TOP OF TEXAS ORTHOPEDICS

Tyler Britten, MD **Tyler Cooper, MD** **Kent Weinheimer, MD**

Patient Information

Full Name: _____ Suffix: (JR, SR, III) _____

Date of birth: _____ SSN: _____

Phone Number: _____ (Cell, Home, Work)

Secondary phone number: _____ (Cell, Home, Work)

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Martial Status: _____ Name of Spouse: _____

Email Address: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____ (Cell, Home, Work)

Responsible Party Information

(Person responsible for receiving bills; if patient, write self)

Full Name: _____ Suffix: (JR, SR, III) _____

Date of birth: _____ SSN: _____

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ (Cell, Home, Work)

Insurance Information

Primary:

Name of insurance company: _____

Subscriber Name (person who holds the insurance): _____

Subscriber DOB: _____ Subscriber SSN: _____

Policy # (ID#, Member #, etc.) _____ Group # _____

Secondary:

Name of insurance company: _____

Subscriber Name (person who holds the insurance): _____

Subscriber DOB: _____ Subscriber SSN: _____

Policy # (ID#, Member #, etc.) _____ Group # _____

Additional information we may need to know regarding insurance:

_____

_____

By signing, *you* certify that the information provided is true and correct. The information will be used to manage account and process insurance claims.

Patient/Guardian signature: _____ Date: _____

TOP OF TEXAS ORTHOPEDICS

Dr. Tyler Britten- Andrea Britten PA
Dr. Tyler Cooper- Alexa Wingo PA
Dr. Kent Weinheimer- Mason Kizziar NP

Patient Name: _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Sex:** (circle) Male or Female

Preferred Pharmacy: _____

Reason for visit- Left or Right (specify body part and location of pain) _____

_____

How long has his been occurring: _____ **Date of onset/ injury:** _____

Pain level: _____ (0-10) **Hand Dominance:** (circle) Right, Left or Ambidextrous

Describe your symptoms:

- ○ Aching
- ○ Bruising
- ○ Catching
- ○ Clicking
- ○ Grinding
- ○ Locking
- ○ Popping
- ○ Pressure
- ○ Gait instability
- ○ Swelling
- ○ Throbbing
- ○ Cramp-like
- ○ Burning
- ○ Dull
- ○ Electric
- ○ Limping
- ○ Numbness
- ○ Pins and Needles
- ○ Radiating
- ○ Stiffness
- ○ Sharp
- ○ Stabbing
- ○ Tender to touch
- ○ Weakness
- ○ Worsening
- ○ Other: _____

Timing of symptoms:

- ○ Began today
- ○ Constant
- ○ Mainly at night
- ○ Occurs in the morning
- ○ Occurs with weightbearing
- ○ Occurs randomly
- ○ Occurs with activity
- ○ Occurs with rest

What are you using to treat symptoms?

- ○ Aspiration
- ○ Brace
- ○ Exercise
- ○ Heat
- ○ Joint steroid injections
- ○ Muscle relaxants
- ○ Narcotics
- ○ NSAIDs (Advil, Aleve, Meloxicam)
- ○ Rest, Ice Elevation
- ○ Tylenol (acetaminophen)
- ○ Physical therapy- **if yes, how long:** _____
- ○ Other: _____

Do you see a cardiologist: YES or NO **Cardiologist Name:** _____

Have you had any X-Ray, CT scan, or MRI? YES or NO _____

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY- Follow up/ Surgical Date: _____

Patient Name: _____ **Date of Birth:** _____

Employer Name: _____ **Job Duties:** _____

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

List ALL Allergies: _____ **Pharmacy:** _____

List Current Medications: _____

_____

_____

_____

Personal History: (circle all that apply)

Anemia
Anxiety
Arthritis
Asthma
Atrial Fibrillation (A-Fib)
Back pain
Blood clot, DVT, Embolism
Cancer: _____
_____
COPD
Depression
Diabetes- (circle) Type 1 or Type 2
Heart Disease
Heart Attack
Hepatitis
High Cholesterol
Heart Arrhythmia
High Blood Pressure
Hypotension
HIV/ AIDS
Gout
Kidney Disease
Liver Disease
Lung Disease
Mental Illness
Migraines
Peripheral Vascular Disease
Rheumatological Disease
_____
Staph
Stroke
Thyroid Disease
Ulcers

Surgical History: (include procedure and date) _____

_____

_____

_____

_____

Social History: (circle)

Tobacco use: Yes or No Vape, Cigarettes, Smokeless tobacco. How much: _____

Alcohol use: Yes or No How much: _____

Recreational drug use: Yes or No How much: _____

TOP OF TEXAS ORTHOPEDICS

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Full payment is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept cash, checks, money orders or credit cards (i.e., VISA, Mastercard, Discover and American Express)

Your insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service.

- If your insurance requires a referral, it is your responsibility to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit, payment in full will be required at the time of the visit.
- Referrals are diagnosis driven. IE: If you were referred for left knee pain, then we can ONLY see you for L knee pain until a new referral is provided for another area of problem.

- If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required if we can't verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and benefits.

- If you have Medicare, PART B you are only responsible for your Medicare deductible and your 20% of the charges at the time of service.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Co-payments and deductibles

- All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. To make payments convenient we accept Visa, Mastercard, Discover, American Express, Money orders, Cash and Checks. The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Proof of insurance

- All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If you do not provide copies at the time that services are to be rendered; your appointment will have to be rescheduled.

Coverage changes

- If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Workers Compensation

- It is the patient's responsibility to provide the following prior to services being rendered... **Failure to comply with this policy will result in your appointment having to be rescheduled**:
  - Claim adjuster name and telephone number with extension, if any
  - Claim number, date of injury and state of injury
  - Workers Compensation carriers name and mailing address for claims

Nonpayment

- It is our office policy that all past due accounts be sent three statements. If payment is not made on the account a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency.

Self-Pay Accounts

- Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Please ask to speak with the Clinic Manager to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Minors

- The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Cancellation of Surgery

- If you need to cancel your surgery that has already been scheduled, you must do so within 72 hours prior to your surgery date. Failure to notify our clinic prior to that 72-hour window will result in a non-refundable fee being charged to your account in the amount of $100.00.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Respectfully,

Top of Texas Orthopedics, PLLC
Dr. Tyler Cooper
Dr. Tyler Britten
Dr. Kent Weinheimer

Printed Patient Name: _____

Signature of Patient/Guardian: _____

Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Top of Texas Orthopedics, PLLC
501 Quail Creek Dr
Amarillo, TX 79124

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name Top of Texas Orthopedics PLLC, Tyler N Cooper MD PA, Britten Orthopedics, PLLC, Kent Weinheimer MD PA
Address 501 Quail Creek Dr
City Amarillo State TX Zip Code 79124
Phone (806) 418-2548 Fax (806) 356-0081

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

**We do not disclose records electronically or on disc

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Fee is waived when releasing information directly to a treating physician or health care facility

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**