irregular Heartbeat	COPD	Congestive Heart Failure	Heart Disease (coronary artery disease)	
High Cholesterol	Heart Attack	High Blood Pressure	Valvular Heart Disease	
Asthma	Sleep Apnea	Pulmonary Embolus (blood clot in the lung)		Stroke
Cirrhosis	Chron's Disease	Ulcerative Colitis	Stomach Ulcers	Eczema
Renal Failure	Recurrent UTI	Kidney Stones	Fractures	ADD/ADHD
Fibromyalgia	Rhuematoid Arthritis	Osteo Arthritis	Congenetial Hip	HIV
Anemia	Sickle Cell Anemia	Lymphoma or Myeloma	Allergies (seasonal)	Lupus
Thyroid Disease	Osteoporosis	Spinal Disc Disease	Alzheimer's	BPH
Chronic Headaches	Parkinson's	Diabetes requiring Insulin	Diabetes NOT requiring Insulin	
Cancer: _____		Drug Use: _____	Smoker: Y N	Pregnant: Y N

PAST SURGICAL HISTORY:

_____

_____

CURRENT SYMPTOMS - ***Please mark on the picture to the right where you feel pain***

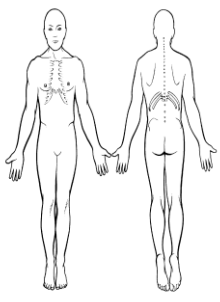
What are your current symptoms and when did they begin?

_____

Have you received treatment for this condition, if so what?

_____

Is this a new or a chronic problem? _____



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NEW PATIENT INFORMATION

Patient Name: _____ **Social Security #:** _____

Address: _____ **City:** _____ **State**_____ **Zip**:_____

Home Telephone Number: _____ **Cell Phone Number:** _____

Date of Birth: _____ **Age**: _____ **Sex:** _____ **Marital Status:** _____

Race: _____ **Ethnicity:** _____ **I decline to disclose this information** _____

Employer: _____ **Work Phone Number:** _____

Employers Address: _____ **City:** _____ **State:** ____ **Zip:**_____

Emergency Contact (outside the home if possible): _____

Relationship to Patient: _____ **Phone Number**: _____

Referring Physician: _____ **Primary Care Physician:** _____

Onset Date (injury, accident, surgery date or recent date symptoms started) _____

GUARANTOR INFORMATION **(Fill out only in the case that Guarantor and Patient are not the same)**

Guarantor Name: _____ **Social Security #** _____

Address: _____ **City:** _____ **State:** _____ **Zip**:_____

Home Telephone Number: _____ **Cell Phone Number:** _____

Date of Birth: _____ **Patient Relationship**: _____

Employer: _____ **Work Phone Number**: _____

Address: _____ **City:** _____ **State:** _____ **Zip**: _____

Billing Information (Please present Insurance Card)

Workers Comp ☐ Auto Accident ☐ Medicare ☐ Group Health ☐ Tricare ☐ Other ☐

OSI
652 N. Houston Ave., #2 New Braunfels, TX 78130
Phone (830)625-0009 Fax (830)624-7505
David B Templin, MD Michael S Vrana, MD

ASSIGNMENT OF BENEFITS:
I hereby assign payment of medical insurance benefits to DAVID B. TEMPLIN, M.D.P.A, MICHAEL S VRANA, M.D. for all services rendered. I understand that I am financially responsible for all charges whether or not payment is made by said insurance company. I understand that I am responsible for all in-network and out-of-network benefits and I am responsible to inquire with my insurance company to know all my benefits prior to my appointment with the doctor. **A $10 late fee will be assessed monthly on delinquent accounts.***A photocopy of this agreement is to be considered as valid as the original

RELEASE OF MEDICAL INFORMATION:
I consent to the release of any medical information necessary to process this claim.*A photocopy of this agreement is to be considered as valid as the original.

PAPERWORK:
Due to the increasing amount of paperwork as of January 1, 2007 there will be a charge of **$10.00 per page** to fill out any disability forms, insurance forms and anything the doctor needs to dictate that does not pertain to workers' compensation. This fee also applies to disability forms for off work due to work related injuries. Please allow **48 to 72 hours** for the forms to be completed. Payment will be expected when you pick up your forms. There will also be a charge for phone consultations with the doctor. Please remember to go over any concerns you may have while you are you appointment.

I have read and understand the policies outlined above.

SIGNED: _____ DATE: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, [Patient->Full Name], understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of *Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:_____

I wish the following individual(s) to have access to my medical information: _____

I fully understand and accept the terms of this consent.

_____ _____
Signature **Date**

Orthopedic & Sports Medicine Institute of New Braunfels

CONSENT TO TREATMENT

1. I have presented myself to this facility for treatment and consent to diagnostic procedures and care provided by my attending provider.
2. I realize I have the right to refuse any drugs, treatments or procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.
3. I understand that if I miss three consecutive appointments that I am subject to discharge. Once I have been discharged, I understand that I will need a new referral for any further care and will be receiving a new evaluation. This is in compliance with the Texas State Law.
4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service and **FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE** for any services not covered by this authorization. **WORKERS COMPENSATION** I hereby authorize my provider to receive my records related to my work injury.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

Signature of Patient (or Parent if patient is a minor –under 18) **Date**

Witness (Authorized signature of facility employee) **Date**

WORKERS COMP

WORKERS COMP or AUTO ACCIDENT ONLY: Claim #_____

If you want us to bill for Workers Comp or an auto accident, we will do so, but we ask that you present us with your private health insurance information as backup.

I do not wish to provide a copy of my private health insurance card.

I realize that if my workers comp or auto benefits should be denied or exhausted that I would be responsible for any charges incurred.

Please sign if you do **NOT** wish to present your private health insurance: _____

Date: _____

Orthopedic & Sports Medicine Institute of New Braunfels

Notice to Patients

Accident Injury Claims-Motor Vehicle Accidents

[Patient->Full Name]

Office Policy

The offices of Dr. David B. Templin, Dr. Michael S. Vrana, and OSINB are <u>not</u> providers for claims regarding accidental injuries as a result of motor vehicle accidents. If you are the victim of a motor vehicle accident and your injury is in any way a result of that accident, please take this form to the front desk so that we may remove your appointment from the scheduling database.

By signing this document you are attesting that your injuries are <u>not</u> related to a motor vehicle accident.

Patient Signature; **[Default->Today's Date]**

Statement of fact

I, the above signed patient attest to a statement of fact regarding my injury. I acknowledge that knowingly or willfully falsifying medical information will result in an immediate collection based upon the care provided. In addition, I will be personally responsible for the debt incurred during my visit and agree to pay a 200.00 $ additional processing fee per visit during which the false or misleading information was provided.