ALL-STAR ORTHOPAEDICS

New Patient Information

Legal Name: _____ _____ _____ _____
Last First Middle Preferred Name

Home Address: _____ _____ _____
Street Apt # City / ST / Zip

Phone(s): Home: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____ Age: _____

Gender: _____ Marital Status: _____ SS#: _____ DL#: _____

Race: _____ Ethnicity: _____ Language: _____

How did you hear about our practice? _____

Primary Care Doctor: _____ Doctor's Phone #: _____

Primary Insurance Information

Name of Primary Policy Holder: _____
as it appears on insurance card

Relationship to Patient: _____

Gender: _____ Date of Birth: _____ SS #: _____

Insurance Company: _____ Insurance Phone #: _____

Policy/ID #: _____ Group #: _____

Insurance Claims Address: _____
Complete Address (Usually on the back of the card)

Secondary Insurance Information

Name of Primary Policy Holder: _____
as it appears on insurance card

Relationship to Patient: _____

Gender: _____ Date of Birth: _____ SS #: _____

Insurance Company: _____ Insurance Phone #: _____

Policy/ID #: _____ Group #: _____

Insurance Claims Address: _____
Complete Address (Usually on the back of the card)

Emergency Contact / Legal Guardian

Name: _____ Phone: _____ Relationship to Patient: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize Las Colinas Orthopedic Surgery and Sports Medicine to release to my insurance company any information acquired in the course of my care and to permit payment directly to Las Colinas Orthopedic Surgery and Sports Medicine dba All-Star Orthopaedics and Sports Medicine for responsibility for any balance remaining after the payment of correct benefits.

_____ _____
Signature of Patient or Legal Guardian Date

Patient Name:_____ Date of Birth: _____ Date of Visit:_____

ALL-STAR ORTHOPAEDICS

Notice of Privacy 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.

Updated November 2013

This Notice of Privacy Practices describes how our practice may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, which will identify its effective date, in our offices and on our website at http://www.allstarortho.com.

Note that we are required to notify you of certain unauthorized access, acquisition or use of your medical information.

1. Uses and Disclosures of Protected Health Information For Which No Patient Authorization Is Required

Treatment: We will use and disclose your protected health information to provide, coordinate, and manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We may also disclose protected health information to other physicians who may be treating you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate the name of your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Patient Name:_____ Date of Birth: _____ Date of Visit:_____

ALL-STAR ORTHOPAEDICS

Notice of Privacy Practices (cont.)

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or our practice has taken an action in reliance on the use or disclosure indicated in the authorization. Examples of uses and disclosures which require authorization include uses or disclosures (i) of psychotherapy notes except in certain circumstances, (ii) for certain marketing purposes, and (iii) in the case of the sale of your PHI to a third party.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Patient Name:_____ Date of Birth: _____ Date of Visit:_____

ALL-STAR ORTHOPAEDICS

Notice of Privacy Practices (cont.)

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and under certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. Examples of these law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, and (3) pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy and Security Rules.

Electronic Disclosure: Please note that Texas law requires that we provide you with notice that your medical information may be subject to electronic disclosure. That is, we may use and disclose your medical information electronically. For example, if your medical information is contained electronically in an electronic medical record with our offices, and another provider who is involved in your treatment requests a copy of your medical records, we may forward such records electronically.

Patient Name:_____ Date of Birth: _____ Date of Visit:_____

ALL-STAR ORTHOPAEDICS

Notice of Privacy Practices (cont.)

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. You have the right to inspect and copy health information that may be used to make decisions about your care. We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We do not have to agree to any restrictions except in situations where you request that we restrict disclosure of your medical information to a health plan and the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law to be disclosed and the medical information solely pertains to an item or service you, or another individual on your behalf, has paid us in full.

If we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.

You may have the right to have your protected health information amended. This means you may request an amendment of protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

ALL-STAR ORTHOPAEDICS

Notice of Privacy Practices (cont.)

3. Complaints/Concerns/Questions

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Officer at 972-556-2885. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the U.S. Department of Health & Human Services.

To file a complaint with our practice, contact our Privacy Officer at:

400 W LBJ Freeway, Suite 330
Irving, TX 75063

To file a complaint with the Secretary of the DHHS contact the:

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

All complaints must be submitted in writing. You will not be penalized for filing a complaint. A complaint must name the entity/person(s) that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable standards, requirements, or implementation specifications stated by HIPAA, as outlined in this Notice. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary of the Department of Health & Human Services for good cause shown. We will not retaliate against you for filing a complaint.

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

ALL-STAR ORTHOPAEDICS

Acknowledgement of Notice of Privacy Practices

I, _____, acknowledge and agree that I have reviewed and/or received a copy of **All-Star Orthopaedics and Sports Medicine's Notice of Privacy Practices updated November 2013**.

_____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Signature of Patient's Legal Representative (if applicable) | Date

_____ _____

Print Name of Legal Representative | Relation to Patient

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

ALL-STAR ORTHOPAEDICS

General Consent for Treatment

I, knowing that I have a condition requiring diagnostic, medical, surgical and or non surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical and or non surgical or other services under the general and specific instruction of **Mark S. Greenberg, M.D.** and/or **Thomas M. Schott, M.D.** and/or **Bing S. Tsay, M.D.** and/or **Stephen J. Timon, M.D.** and/or **Michael K. Hahn, M.D.** and/or **Kevin M. Honig, M.D.** and/or **W. Grear Hurt, M.D.** and/or **Brian E. Straus, M.D.** and/or any other licensed healthcare service provider, his/her assistants and/or his/her designee as is necessary in his/her judgment and employed by All-Star Orthopaedics and Sports Medicine.

I also acknowledge that no guarantees have been made to me as to the results of the treatments or examination and that this possible risks, benefits and complications of the said procedure have been discussed with me by the service provider.

ALL-STAR ORTHOPAEDICS

Prescription Refill Policy

Please sign below to indicate that you have read and that understand our policy on obtaining prescription refills.

Prescriptions will only be written and refilled from Monday through Friday during the hours of 8:30 am to 4:00 pm. No prescriptions will be written or called in after these hours or on holidays and weekends. Therefore, it is your responsibility to closely monitor your supply of medications. We recommend that you make your prescription requests at least 48 hours prior to running out of your prescriptions.

ALL-STAR ORTHOPAEDICS

Financial Disclosure Notice to Beneficiary

This is a notice informing you that some or all physicians of All-Star Orthopedics and Sports Medicine have an ownership interest in the entities listed below. As owners, we may, indirectly, receive compensation for services you receive at these entities.

Irving Coppell Surgical Hospital
Baylor Surgicare at Grapevine
Baylor Medical Center at Trophy Club
Northwest Ambulatory Surgery Center of Southlake
Pine Creek Medical Center
Texas Health Center for Diagnostics & Surgery Plano
Texas Monitoring LLC

By signing below, you are acknowledging that you have received a notice of the information provided above.

_____ _____

Signature of Patient or Legal Guardian Date

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

ALL-STAR ORTHOPAEDICS

Financial Agreement

I agree to pay for services rendered. If applicable, I agree to pay for my co-payment at the time of service and I understand that I will be fully responsible for any services deemed as non-covered or denied by insurance company. I also understand that there may be a patient responsibility balance even after my insurance company has made a payment.

I agree to comply quickly with any request by my insurance company or All-Star Orthopaedics and Sports Medicine to assist in quick and efficient payment of my medical claim.

I accept that it is my responsibility to understand and verify that the physicians of All-Star Orthopaedics and Sports Medicine are in-network with my insurance plan including any facilities that I may be referred to for surgery, physical therapy, further testing and/or other types of ancillary services etc.

If my insurance company requires a referral to see a specialist, I agree to be ultimately responsible in obtaining my referral along with the assistance of a representative from the specialist's office.

Payment can be made in the form of cash, verifiable check, and/or credit card. There will be a $25.00 per check charge for all returned checks as having non-sufficient funds.

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below. Further, I assign insurance benefits for all services rendered by **Mark S. Greenberg, M.D.** and/or **Thomas M. Schott, M.D.** and/or **Bing S. Tsay, M.D.** and/or **Stephen J. Timon, M.D.** and/or **Michael K. Hahn, M.D.** and/or **Kevin M. Honig, M.D.** and/or **W. Grear Hurt, M.D.** and/or **Brian E. Straus, M.D.** and/or any other licensed healthcare service provider employed by the company. Additionally, I agree to release all such medical information as may be necessary to assist in payment of medical claims.

ALL-STAR ORTHOPAEDICS

Fees for Form Completion

Due to the dramatic increase in requests and demands by third parties for form completion, All-Star Orthopaedics and Sports Medicine will begin assessing a fee for such completion. This fee is intended to compensate the physician for the time and expertise required to review and complete the necessary forms.

Effective immediately the fee schedule below will apply to form completion requests. All usual methods of payment will be accepted. Payment must be made before the completed form is released.

Once payment is made we commit to completing your form within 72 hours. Please plan accordingly when submitting your form.

School Forms	$15.00
Sports Participation Forms	$15.00
Paperwork for Patient Assistance	$25.00
Return to Work	$25.00
Disability Forms	$25.00
FMLA Forms	$25.00
Insurance Forms	$25.00

_____ _____

Signature of Patient or Legal Guardian Date

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

ALL-STAR ORTHOPAEDICS

Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby give permission to All-Star Orthopaedics and Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following members (relatives or close personal friends):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

[ ] I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical conditions.

How to Contact

I wish to be contacted in the following manner:

Home Phone:
[ ] OK to leave message with detailed information
[ ] Leave message/voicemail with call back number only

Work Phone:
[ ] OK to leave message with detailed information
[ ] Leave message/voicemail with call back number only

Cell Phone:
[ ] OK to leave message with detailed information
[ ] Leave message/voicemail with call back number only

Written Communication:
[ ] OK to mail to my home address: _____

_____

[ ] OK to mail to my work/office address: _____

_____

[ ] OK to fax to this number: _____

Email:
[ ] OK to send email to this address: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that the request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information. ***THIS IS NOT A REQUEST TO RELEASE MEDICAL RECORDS.***

_____ _____

Signature of Patient or Legal Guardian Date

Patient Name:_____ Date of Birth: _____ Date of Visit:_____

ALL-STAR ORTHOPAEDICS

X-Ray Consent

Male Patients:

I hereby authorize the radiology technician on duty to take necessary x-rays as ordered by my physician.

_____ _____

Signature of Patient or Legal Guardian Date

Female Patients:

I hereby authorize the radiology technician on duty to take necessary x-rays as ordered by my physician.

Please complete the following:

- Date of last menstrual cycle: _____
- Form of birth control:
    - birth control pills/ injections
    - NuvaRing
    - IUD
    - condoms
    - tubal ligation/ hysterectomy
    - abstinence
    - husband vasectomy
    - other:_____

_____ _____

Signature of Patient or Legal Guardian Date

Patient Name:_____ Date of Birth: _____ Date of Visit:_____

ALL-STAR ORTHOPAEDICS

ICD-10 Questionnaire

Is this visit resulting from an injury? (Circle One)

YES **NO**

When did you get injured? (Please be as specific as possible; e.g., May 1, 2015 or 5/1/2015.)

_____

Where were you when you got injured? (e.g., home, school, work, playground, etc)

_____

What were you doing when you got injured? (e.g., playing football, jogging, cooking, cleaning, etc)

_____

Please provide any addition details regarding your injury.

_____

_____

_____

_____

_____

_____

_____

_____

As of October 1, 2015, your insurance carrier is requiring us to submit the above information along with the claim for your visit. Please provide as detailed information as possible in order to ensure your claim is processed smoothly and in a timely manner. Failure to provide relevant detailed information can lead to claim denial and in turn you will be responsible for all charges.

_____ _____

Signature of Patient or Legal Guardian Date