

ACKNOWLEDGEMENT OF NOTICES

Fondren Orthopedic Group, L.L.P.

_____ I acknowledge and agree that I have reviewed a copy of Fondren Orthopedic Group's **Notice of Privacy Practices** and have completed the form below to the best of my knowledge.

_____ I acknowledge and agree that I have reviewed a copy of Fondren Orthopedic Group's **WELCOME TO OUR PRACTICE** and understand that I will be asked for copays/deductibles at the time of check-in.

_____ I also understand that I must have a referral if I have an HMO or POS plan.

_____ I also understand that I must call the pharmacy to request a prescription refill. Refills ARE NOT approved after normal business hours, weekends or holidays.

_____ Minor Children (under age of 18 years) must be accompanied by a parent during an office visit.

_____ FMLA/Disability/Insurance Forms all incur a \$20.00 per form charge to be filled out.

_____ Pursuant to the requirements of Section 105.002 of the Texas Occupations Code, this is to inform you that each of the physicians in the Kingwood Practice has a financial ownership interest in the entities listed below, and may, indirectly, receive compensation for services you receive at these entities.

Memorial Hermann Surgical Hospital
300 Kingwood Medical Drive
Kingwood, Texas 77339

Fondren Orthopedic Group - Kingwood MRI
601 Rockmead Drive
Kingwood, Texas 77339

Fondren Orthopedic Group – Atascocita Physical Therapy
18411 W. Lake Houston Parkway, Ste 550
Humble, TX 77346

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

Signature of Patient or Guardian

Relationship to Patient

Date

Clinic Use Only

Fondren Orthopedic Group, L.L.P. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices, Welcome to our Practice and Patient Financial Disclosure Notice.

Signature of Employee

Date

Fondren Orthopedic Group, L.L.P.

7401 South Main Street
Houston, TX 77030-4509
713-799-2300

Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.**, your medical provider, to: (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from the redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

Print Patient's Name

Patient's Signature

Date

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

Print Legal Representative's Name

Legal Representative's Signature

Date

PATIENT QUESTIONNAIRE

NAME: _____ DOB: _____ TODAY'S DATE: _____
OCCUPATION: _____
CHIEF COMPLAINT: _____ DATE OF INJURY: _____
AFFECTED SIDE? R or L DESCRIBE PROBLEM: _____

PAST MEDICAL HISTORY (CHECK ANY THAT APPLY TO YOU) _____ NONE APPLY

<input type="checkbox"/> ANEMIA	<input type="checkbox"/> CA LUNG	<input type="checkbox"/> IRREGULAR HEARTBEAT	<input type="checkbox"/> OSTEOARTHRITIS
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> CA OVARIAN	<input type="checkbox"/> HEPATITIS A B C	<input type="checkbox"/> PNEUMONIA
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> CA PROSTATE	<input type="checkbox"/> HIV	<input type="checkbox"/> POOR CIRCULATION
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> CA THYROID	<input type="checkbox"/> HYPERTHYROIDISM	<input type="checkbox"/> PULMONARY EMBOLISM
<input type="checkbox"/> BLOOD CLOT	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> HYPOTHYROIDISM	<input type="checkbox"/> REFLUX
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> CHRONIC BACK PAIN	<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> RHEUMATOID ARTHRITIS
<input type="checkbox"/> CANCER	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> SEIZURE
<input type="checkbox"/> CA BRAIN	<input type="checkbox"/> DIABETES	<input type="checkbox"/> LUNG PROBLEMS	<input type="checkbox"/> SLEEP APNEA
<input type="checkbox"/> CA BREAST	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> LUPUS	<input type="checkbox"/> STROKE
<input type="checkbox"/> CA CERVICAL	<input type="checkbox"/> CON. HEART FAILURE	<input type="checkbox"/> MIGRAINES	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> CA COLON	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> NEUROLOGICAL DISORDER	<input type="checkbox"/> UTI
<input type="checkbox"/> CA KIDNEY	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> NUMBNESS/TINGLING	<input type="checkbox"/> OTHER _____

PAST SURGICAL HISTORY (CHECK ANY THAT APPLY TO YOU) _____ NONE APPLY

<input type="checkbox"/> ABDOMINAL SURGERY	<input type="checkbox"/> GALLBLADDER REMOVAL	<input type="checkbox"/> PARATHYROIDECTOMY
<input type="checkbox"/> AMPUTATION	<input type="checkbox"/> GASTRIC BYPASS/BANDING	<input type="checkbox"/> PNEUMONECTOMY
<input type="checkbox"/> ANGIOPLASTY	<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> PROSTATECTOMY
<input type="checkbox"/> APPENDECTOMY	<input type="checkbox"/> HEMORRHOIDECTOMY	<input type="checkbox"/> ROTATOR CUFF REPAIR
<input type="checkbox"/> ARTHROSCOPY KNEE	<input type="checkbox"/> HIP REPLACEMENT	<input type="checkbox"/> SPINE SURGERY CERVICAL
<input type="checkbox"/> ARTHROSCOPY SHOULDER	<input type="checkbox"/> HYSTERECTOMY COMPLETE	<input type="checkbox"/> SPINE SURGERY THORACIC
<input type="checkbox"/> BRONCHOSCOPY	<input type="checkbox"/> HYSTERECTOMY PARTIAL	<input type="checkbox"/> SPINE SURGERY LUMBAR
<input type="checkbox"/> CABG	<input type="checkbox"/> INTERVENTIONAL PAIN PROCEDURES	<input type="checkbox"/> TONSILLECTOMY
<input type="checkbox"/> CAROTID ENDARTERECTOMY	<input type="checkbox"/> KNEE REPLACEMENT	<input type="checkbox"/> TURP
<input type="checkbox"/> COLON RESECTION	<input type="checkbox"/> KYPHOPLASTY	<input type="checkbox"/> VASECTOMY
<input type="checkbox"/> FEMORAL BYPASS	<input type="checkbox"/> NEPHRECTOMY	<input type="checkbox"/> VERTEBROPLASTY
<input type="checkbox"/> FRACTURE REPAIR	<input type="checkbox"/> PACEMAKER	<input type="checkbox"/> OTHER _____

FAMILY HISTORY (CHECK ANY THAT APPLY) _____ NONE APPLY

<input type="checkbox"/> ANESTHESIA PROBLEMS	<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIABETES
<input type="checkbox"/> OSTEOPOROSIS	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HYPERTENSION (MOM)	<input type="checkbox"/> HYPERTENSION (DAD)
<input type="checkbox"/> STROKE	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> CANCER	<input type="checkbox"/> CA BREAST
<input type="checkbox"/> CA CERVICAL	<input type="checkbox"/> CA COLON/RECTAL	<input type="checkbox"/> CA BRAIN	<input type="checkbox"/> CA LUNG
<input type="checkbox"/> CA OVARIAN	<input type="checkbox"/> CA PROSTATE	<input type="checkbox"/> CA KIDNEY	<input type="checkbox"/> CA THYROID
<input type="checkbox"/> OTHER _____			

SOCIAL HISTORY (CHECK ALL THAT APPLY TO YOU) _____ NONE APPLY

<input type="checkbox"/> SINGLE	<input type="checkbox"/> CIGARETTE SMOKING	<input type="checkbox"/> PHYSICAL WORK	<input type="checkbox"/> STUDENT
<input type="checkbox"/> MARRIED	<input type="checkbox"/> PIPE SMOKING	<input type="checkbox"/> SEDENTARY WORK	<input type="checkbox"/> REGULAR DUTY
<input type="checkbox"/> DIVORCED	<input type="checkbox"/> CHEWING TOBACCO	<input type="checkbox"/> RETIRED	<input type="checkbox"/> LIGHT DUTY
<input type="checkbox"/> WIDOWED	<input type="checkbox"/> ALCOHOL	<input type="checkbox"/> HOMEMAKER	<input type="checkbox"/> OUT OF WORK

MEDICATIONS TAKEN DAILY (NAME AND DOSAGE) _____ NONE

PHARMACY USED: _____ **PH#** _____

ALLERGIES TO MEDICINE: (LIST ALL) _____ NO ALLERGIES

REVIEW OF SYSTEMS

(Please circle YES or NO if any currently apply to you)

PRINT PATIENT NAME: _____ PATIENT DOB: _____ DATE: _____

Have you had any new symptoms? Yes No Do you have diabetes? Yes No

GENERAL:

Fever? Yes No
Chills? Yes No
Sweats? Yes No
Weakness? Yes No
Malaise?(discomfort) Yes No
Abnormal Weight Loss? Yes No
Sleep Disturbance? Yes No

SKIN:

Sensation Disturbance? Yes No
Bruising? Yes No
Birthmark? Yes No
Rash? Yes No
Itching? Yes No
Dryness? Yes No
Suspicious Lesions? Yes No

EYES, EARS, NOSE, THROAT:

Double Vision? Yes No
Blurred Vision? Yes No
Eye Irritation? Yes No
Eye Discharge? Yes No
Vision Loss? Yes No
Eye Pain? Yes No
Light Sensitivity? Yes No
Earache? Yes No
Ringing in Ears? Yes No
Nasal Congestion? Yes No
Nosebleeds? Yes No
Sore Throat? Yes No
Difficulty Swallowing? Yes No
Hearing Loss? Yes No

NEUROLOGICAL:

Headaches? Yes No
Memory Loss? Yes No
Confusion? Yes No
Transient Paralysis? Yes No
Weakness? Yes No
Numbness? Yes No
Tingling? Yes No
History of Seizures? Yes No
Syncope?(fainting) Yes No
Tremors? Yes No
Vertigo?(dizzy) Yes No

CARDIAC:

Chest Discomfort? Yes No
Chest Pains? Yes No
Palpitations? Yes No
Syncope?(fainting) Yes No
Shortness of Breath? Yes No
Numbness in Arms? Yes No
Swelling of Limbs? Yes No

PSYCHIATRIC:

Depression? Yes No
Anxiety? Yes No
Memory Loss? Yes No
Mental Disturbance? Yes No
Suicidal Thoughts? Yes No
Mood Disorders? Yes No
Paranoia? Yes No
Sleep Disturbances? Yes No
Eating Disorder? Yes No

RESPIRATORY:

Cough? Yes No
Shortness of Breath? Yes No
Wheezing? Yes No
Chest Congestion? Yes No

ENDOCRINE:

Sensitivity to Cold? Yes No
Sensitivity to Heat? Yes No
Abnormal Weight Gain? Yes No
Excessive Thirst? Yes No
Excessive Urination? Yes No
Excessive Hunger? Yes No
Diabetes? Yes No

GASTROINTESTINAL:

Nausea? Yes No
Vomiting? Yes No
Diarrhea? Yes No
Constipation? Yes No
Abdominal Pain? Yes No
Blood in Stool? Yes No
Heartburn? Yes No

HEMATOLOGIC / LYMPHATIC:

Chronic Infections? Yes No
Abnormal Bruising? Yes No
Bleeding? Yes No
Enlarged Lymph Nodes? Yes No

GENITOURINARY:

Painful Urination? Yes No
Blood in Urine? Yes No
Urinary Frequency? Yes No
Urinary Hesitancy? Yes No
Incontinence? Yes No

ALLERGIC / IMMUNOLOGIC:

Hives? Yes No
Hay Fever? Yes No
Persistent Infections? Yes No
HIV Exposure? Yes No
Runny Nose? Yes No
Sinus Congestion? Yes No

MUSCULOSKELETAL:

Back Pain? Yes No
Joint Pain? Yes No
Joint Swelling? Yes No
Muscle Soreness? Yes No
Arthritis? Yes No

EXTREMITIES:

Redness of a limb? Yes No
Swelling of a limb? Yes No
Discoloration of a limb? Yes No