WELCOME TO DR. WARNOCK'S OFFICE

Name_____ Date_____

Age_____ Sex_____ Date of Birth____/____/_____ Height_____ Weight_____

Pharmacy Name/ Location:_____ Pharmacy Phone #_____

Have you or a family member been seen by Dr. Warnock?
_____Yes _____No

Who referred you to Dr. Warnock? Circle Below

Emergency Room	Physician	Internet
Insurance	Friend	Other

If other please list:

_____

The main reason for my visit today is:

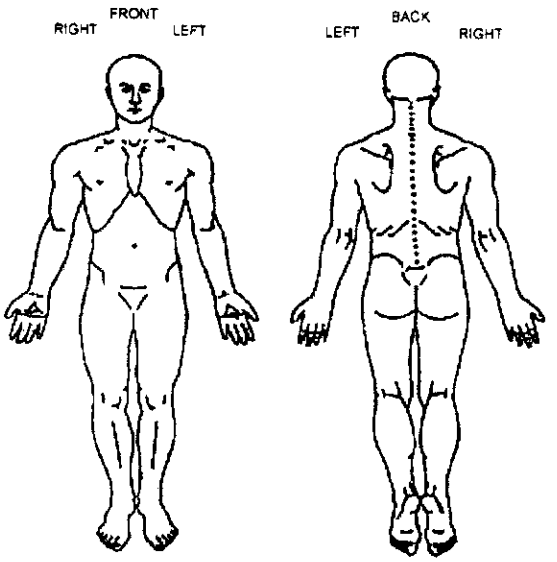
_____

_____

Pain Level on a Scale of 1-10 _____

My pain/injury is located: ____Right ____Left ____Both

Please circle the area where you hurt.



The date my injury/symptoms started was:

_____

I have had this pain for how long:

_____Days _____Months _____Years

Is this a work related injury?

____Yes ____No

Describe how your injury occurred: Fall, etc.

_____

_____

The pain is worse when I:

_____

_____

The pain is better when I:

_____

_____

I have had the following treatment(s) for this problem:

_____ Medication
_____ Injections
_____ Physical Therapy
_____ X-rays
_____ MRI
_____ Surgery

For this problem I have seen:

_____ Primary Care Physician
_____ ER Doctor
_____ Chiropractor
_____ Trainer
_____ Work Doctor
_____ Other _____

Medications

I take the following Medications:

_____

_____

_____

Do you take Blood Thinners? Yes / No

Allergies

I am allergic to the following:

_____ X-ray dye
_____ Iodine
_____ Shell Fish
_____ Penicillin
_____ Codeine
_____ Medications (Please List)

_____

Medical History

List your Current medical conditions:

_____

_____

_____

Are you a Diabetic? Yes / No

Do you take Insulin? Yes / No

Are immunizations up to date? Yes / No

Is Flu Vaccination up to date? Yes / No

Surgical History

Please list all prior surgeries:

_____

_____

_____

Social History

Occupation _____

Marital status:
_____ Single _____ Divorced
_____ Married _____ Widowed

Tobacco: How Often:
_____ Yes _____ Per Day
_____ No _____ Other

Alcohol:
_____ Never
_____ Social
List type and amount per week _____

Family History

List of diseases that run in your family:

_____ High Blood Pressure
_____ Diabetes
_____ Heart Problems
_____ Arthritis
_____ Cancer
_____ Gout

Ethnicity _____

Please circle the following, describing any symptoms you may have:

Fever	Loose Teeth
Chest Pain	Angina
Skin Infections	Rashes
Cracked teeth	Weakness
Mouth/Tooth Infection	Gout
Head or eye problems	Bleeding
Difficulty breathing	Depression
Difficulty urinating	Anxiety
Infections	Hot flashes
Irregular menstrual cycles	Clotting Disorder
Numbness/Tingling	

PATIENT INFORMATION SHEET

Date:_____ Account#_____

Patient's **LEGAL** name:_____ Date of Birth:_____
(First) (Middle) (Last)

SS#_____ Address:_____
(Street) (Apt#) (City, State, Zip Code)

Home#_____ Work#_____ Cell#_____

Marital Status: M S D W (Circle One) Sex: Male / Female (Circle One) Ethnicity: _____

Employer/School Name: _____

Address:_____ Occupation: _____
(Street) (City, State, Zip Code)

If patient is a Minor – Name of person responsible: _____ Relationship: _____

Address:_____ Home#_____ Cell#_____
(Street) (City, State, Zip Code)

PRIMARY INSURANCE: INS Holder's **LEGAL** name: _____

Relationship to Patient: _____ Date of Birth: _____ SS#_____

Insurance Co: _____ Policy #_____ Group#_____

Employer Name/ Address: _____PH#_____

SECONDARY INSURANCE: INS Holder's **LEGAL** name:_____

Relationship to Patient: _____ Date of Birth: _____ SS#_____

Insurance Co: _____ PH# _____ Policy #_____ Group#_____

Employer Name/ Address: _____PH#_____

EMAIL ADDRESS: _____ Preferred Language:_____

PHARMACY NAME: _____ PHARMACY PHONE # _____

I hereby authorize the OrthoLoneStar . to receive payment of the surgical/medical benefits for services and of the release of any information acquired for processing insurance claims and to other doctors or health care facilities and I hereby unconditionally guarantee full and prompt payment of all services and product charges rendered to me.

Signature:_____ Date: _____

FONDRENORTHOPEDICGROUP

FINANCIAL POLICY

The physicians and employees of OrthoLoneStar are dedicated to providing the best possible care to you at the best possible value; therefore, we regard your understanding of our financial policies an essential element of your treatment. Our intent is to be fair, transparent, caring and accessible. If you have any questions, please discuss them with one of our staff members.

Your signature below authorizes the following:

- I/we assign to OrthoLoneStar, PLLC ("OLS") all insurance benefits or Medicare benefits to which it may be entitled for services rendered by its providers and authorize direct payment to the practice. This assignment includes without limitation major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for personal injury caused by a third party. I/we agree to pay practice for all charges not paid pursuant to this assignment.
- For ERISA, out-of-network, and self-funded plans, I assign and convey directly to OLS, as my designated authorized representative, all insurance reimbursement for services rendered by OLS regardless of network participation status. I authorize OLS and its authorized agents to negotiate, discuss, appeal and, in any other way, communicate with my insurance company to determine final payment for services I received. OLS has full authorization to accept or reject any proposed reimbursement proposal, and to act as necessary to accomplish the final adjudication of any claims. The results of that determination are binding upon me/us.
- Release of pertinent medical information to your insurance carrier(s).
- Administrative charges for completion of forms such as disability and FMLA forms, medical records copies, CDs of images, printed films, or similar items. Please consult with a staff member for these charges.
- If, after all your claims have been paid, the resulting balance is a credit of $5.00 or less, you will authorize us to write off this balance. Amounts greater than $5.00 will be refunded to you.
- I/we understand that insurance coverage and verification is not a guarantee of payment. I/we agree that I/we am/are ultimately responsible for any balance due after my insurance has paid or denied my claim(s). I/WE UNDERSTAND THAT I/WE AM/ARE RESPONSIBLE FOR ANY CHARGES IF THE INSURANCE COMPANY DENIES A CLAIM FOR ANY REASON INCLUDING STATING THAT IT IS INVESTIGATIONAL, EXPERIMENTAL, A PRE-EXISTING CONDITION, AUTO RELATED OR ACCIDENT-RELATED WHERE LIABILITY INSURANCE IS INVOLVED, OR ANY OTHER NON-COVERED SERVICE(S).

Responsibilities and acknowledgement of financial policy specifics:

- Please present your insurance card and photo ID at each appointment. Please share address, telephone number and/or insurance information updates any time a change occurs.
- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, and most major credit cards. Other financing options may be available. Please ask our staff about these programs.
- Payment of your deductible and coinsurance will be required for your calculated portion of our fees, based on your insurance contract, in advance of any scheduled surgical procedures and diagnostic testing. Any balance remaining after your health plan pays its portion is your responsibility and payment for balance is due upon notification from our office. Any overpayment will be refunded directly to you.
- You may be asked to put a credit card on file, which will only be charged according to the terms you agree to when placing such card on file. By processing your insurance first, we will only charge you for your exact out-of-pocket responsibility. You will receive notification containing a summary of charges and an estimate of what we believe you will owe. After your insurance has processed your claim, you will receive a second notification informing you of the actual amount you owe and notifying you that your card will be charged. Contact the practice if you have questions once you receive this notification.
- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the practice. If your insurance does not pay, we will look to you for payment of your balance in full.

- All health plans are not the same and do not cover the same services. If 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. You are responsible for knowing and understanding your insurance benefits.
- You will be responsible for promptly responding to your insurance company to provide additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full, by you.
- Responsibility for payment for patients who are minors whose parents are divorced rests with the parent who seeks the treatment or the adult accompanying the minor for all services rendered to the minor patients regardless of any court order responsibility judgement.
- Appointment Cancellations within 24 hours of scheduled time may result in a charge.
- Failure to notify us 48 hours before canceling a surgery may result in a charge.
- Returned checks for any reason will result in a charge.
- Some orthopedic supplies are not covered by your insurance, in which case we will require payment at time of service. A deposit will be collected upon receipt of certain Durable Medical Equipment items.
- All HMOs and some PPOs require prior authorization or referral from your primary care physician for each visit. This is your responsibility. IF YOU DO NOT HAVE THIS REFERRAL NUMBER AT THE TIME OF YOUR APPOINTMENT, YOUR BENEFITS MAY BE PAID AT A REDUCED RATE OR NOT PAID AT ALL AND YOU WILL BE RESPONSIBLE FOR THE CHARGES.
- When you are charged a "global" fee for surgery or office care of a fracture, laceration repair, excision of an ingrown toenail, or other medical procedure, that fee includes the service on the day it is performed and routine follow up care as well. The global period ranges from 10 to 90 days depending on the procedure and your health plan. Injections, X-rays, and supplies (such as casting or dressing materials, splints, braces, etc.) are not included in the "global" fee and a charge will be made for these items. Services related to complications are not included in the global fee.
- Please note there are no refunds or returns on all braces/soft goods.
- If you do not pay your balance and we are required to use a third party to collect your balance, an administrative charge of up to 25% of the balance may be added to the amount you owe.

I have read and understand the financial policy outlined above, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by OLS.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

Patient Name: _____ Patient ID: _____

Consent for Care and Treatment

I hereby agree and consent for OrthoLoneStar, PLLC and its subsidiaries and affiliates (collectively "Fondren" as used throughout this form) to furnish medical care and treatment to the patient listed above considered necessary and proper in diagnosing or treating her or her physical condition. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the procedures or treatments. I understand that, should I leave the facility without written consent of my attending physician, I hereby relieve the physician and the facility of all responsibility of my action.

Medication Consent

I give permission for Fondren to access my pharmacy benefits data electronically through online services. This consent will enable Fondren to determine the pharmacy benefits and drug copayments for my health plan, check whether a prescribed medication is covered (in formulary) under my plan, display therapeutic alternatives that preference rank (if available) within a drug class for medications, determine if my health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to those pharmacies and download a historic list of all medications prescribed for me by any provider.

Physician's Assistant and Certified/Nurse Practitioner Consent

Fondren and its affiliates utilize Physician's Assistants and Nurse Practitioners (collectively known as "Non-Physician Practitioners") to assist in the delivery of orthopedic medical care. I acknowledge a Non-Physician Practitioner is not a physician. Texas licenses Non-Physician Practitioners. Non-Physician Practitioner can, under the supervision of a physician, diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care and assist at surgery. Supervision does not require the constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. Fondren, its employees, and affiliates, may bill your insurer or plan administrator fiduciary separately to obtain payment for the services of Non-Physician Providers. I acknowledge this information and consent to the services of Non-Physician Practitioners for my health care needs. I understand that, at any given time, I can request to see the physician instead of a Non-Physician Practitioner.

Patient Referral

I understand that, in some cases, my physician or Non-Physician Practitioner may refer me to an out-of-network provider and that I may have more out-of-pocket costs from such out-of-network provider. It is the patient's responsibility to ensure that any provider from whom the patient seeks treatment is in or out-of-network.

Disclosure of Physicians' Ownerships Interests

Our providers are committed to helping facilitate exceptional care at various healthcare facilities and through other health care providers. By maintaining ownership in other facilities and health care providers, our providers are able to have a voice in administrative and operational direction, resulting in a higher overall quality of care. Pursuant to Federal and Texas Law, I have been informed that either OrthoLoneStar, PLLC, or one or more of its affiliates, physicians, or owners, have a financial interest in one or more of the following organizations: Fondren Advanced Care PLLC and South Main Surgical Alliance, PLLC. You may receive separate billing from each entity. We want you to know that you do have the option to use an alternative health care provider should you choose.

Telephone Consumer Protections Act (TCPA) Notice

I agree that Fondren, or any other collection or servicing agency or agencies retained by Fondren (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers that may result in my incurring fees for the call or text message. I am consenting to communication by email as required by 15 U.S.C. §7001and related state regulations and statutes.

I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre- recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address that I provide to the facility or is otherwise associated with my account.

Email and Text Message Communications

I consent and state my preference to have Fondren communicate with me by email or standard SMS (text) messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. If you do not want to be contacted via email or text message, please indicated your preference by checking this box: ☐

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP

Release and Acknowledgement

Patient Name: _____ Patient ID: _____

Release of Photos/Radiographs/Videos for Website Publication

☐ I give permission to OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate scientific papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied. I understand that no personally-identifying information will be used.

☐ I DO NOT consent to the use of any pictures/videos/radiographs obtained during my treatment.

Acknowledgement of Receipt of Notice of Privacy Practices

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for review on our website and our front desk.

☐ I acknowledge that I was provided access to a copy of the Notice of Privacy Practices that I have read (or had the opportunity to read if I so choose) and understand the Notice.

☐ I refuse to sign this acknowledgement.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP

Friends and Family Information Disclosure

Patient Name: _____ Patient ID: _____

☐ I authorize the release of medical information (by telephone, mail or otherwise) by physicians and staff of OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates to:

Name and Relationship	Address/Phone Number
_____	_____
_____	_____
_____	_____

☐ I DO NOT authorize the release of medical information to my family members.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP

Workers' Compensation Disclosure

Patient Name: _____ Patient ID: _____

IMPORTANT NOTICE

The following physicians are non-participating physicians in the Texas Workers' Compensation Program. Therefore, they are not listed as part of the ADL (Approved Doctor List) of the TWCC (Texas Workers' Compensation Commission) and are not authorized in any capacity to treat patients for any work-related injury under the TWCC system.

The following listed are Non-ADL Physicians:

Gary T. Brock M.D.
Jeffrey A. Kozak M.D.
Richard J. Kearns, M.D.

The following physicians do not accept Texas Workers' Compensation related patients:

Jeffrey A. Kozak, M.D.
Holly J. Jones, M.D.
Gregory W. Stocks, M.D.

According to Texas Labor Code § 413.042, the patient is responsible for ALL healthcare expenses incurred if he or she violates Texas Labor Code § 408.022 relating to the selection of a doctor and receives medical treatment from a physician NOT chosen from a list of doctors approved by the commission.

Patient Certification: I hereby certify that the information provided by me is truthful, accurate and correct. I fully understand the above-referenced state law as well as any related regulations.

I have read and understand the above statement regarding WORKERS' COMPENSATION BENEFITS coverage.

☐ This is a work-related condition, injury or symptom.
☐ This is NOT a work-related condition, injury or symptom.

I am scheduled to see Doctor: _____

Financial Obligation: I understand if the information that I provide is inaccurate, OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates (collectively, "Fondren") may not be able to collect payment from the insurance company. I also understand and acknowledge that providing false information on the completed forms will result in serious legal consequences for myself.

I hereby affirm that I am responsible to pay Fondren on demand for my medical services if I violated Texas law and knowingly selected a physician not chosen from a list of doctors approved by the Texas Workers' Compensation Commission. Further, I understand that I will be financially liable if my insurance company declares the service to be work-related resulting in a request for refund, if I do not dispute the issue to declare otherwise.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP

Patient Financial Disclosure Notice

Patient Name: _____ Patient ID: _____

Pursuant to the requirements of section §105.002 of the Texas Occupations Code, this is to inform you that each of the physicians listed below have a financial ownership interest in Texas Orthopedic Hospital, 7401 Main Street, Houston, Texas 77030 (the "Hospital") and may, indirectly, receive compensation for services you receive at the Hospital.

You, as the patient of one of these physicians, have the option of using an alternative health care facility, other than the Hospital, if you so desire.

James B. Bennett, M.D.
David M. Bloome, M.D.
Mark R. Brinker, M.D.
Gary T. Brock, M.D.
Barrett S. Brown, M.D.
Robert L. Burke, M.D.
C. Craig Crouch, M.D.
T. Bradley Edwards, M.D.
Hussein A. Elkousy, M.D.
Tomiko Fukuda, M.D.
Idris S. Gharbaoui, M.D.
Mufaddal M. Gombera, M.D.
Robin N. Goytia, M.D.
Richard J. Kearns, M.D.
Jeffrey A. Kozak, M.D.
David P. Loncarich, M.D.
Randy M. Luo, M.D.
Vasilios Mathews, M.D.
Michael T. McCann, M.D.
Thomas L. Mehlhoff, M.D.
Anay R. Patel, M.D.
Gregory W. Stocks, M.D.
Ryan M. Stuckey, M.D.
J. Bryan Williamson, M.D.
David W. Wimberley, M.D.

By signing below, you are attesting that you have read and understand the information provided above.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP

Opioid (Narcotic) Prescription Policy

Patient Name: _____ Patient ID: _____

We understand that physical pain is interpreted differently among all of us and we are sensitive to the fact that many of our patients present to us with physically painful conditions. However, it is also our duty as physicians to minimize harm to patients. Narcotic addiction is a national epidemic. Physicians have been placed on the front line of managing this epidemic and are held accountable. In order to protect our patients and maintain our professional standing, OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates have an established policy for prescribing narcotics.

- Narcotics will not be prescribed for chronic pain conditions; however, they can be prescribed for acute conditions at the discretion of the treating physician.
- If you are under the care of a pain management physician, we expect you to disclose this information on your first visit. Failure to do so would violate your contract with your pain management physician.
- Narcotics will be prescribed post-operatively for a maximum of six to eight weeks depending on the type of surgical procedure performed.
- Prescriptions for narcotics will be dispensed in accordance with the Texas Prescription Monitoring Program. They may not be "called in" to your pharmacy.
- Your prescription history will be reviewed prior to the prescribing of any narcotic medication, pursuant to the Texas Prescription Monitoring Program.
- If you are taking narcotics prescribed by a pain management physician, you will need to receive your post-operative pain medicine from that physician.
- Long-term pain medication needs will require a referral to another physician, such as a pain management physician or primary care provider.
- Refills may take up to three days to process, so you must call well in advance. No refills will be authorized after hours or on weekends. NO EXCEPTIONS. On-call physicians are not authorized to refill narcotic pain medication. You may be asked to come to the office to be reevaluated prior to receiving a refill.
- Lost, damaged or stolen prescriptions will NOT be replaced.
- All medications are to be used as prescribed. Adjustments or increases in the amount of medication should not be done without discussion with the prescribing provider.
- Adverse reactions are to be reported to the physician's office immediately.
- Combining narcotic pain medications may have unrecognized or unpredictable interactions with other pain medications.
- Operating heavy equipment or driving is not permitted when using narcotic pain medications.

We have created this policy to ensure the health and safety of our patients. We appreciate your cooperation.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

OrthoLoneStar