ConquestMD™
Spine Care and Sports Medicine, PLLC

ALPHA ORTHOPEDICS

Ainsworth B. Farrell, M.D. Charles Toulson, M.D. John A. Mohnickey, PA-C, SA, ST

Main Office - 6850 TPC Drive - Suite 212 - McKinney TX 75070
Phone: 214.544.9887 www.conquestmd.com www.alphaortho.net

Patient Demographics

PATIENT INFORMATION: (Please Print)

Patient's Legal Name: ______________________ Date of Birth: ____________ Age: ________

Address ______________________ City ____________ St ______ Zip ________

Home #: ____________ Work #: ____________ Cell #: ____________

Email: ____________ Gender: M / F Social Security #: ____________

Driver's License #: ____________

Patient/ Parent's Employer: ____________

Address: ______________________ City: ____________ St ______ Zip ________

IF PATIENT IS UNDER 18 YEARS OF AGE OR RESIDING WITH PARENTS, PLEASE COMPLETE

Father's Name: ____________ Phone # ________ Date of Birth ______ SS # ________

Mother's Name: ____________ Phone # ________ Date of Birth ______ SS # ________

PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY:

Name ______________________ Relationship to Patient ____________

Address ______________________ Home # ____________ Work # ____________

IS THIS A WORK RELATED ACCIDENT? O YES O NO

INSURANCE INFORMATION:

Primary: Insurance Company: ____________ Policyholder's Name: ____________

Policyholder's Date of Birth: ____________ Social Security #: ____________

Relationship to Patient: ____________ Policyholder's Employer: ____________

Policy ID#: ____________ Group #: ____________

Secondary: Insurance Company: ____________ Policyholder's Name: ____________

Policyholder's Date of Birth: ____________ Social Security #: ____________

Relationship to Patient: ____________ Policyholder's Employer: ____________

Policy ID#: ____________ Group #: ____________

PLEASE GIVE INSURANCE CARD (S) AND PHOTO ID TO RECEPTIONIST FOR COPYING.

Authorization: My signature indicates that I have read the above and grant authorization of treatment and am responsible for payment of fees. I also authorize the release of any medical information requested by my insurance carrier and authorize payment of medical benefits to the physician. Photostat of the above is as valid as the original.

Patient or Guardian Signature: ______________________

Charles Toulson M.D.
John A. Mohnickey, PA-C, SA, ST

MEDICAL HISTORY

Patient Name: ______________________________

Referred by: Name______________________________
(Circle One) Doctor Hospital Relative Friend Advertisement

Patient's Primary Care Physician: ______________________ Phone # ____________

Pharmacy: ______________________ Phone #: ____________

Where/What are your current problems? ______________________________

What side of body? (Circle) LEFT RIGHT BOTH

Were you injured? YES NO If so, where and how? ______________________________

Date your symptoms/problems begin? ______________________________

Severity on a scale of 1-10: ____________

Did another physician treat you or were you seen at a hospital? ☐ YES ☐ NO

Name and Date: ______________________________

Have you had x-rays, an MRI, CT scan, ultrasound, or other (circle)? Where/when?

____

Did you have surgery performed? ☐ YES ☐ NO

Date and Type: ______________________________

MEDICATIONS AND DOSAGES (INCLUDE OVER-THE-COUNTER MEDICINES AND INHALERS)

Medication + mg	Dose/how taken	Medication + mg	Dose/how taken

ALLERGIES (MEDICATION AND OTHERS, INCLUDE TYPE OF REACTION): (circle)

adhesive tape ____________ aspirin ____________ antibiotics ____________
codeine ____________ foods ____________ horse serum____________
IVP dye ____________ latex ____________ morphine____________
Penicillin ____________ pollen____________ sulfa ____________
tetanus ____________
Others: ______________________________

SURGERIES (circle) AND DATES:

Appendectomy ____________cardiac bypass ____________ cataracts ____________
fracture repair ____________ gall bladder ____________ hip replacement R L ____________
hernia ____________hysterectomy ____________ knee cartilage R L ____________
knee ligament R L ____________knee replacement R L ____________ shoulder surgery R L ____________
tonsillectomy ____________
Others: ______________________________

Patient Name: ____

DO YOU HAVE: (please check)

GENERAL:

☐ cancer of ______________________ ☐ diabetes-insulin dependent ☐ diabetes-diet or medication controlled ☐ thyroid disease ☐ fever ☐ night sweats ☐ rapid weight loss or gain ☐ fatigue ☐ anxiety/panic attacks ☐ depression ☐ jaundice ☐ hepatitis ☐ alcoholism ☐ major injuries ☐ swollen ankles
☐ other: ____

EYES/EARS/HEAD:

☐ glaucoma ☐ cataracts ☐ blindness ☐ contacts ☐ partial plate ☐ dentures ☐ hearing loss ☐ hearing aids ☐ migraine headaches
☐other: _________________

HEART:

☐ heart attack ☐ chest pain/angina ☐ heart failure ☐heart murmur ☐ palpitations ☐ rheumatic fever ☐ pacemaker

☐ other _______________________

LUNGS:

☐ asthma ☐ recurrent bronchitis ☐ emphysema ☐ COPD ☐ TB ☐ pneumonia ☐ shortness of breath at night ☐ pulmonary embolus ☐ shortness of breath with mild exertion ☐ recent exposure to TB ☐other________________

BREASTS:

☐ lump ☐ biopsy ☐ fibrocystic disease ☐ mastectomy
☐other____________________________________

ABDOMEN:

☐ heartburn ☐ hiatal hernia ☐ GERD ☐ frequent nausea/vomiting ☐ inguinal hernia ☐ liver cirrhosis ☐ peptic ulcer disease ☐ other _______________

URINARY TRACT:

☐ recurrent bladder/kidney infections ☐ recent infection

☐ bladder control problems ☐ prostate disease ☐ kidney stones ☐ kidney failure ☐ dialysis ☐ kidney transplant

☐ other : ___________________________

BONE/JOINTS:

☐ stroke ☐ paralysis ☐ numbness or tingling ☐ weakness of arms or legs ☐ seizure ☐ epilepsy ☐ dizzy spells ☐ black-out spells ☐ memory lapses ☐ head injury ☐ Alzheimer's disease
other: ________

NEUROLOGICAL:

☐ easy bruising ☐ excessive bleeding ☐ taking blood thinners: _______ ☐ anemia ☐ blood clots ☐ phlebitis.
☐ PVD ☐ sickle cell trait or disease ☐ AIDS ☐ HIV
☐ blood transfusions ☐ other: __________________

BLOOD/VESSELS:

☐ rheumatoid arthritis ☐ osteoarthritis ☐ osteoporosis ☐ gout ☐ back pain ☐ joint pains ☐ muscle cramps ☐ fractures
☐ other: ____________________

Patient Name: ______________________________

ANESTHESIA HISTORY: Date of last anesthetic: ______________________
Have you ever had an adverse reaction/problem with anesthesia? ☐ Yes ☐ No Explain:
____

Have you had blood relatives with anesthesia problems? ☐ Yes ☐No Explain:
____

SOCIAL HISTORY:
Tobacco History? __________Smoke ______ pack(s) of cigarettes daily for ____ years. Quit smoking__________.

Drink ______ (beers, alcoholic drinks, glasses of wine) per (day, week, month, year).

Have you ever been addicted or dependent on drugs or pain medication? ☐ Yes ☐ No
Type: ______________________
____

Height: __________ Weight: ________

Are you pregnant? ☐ Yes ☐ No Start date of last menstrual period ____/_____/_____

Name of person completing form if other than patient: ______________________

AUTHORIZATION:
My signature indicates that I have read the above and grant authorization and I am responsible for payment and fees.

______________________ ______________________________
Date Patient, Parent or legal guardian signature

Photostat of above is as valid as the original

If you neglect to advise Alpha Orthopedics before your first appointment that this is work related , the below statement applies:

I understand and agree that I am responsible for all charges for services rendered in the event that my claim for Worker's Compensation benefits is denied.

______________________________ ______________________
Signature of Patient/Responsible Party Date

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HIPPA - Consent for Additional uses of Health Information

Patient Name (Print): ______________________________

Additional Uses of Information
Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you **do not** want us to contact you via the phone number you have already provided, and/or leave a voice message on those phone numbers, please choose one or more of the following alternate methods for us to use to contact you:

May we leave messages concerning your appointment with anyone at your workplace?

O Yes O No O N/A

May we leave messages on your voicemail at work?

O Yes O No O N/A

May we leave messages on you voicemail at home?

O Yes O No O N/A

If you are over (or under) the age of 18, may we discuss your appointments and/or treatments with your parents?

O Yes O No O N/A

If you are over the age of 18, may we discuss you appointments and/or treatments with your children?

O Yes O No O N/A

If you answered "no" to any of the above, please inform us of your preferred method of contacting you.

____

____

Please provide us with names of those persons, if any, with whom we may discuss your appointments and/or treatment:

____

____

______________________________ ______________ ______________
Signature of Patient (or Person Authorized to Give Informed Consent for the patient) **Date** **Time**

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HIPPA 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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of your laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or credit card companies that you may use to help pay for services. For example, your health plan may request and receive information on dates of service, services provided, and medical condition being treated.

Health Care Operation. Your health information may be used as necessary to support the day-to-day activities and management of **ConquestMD Spine Care and Sports Medicine, PLLC.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research. Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information the review is not removed from the premises of this practice. Provider may also disclose the medical of decedents for a research project, so long as the information is necessary for the research.

Other Use and Disclosure Requires Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment;
- The right to inspect and copy your protected health information;
- The right to amend or submit corrections to your protected health information;
- The right to receive an accounting of how and to whom your protected health information has been disclosed; and
- The right to receive a printed copy of this notice.

Practice Duties. We are required by law to maintain the privacy of you protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPPA Privacy Officer
MedicalEdge Healthcare Group, Inc.
9229 LBJ Freeway
Dallas, TX 75243
(972) 739-3753

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.

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Notice of Office Policies

Thank you for choosing us for your healthcare needs. We would like to take this time to explain our office policies. Please carefully read and initial the information below.

_________ Initial

Office Hours: Our office is open Monday to Friday, 8:00AM to 5:00PM. Lunch is between 12:00PM to 1:00PM. If you should have a medical emergency after hours, please contact our office at (214) 544-9887 and the answering service will contact our Physician. **Medication refills are not handled after 4:00pm or on holidays/weekends and are not considered a medical emergency.**

_________ Initial

Insurance: We will file an insurance claim with your insurance company. However, your deductibles and co-payments/co-insurance payments are expected at the time services are rendered. In order to file your insurance claims appropriately, we ask that you keep our office informed of any insurance or address changes during your course of treatment. If you are insured under an HMO, MC, POS or EPO policy, it is your responsibility to obtain a referral from your primary care physician for your initial visit.

_________ Initial

Work Related Injuries: It is your responsibility as the employee to provide the Injury Status Report to your employer. Failure to do so may result in claim denial and/or loss of benefits. We will provide information to the Case Manager or Adjuster, including treatment plans and appointment compliance reports.

_________ Initial

Appointments: There is a **$25.00** missed appointment fee. It is your responsibility as the patient to contact the office **24 hours** before your appointment if you need to cancel or reschedule your appointment.

_________ Initial

Forms: FMLA, Disability, Ect: Forms will be completed within 5 business days. There is a minimum charge of **$25.00** payable to the office due at the time the forms are dropped off at the office.

_________ Initial

Prescription Refills: Medication refills are done only during regular office hours. **Refills are not addressed after 4:00pm or on holidays/weekends.** It may take up to 2 business days for your request to be handled.

_________ Initial

Medical Records: Our office utilizes Health Mark Group for copying medical records. This service may take up to 7 business days to be completed. There is a **minimum charge of $25.00** for this service. Records to other physicians are done free of charge.

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Acknowledgement of Receipt of Office Policies Notice

By signing below, I acknowledge that I have read and fully understand the office policies of the medical practice.

I understand that the medical practice may amend or revise these policies at any time.

I assume full responsibility for any balance owed after my insurance plan has paid including any supplies or services that are not a covered benefit.

____

Name of Patient (Print)

____________________________ _______________

Signature of Patient **Date**

____________________________ _______________

Signature of Patient Representative **Date**

(Required if the patient is a minor or an adult who is unable to sign this form)

____

Relationship of Patient Representative to Patient

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Financial Responsibility Agreement

______ Initial — I understand and agree that I will be financially responsible for any and all charges not paid by my insurance company for my visit(s). This includes any medical visit , service, lab testing, x-ray (s), and any other screening or diagnostic testiing ordered by the physician or the physician's staff.

______ Initial — I understand and agree that it is my responsibility, and not the responsibility of the physician or the physician's staff, to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG or any other screening or diagnostic testing ordered by the physician or the physician's staff.

______ Initial — I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual or customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment at the time of service for all office visits, injections, x-rays, lab testing, and any surgical procedures that have been ordered. Additional surgical procedures cannot be anticipated until surgery has been performed, therefore, there may be additional balance due for those unexpected procedures.

______ Initial — I understand and agree that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company and/or plan. If my insurance company or plan does not recognize the physician or provider I am seeing, it may result in claims being denied, higher deductible or out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

______ Initial — If I am a Worker's Compensation patient, I understand that I am to provide all necessary billing information. I am to provide my date of injury, claim number, adjustor name and contact information, employer information and insurance carrier information including phone and fax numbers. I understand that if my Worker's Compensation claim has been denied, I am responsible for payment in full.

Print Name: ______________________________
(patient or responsible party)

Signature: ______________________________ **Date:** __________
(patient or responsible party)

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Acknowledgement of Receipt of HIPPA Notice and Privacy Practices

Our medical practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

____

Name of Patient (Print)

______________________________ ____________________

Signature of Patient **Date**

______________________________ ____________________

Signature of Patient Representative **Date**

(Required if the patient is a minor or an adult who is unable to sign this form)

____

Relationship of Patient Representative to Patient