PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand **ORTHOPEDIC AND SPORTS MEDICINE INSTITUTE OF NEW BRAUNFELS** ("OSINB, PA") is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize OSINB, PA or his/her designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

Please DISCLOSE the above information to:

Emergency Contact:____________________________ Telephone:________________
Address:____

Name/Entity:__________________________________ Telephone:________________
Address:____

Name/Entity:__________________________________ Telephone:________________
Address:____

1. Description of the information to be used or disclosed (check as appropriate):

☐ **a. MY ENTIRE RECORD, ALL DEMOGRAPHIC INFORMATION AND ALL PROFESSIONAL SERVICES AT OSINB, PA.**

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply)**:

- ☐ Alcohol and Drug Abuse Treatment*
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment
- ☐ Genetic Information (including, but not limited to, Genetic Test Results).

(<u>NOTE</u>: If you checked "my entire record," please skip to number 2. Otherwise, please continue with b. and c. below.)

☐ **b. OR SPECIFIC CONDITION __________________________________.**

I ☐ do ☐ do not authorize this information to be disclosed electronically.

1. **Purpose(s) for disclosure of the information:**

____

____

(NOTE: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure.")

2. **Right to revocation**. I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, OSINB,PA must receive the revocation in writing, and the revocation must include:

   a. My name and address,
   b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
   c. My desire to revoke this authorization, and
   d. The date of the revocation, and my signature.

   OSINB,PA will accept written revocations of this authorization via:

   ☐ Certified U.S. mail

   ALL revocations must be sent to Magan Woodruff, and are not effective until received by him/her.

3. **This authorization shall expire on _____________.** After this date/event, OSINB, PA can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

4. I fully understand and accept the terms of this authorization.

______________________________ ______________________________

Signature of Patient or Patient's Representative **Date**

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Name of Patient

______________________________ ______________________________

Name of Representative (if applicable) **Description of Representative's authority to act for patient**

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*CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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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)

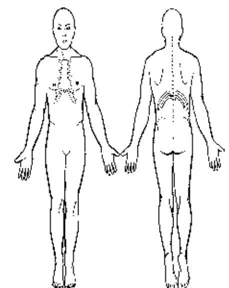
Irregular Heartbeat	COPD	Congestive Heart Failure	Heart Disease (coronary artery disease)	
High Cholesterol	Heart Attack	High Blood Pressure	Valvular Heart Disease	
Asthma	Sleep Apnea	Pulmonary Embolus (blood clot in the lung)		Stroke
Cirrhosis	Crohn's Disease	Ulcerative Colitis	Stomach Ulcers	Eczema
Renal Failure	Recurrent UTI	Kidney Stones	Fractures	ADD/ADHD
Fibromyalgia	Rheumatoid Arthritis	Osteo Arthritis	Congenital 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:** ________________ **St:**______**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) _____________________________

POLICY HOLDER

Patient Name: SELF OR ____________________________________**Social Security #:**____________________

Address: ____**City:** _________ **St:**_________**Zip:**___________

Home Telephone Number: ______________________**Cell Phone Number:** _____________________________

Date of Birth: ____________**Age:** __________**Sex:** __________ **Marital Status:** ____________________

IF PATIENT IS UNDER 18, GUARANTOR INFORMATION

Guarantor Name: __________________ **Social Security # :** ___-__-____

Address:_____________________ **City:** _________________ **State:**___________ **Zip:**____________

Home Telephone Number: ________________ **Cell Phone Number:** _________________

Date of Birth: ___________ **Patient Relationship:**_____________

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.**

ASSIGNMENT OF BENEFITS:
I hereby assign payment of medical insurance benefits to DAVID B. TEMPLIN, M.D.P.A, MICHAEL S VRANA, M.D., TRENT J. TWITERO, M.D., IAN RATHEAL, 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

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 at your appointment.

I have read and understand the policies outlined above.

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

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Witness (Authorized signature of facility employee) Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name:______________________________

Date of Birth:______________________________

I acknowledge that OSINB,PA provided me with a written copy of its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

______________________ ______________________

Patient Signature Date

______________________ ______________________

Personal Representative Signature (if applicable) Relationship to Patient

****WORKERS COMPENSATION****

If you want us to bill for Workers Comp within the Alliance network please provide claim information below. If we are not in network you will be a self pay patient and a deposit may be required.

Claim #______________________________
Adjuster______________________________
Adjuster Phone Number______________________________
Date of Injury______________________________

<u>Notice to Patients</u>

Accident Injury Claims-Motor Vehicle Accidents

Patient Name :______________________

Office Policy

The offices of Dr. David B. Templin, Dr. Michael S. Vrana, Dr. Trent J. Twitero, M.D., Dr. Ian Ratheal, and OSINB,PA are <u>not</u> providers for claims regarding accidental injuries as a result of motor vehicle accidents, workers compensation, or third party liability claims.

Is your appointment a result of:

Motor Vehicle Accident? YES NO

Worker Related Injury? YES NO

Third Party Liability Claim YES NO

Are you filing a Litigation Claim YES NO

By signing this document you are attesting that your injuries are <u>not</u> related to a motor vehicle accident, work related, third party, or litigation. OSINB, PA will not file to your health insurance and you will be a self pay patient if your injuries are the responsibility of a third party. A deposit may be required to be seen and payment is due at the time of service. We do not negotiate or contact third party for payment. Any claims filed and recouped by your insurance carrier will be patient responsibility.

Patient Signature; 1/11/2023

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.

PATIENT PORTAL CONSENT FORM

Access to this secure Patient Portal is an optional service, and may be suspended or terminated at any time and for any reason. I understand that my access to this Portal will not affect the current level of care I'm already receiving from OSI. I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the patient portal and agree that I understand the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from OSI should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I understand that this agreement will remain in effect unless otherwise modified by myself or OSI. It is my responsibility to notify OSI if there is a change in my email account or I feel that my secure password has been breached. I agree not to hold OSI or any of its staff liable for network infractions beyond its control.

Please print all information clearly.

Full Name ____**Date of Birth**__________________

Confidential e-mail address____

Signature____**Date**_________________________

Patient Portal website is http://osinb.com/patient-portal. Our clinic's main website is www.osinb.com. More general information about our clinic and medical links/ information are located there. Upon signing this document, your signature on this form is your agreement to the Policy and Procedure for our Patient Portal.

Orthopedic Sports Medicine Institute of New Braunfels

960 Gruene Rd., Ste 101 New Braunfels, TX 78130

Tel: 830-625-0009 Fax: 830-624-7505

PATIENT PORTAL POLICY AND PROCEDURES

OSI provides this site in partnership with e-MDs for the exclusive use of its established patients. The patient portal is designed to enhance patient - physician communications. All users must be established by a previous office visit. We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information. OSI maintains the information on the patient portal, at its current physical facility- 960 Gruene Rd., Ste 101, New Braunfels, TX. 78130.

Policies and Limitations:

The patient portal is provided as a courtesy to our valued patients. We are focused on providing the highest level of service and health care. However, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal. Also the following polices and limitations apply:

1. **Do not use portal communication if there is an emergency, please dial 911 or go to the Emergency Room**.
2. No Internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and sees a provider.
3. Sensitive subject matter (HIV, mental health, work excuses, etc.) is not permitted.
4. No request for narcotic pain medication will be accepted through the portal.
5. No request for refill medication not currently being treated by our providers.
6. After you agree to the Policy and Procedures and sign the Consent Form, we will attempt to send a "welcome message" email to you. This will provide a link to the Portal login screen. *If you have not received an email form us within 3 working days, please CALL the office. We will not respond directly to your email. All electronic communications must be through the Patient Portal.
7. We will normally respond to non-urgent email inquiries within 24hrs but no later than 3 business days after receipt. * If you have not received an email from us within 3 working days, please CALL the office.

Guidelines and Security

OSI offers secure viewing and communication as a service to our patients who wish to view parts of their records and communicate with our staff. The patient portal is provided in partnership with e-MDs on HIPAA compliant VPN with high-level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. All new and established patients have signed HIPAA agreement form and have HIPAA agreement form or need to reacquaint with our HIPAA policy, a copy can be provided to you for your review. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. By signing our Consent Form, you accept the risks and agree to the conditions of participation. Once this form is agreed to and signed, we will send you an email notification that tells you how to log in for the first time. Please keep this email in a safe place for future reference. Following the instructions on the email, you should be able to login using the user name and password provided. Once logged into the portal, you should go to "My Account" on the top right of the page. Here you can change your user name and password to something only you will know. *This is essential to make sure your information remains secure and private.*

Protecting Your Private Health Information and Risks

While we try and ensure that all communication through the portal is secure, keeping it secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure the two factors are present. We need you to make sure we have your correct email address and you MUST inform us if it ever changes. If you think someone has learned your password, you should promptly go to the Patient Portal and change it. If you forgot your password please use the "forgot password" option on the portal or call our office. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information, including your email addresses.