PATIENT INFORMATION FORM

TODAY'S DATE (mm/dd/yyyy): _____/ _____/ _____

PATIENT INFORMATION

Last Name	First Name	Preferred Name	MI

Date of Birth	Driver's License Number	Social Security #

Gender: [ ] Male [ ] Female | Marital status (Check one) [ ] Single [ ] Married [ ] Divorced [ ] Widow(er) [ ] Partner [ ] Separated [ ] Unknown

Home Street Address	City	State	Zip Code

Home #	Work #	Cell #	Email

Preferred Language: [ ] English [ ] Spanish [ ] Vietnamese [ ] Other

Contact Preference: [ ] Home Phone [ ] Work Phone [ ] Mobile Phone [ ] Mail [ ] Portal

Chose clinic because / Referred to clinic by (please check one box): [ ] Physician [ ] Insurance Plan [ ] Hospital [ ] Yellow Pages [ ] Family [ ] Friend [ ] Close to home / work [ ] Other _____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

[ ] Check here if same as above

Guarantor Name	Address

Patient's relationship to Guarantor

[ ] Self [ ] Spouse [ ] Child [ ] Other _____

NEXT OF KIN

Name	Relationship	Phone

INSURANCE INFORMATION

Please complete items below if Not included on Insurance card(s)

Primary Insurance	ID certification #

Insurance Address

Subscriber's name	Birthdate	Policy / Group #	Co-pay
			$_____

Patient's relationship to policy holder

[ ] Self [ ] Spouse [ ] Child [ ] Other _____

Secondary Insurance (if applicable)	ID certification #

Insurance Address

Subscriber's name	Birthdate	Policy / Group #	Co-pay
			$_____

Patient's relationship to policy holder

[ ] Self [ ] Spouse [ ] Child [ ] Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home #	Work / Cell #

I hereby authorize payment directly to CHRISTUS Ortho and Sports Medicine for any surgical and/or medical benefits, if any, otherwise payable to me. I also authorize CHRISTUS Ortho and Sports Medicine to file all necessary papers for insurance and to release any and all copies of medical records requested by my insurance company for the purpose of determining benefits. I understand such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. I acknowledge full responsibility for the payment of such services and agree to pay my bill in full AT THE TIME OF SERVICES unless other arrangements are made with the financial department.

Patient / Guardian Signature	Date

New Patient Questionnaire

Today's Date: _____

Patient Name:_____ Date of Birth: _____
Reason for Visit:_____ Side: Right / Left / Both
Primary Care Provider:_____
Who referred you: _____

Please complete the following. * are must fill fields **Is your injury the result of:**

*Athletic Injury: Yes / No
*Referral Source: Coach / Athletic Trainer / School/Other _____

*Workman's Compensation Claim: Yes / No
*Adjustor Name and Contact Number: _____

*Motor Vehicle Accident: Yes / No
*Liability Insurance Information: _____

Accident/Injury information:

*Date of Accident/Injury: _____Location of Accident/Injury: _____
*Details of Accident/Injury: _____

Not an Accident/Injury; how long has it bothered you: _____
Have you taken ANY medications for this (Prescription or Over the Counter):

_____

Have you had any treatment for this problem (Doctors, Physical Therapy, etc.,)

_____

Rate your pain/discomfort by circling: None = 1 2 3 4 5 6 7 8 9 10 = Severe
Quality of the pain (circle): Sharp Dull Throbbing Burning Other:

_____

What makes your condition/injury better: _____
What makes your condition/injury worse: _____

List any Allergies to medications? _____

Medications:

List all current medications. Include dosage and reason.

CHRISTUS SANTA ROSA

Surgical History:

Past Medical History

Have you ever had (circle all that apply)

Excessive Bleeding	Edema/leg swelling	Diabetes	Rheumatoid Arthritis	Osteoporosis
Osteoarthritis	Heart Swelling	Claudication/Calf Pain	Ulcer	Reaction to Anesthesia
Heart Attack	Irregular Heartbeat	Hypertension	On blood thinner/Aspirin	Blood/Clot
Sleep Apnea	COPD	Fibromyalgia	Hepatitis	Muscle Disease
Kidney Disease	Gout	Stroke	Asthma	Thyroid Disease
Other:	Other:	Other:	Other:	Other:

Family History

Please check any family member next to the condition; Mark (A) Alive or (D) Deceased

	Mother	Father	Brother	Sister	Daughter	Son
Cancer- What type?						
Diabetes						
Heart Disease						
Hypertension						
Asthma						
High Cholesterol						
Rheumatoid Arthritis						
Lupus						
Stroke						
Thyroid Disease						
Seizures						
Other						

Social History:

Marital Status: Single Married Divorced Widowed Number of Children: _____

Occupation: _____ Employer: _____

Tobacco Use: Yes / No Pack per day: _____ Years: _____ Date Quit: _____

Alcohol Use: Yes / No Drinks per Week: _____

Marijuana Use: Yes / No

Fitness / Sports / Athletic Activities: _____

REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____, request communication of my protected health information by CHRISTUS Ortho and Sports Medicine by alternative means or at alternative locations. I understand this request applies only to communicate from CHRISTUS Ortho and Sports Medicine.

I wish to be contacted in the following manner: (check all that apply)

_____*Home Telephone _____
__OK to leave a message with details
__Leave message with call-back number only

_____Written Communication
__OK to mail to my home address
__OK to mail to my work/office address

_____*Work Telephone _____
__OK to leave a message with details
__Leave message with call-back number only

_____*Cell Telephone _____
__OK to leave a message with details
__Leave message with call-back number only

_____Other _____

***As a service to our patients, we provide courtesy appointment reminder calls and other important calls that may be placed using an automated or prerecorded message. By Providing your cell phone number, you consent to receiving such calls at this number.**

I wish for the following individuals to be allowed information verbally:

Name: _____ Phone # _____ Relationship to patient: _____

Name: _____ Phone # _____ Relationship to patient: _____

Name: _____ Phone # _____ Relationship to patient: _____

Note: This request will remain in effect until you notify us of a change

_____
Patients Name (PRINT)

_____
Patient's Guardian/Representative (PRINT)

_____
Signature of Patient

_____
Signature of Guardian/Representative

_____
Date

_____
Relationship to Patient/Representative Authority

_____
Date of Birth

_____
Date

The Identity of the requestor has been validated either with a picture ID, such as a driver's license or passport, or comparison of signatures documented in the medical record by: _____

Authorization for Use and Disclosure of Protected Health Information Patient Identification

X

Printed Name:_____ Date of Birth:_____

Address: _____

Social Security #: _____ Telephone: _____

Information to be Released — Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

[ ] Complete health record	[ ] Diagnosis & treatment codes	[ ] Discharge summary
[ ] History and physical exam	[ ] Consultation reports	[ ] Progress notes
[ ] Laboratory test results	[ ] Radiology reports/images	[ ] Cardiac imaging
[ ] Photographs, videotapes	[ ] Complete billing record	[ ] Itemized bill
[ ] Discharge Instructions	[ ] Pulmonary function results	[ ] Immunization Record
[ ] Release Of Information (ROI) Abstract — History &Physical **(H&P),** Discharge Summary, Labor & Delivery Note, Operative Report, Procedure Note, Consultation, Laboratory, Pathology, X-ray reports.		

Other (specify) _____

Purpose of Request

[ ] Treatment or consultation [ ] At the request of the patient [ ] Billing or claims payment

Other (specify) _____

Send / Release Information

[ ] Paper [ ] CD **[ ]** Electronic Portal (E-mail notification when access is available)

***Please initial if you** have **requested your information to be sent to you in an unencrypted electronic format**. _____

Release to Name: _____

Mail to Name: _____

Mail to Address: _____

E-mail Address:_____

Drug and/or Alcohol Abuse. and/or Psychiatric, and/or H1V/AIDS Records Release

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and/or psychiatric treatment I have been afforded the opportunity to sign a specific authorization. ***Initial One:*** Yes_____ No _____ Not Applicable _____

I understand if my medical or billing records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.
Initial One: Yes _____ No _____ Not Applicable _____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the office of Ortho San Antonio. Unless revoked, this authorization will expire on the following date or event or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize CHRISTUS Santa Rosa to release the protected health information specified above.

X

Signature: _____ Date: _____

Authority of Personal Representative to Request Disclosure: _____

Identity of Requestor Verified via: ( ) Photo ID ( ) Matching Signature **( )** Other, specify _____

Verified by:_____

Letter of Explanation

Ortho HOPD Provider-based Clinics

X **Patient name:** _____ X **Date of birth:** _____

Guarantor, if other than patient: _____ Relationship to patient: _____

Thank you for choosing your physician and CHRISTUS Santa Rosa Hospital – *Medical Center* to assist with your health care needs.

We share this note to inform you that you are being treated in a provider-based clinic, which is a department of CHRISTUS Santa Rosa Hospital – *Medical Center*. Patients visiting a provider-based clinic **will receive a bill from your physician** for any professional services (physician services) provided **and a separate bill from the CHRISTUS Santa Rosa Hospital - *Medical Center*** for facility-related fees. The provider-based model requires that these be split and billed separately. This is similar to the way CHRISTUS bills for other hospital based services like the Emergency Department, Therapy Services, Lab services and surgical procedures where the physicians bill individually for their services. That is why patients will receive a bill from the hospital and from the physician.

The specific amount you will be responsible for, if any, will be based on your individual insurance plan and will take into account your plan's contracted rates for the services provided and then applying any deductibles, co-payments or co-insurance. Secondary insurance, if applicable, could also impact the amount you owe.

For example:

Office Visits — Your physician bills for the physician component of the visit ($50-$100*); CHRISTUS Santa Rosa bills for the facility component of the visit ($115-$155*).

X-Rays — Your physician bills for the reading of the X-Ray ($7-$15*); CHRISTUS Santa Rosa bills for the x-ray itself (most between $80 and $250 each*).

Injections — Your physician may recommend administering one or more injections as part of your treatment plan. When you receive a bill from CHRISTUS for the injection(s), it will appear as **361 OR SVC MINOR SURGERY**. This definition was determined by the Government Agency that regulates the codes that CHRISTUS Health and all other health care institutions use to bill patients. The standard amount for the administration of the medication is $236*. This is separate from the physician's professional fee for the injection of the medication.

*Amounts listed above reflect *total charges* not necessarily the patient's out-of-pocket expenses.

The medication cost will be listed separately using code **636 Drug SPEC ID DETAIL**. The charge amount for the medications will vary depending on what the physician orders. Some of these medications may be more cost effective for you to purchase through your pharmacy, and bring to your appointment for injection. Your physician and CHRISTUS Santa Rosa Hospital – *Medical Center* can help you with this process.

*Amounts listed above reflect *total charges* not necessarily the patient's out-of-pocket expenses.

As your health care providers, your physician and CHRISTUS Santa Rosa are committed to offering you the best care possible.

X **Signature:** _____ X **Date:** _____

CHRISTUS SANTA ROSA Hospital - *Medical Center*