SOUTHWEST ORTHOPEDIC ASSOCIATES

Joseph Daniels, D.O. Gregory Todd Moore, D.O.

Today's Date: _____ **Physician to be seen:** _____

Last Name: _____ First Name: _____

DOB: _____/_____/_____ Age: _____ Gender: Male Female (Circle one)

Home #: _____ Cell/Work (specify)#: _____

Home Address:_____ City:_____ State:_____ Zip:_____

Circle One: Race: SSN#: _____

Asian, African American, Hispanic, Indian, Latino, White, Other: (Specify)_____ Ethnicity: Hispanic or Latino, Non Hispanic or Latino Refuse to Report (Circle one)

Marital Status: Married, Divorced, Widowed, Single

Emergency Contact:_____ Relationship to Patient:_____

Home #: _____ Cell/Work (specify)#: _____

Primary Care Physician:_____ Referring Physician:_____

Preferred Pharmacy:_____ Pharmacy Phone #: _____

Is this a work related injury? Y ☐ N ☐ Complete Below:

Workers Compensation Information (If Applicable, fill out completely)

Date of Injury: _____

Adjustor Name: _____ Ph#: _____

Employer Contact Name: _____ Ph#: _____

Claim #: _____ Employer Address: _____

Insurance Information

Primary Insurance Carrier: _____ Name on policy: _____

Policy Holder's SSN: _____ Your Relationship to Insured: _____

Policy Holder's Employer: _____ Policy Holder's DOB: _____

Member ID#: _____ Group#: _____

Secondary Insurance Carrier: _____ Name on policy: _____

Policy Holder's SSN: _____ Your Relationship to Insured: _____

Policy Holder's Employer: _____ Policy Holder's DOB: _____

Member ID#: _____ Group#: _____

With my signature below, I hereby acknowledge and authorize the following:

- **Consent for treatment, administration of medications and performance of any procedures that may be considered necessary or advisable.**

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient (or guardian) Signature: _____Date: _____

PLEASE FILL OUT COMPLETELY

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Patient Name: _____ Date of Birth: _____

Please list any known allergies and type of reaction: ☐ No known Allergies

_____

_____

Are you allergic to Latex: Y ☐ N ☐

List of Medication and Dosage: **☐See list provided by patient**

_____

_____

_____

_____

Have you had any past problems with anesthesia? Y ☐ N ☐

If yes please explain:

_____

Height: _____ Weight: _____

Chief Complaint

Reason for your visit today: _____

Symptoms:_____

Date of Injury or when symptoms started: _____

Describe how the injury or problem occurred:_____

What treatments have you already tried?:_____

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient (or guardian) Signature: _____Date: _____

PLEASE FILL OUT COMPLETELY

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Acknowledgement and Acceptance of Privacy Notice and Practices (HIPAA)

I acknowledge I have been given an opportunity to read the offices' Privacy Practices. I give my consent to release personal information for the purposes of treatment, referrals, and payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

I also understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person(s) permitted to receive my medical records other than listed in the above paragraph:

- ☐ No restrictions- may release information if requested to anyone
- ☐ Restrictions: list who we may release information to regarding your healthcare

_____

_____

I wish to be contacted in the following manner (Check all that applies):

Home ph#: _____ Cell#: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Work ph #: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Patient (or guardian) Signature: _____ Date: _____

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Office policies

Welcome to Southwest Orthopedic Associates. We realize you have a choice for your medical care and we are pleased you have chosen us to provide your care. Please be advised that our offices house four physicians, an ambulatory surgery center and a physical therapy center. Due to services being rendered in three separate areas, the wait times vary based on the number of patients being treated in that particular area. Please do not be alarmed if someone who comes in after you is called back before you as they may be being seen in a different area. As long as you sign in, our receptionist will process your paperwork and get you in an exam room as quickly as possible. It is very important that you notify our receptionist of any address changes, phone number changes, or change in insurance **before** you are seen.

Prescription Request

Please contact your pharmacy to request medication refills. Your pharmacy will notify our office of your refill request. We require 24 hours for refill request. Please be aware that refills received on Fridays or holidays may not be authorized until the next business day. (NOTE: Physicians do not refill narcotic prescriptions without being seen in the office.)

Clinical Questions

Please be aware if you call our office with a clinical question, our physicians and nursing staff are in clinic during the day and cannot be called away from patients to speak to you. Our receptionist will get your message to our clinical staff and they will return your call as soon as possible. (NOTE: if you have recently had surgery, please notify our receptionist of any problem you are experiencing and she will immediately notify a member of our clinical staff.)

Accepted Payments

All payments are required at the time services are rendered. All major credit and debit cards are accepted. Personal checks accepted for amounts of $150 or less.

Patient Forms

Please be aware that we charge $30.00 to complete the following paperwork:
Insurance Forms
AFLAC
FMLA
Disability
We require 7-10 business days to complete any paperwork given.

I have read and fully understand the above information.

Patient (or guardian) Signature: _____ Date: _____

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Privacy Notice & Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Please let the front desk know if you would like a copy of this document.

If you have any questions or complaints, please contact:
Office Coordinator 6311 Southwest Blvd. Fort Worth, TX 76132 (817) 731-9400

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