

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 \$15.00 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 Clear Lake Practice has a financial ownership interest in the entities listed below, and may, indirectly, receive compensation for services you receive at these entities.

Clear Lake Physical Therapy
520 Blossom
Webster, Tx. 77598

Fondren Orthopedic Group-Clear Lake MRI
520 Blossom
Webster, Tx. 77598

Fondren Orthopedic Group – Clear Lake Osteoporosis
520 Blossom
Webster, Tx. 77598

Houston Physicians' Hospital
333 N. Texas
Webster, Tx. 77598

Houston Physicians' Surgery Center
3810 Hughes Court
Dickinson, Tx. 77539

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: _____

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

WAS THIS RELATED TO AN AUTOMOBILE ACCIDENT? _____ Y _____ N

NEW PATIENT BACK, NECK AND HIP QUESTIONNAIRE

NAME: _____ **AGE:** _____ **DATE:** _____

How long have you had this problem? _____

Did you have an injury? YES or NO Was this work related? YES or NO

Date of injury: _____

How injury occurred: _____

Have you seen other physicians for this? YES or NO

List names: _____

What treatment have you had? Please include self treatment. (please circle)

NONE

Medications (list) _____

Brace

Physical Therapy

Home Exercise Program

Injections / Shots

Have you had any trouble with control of your bladder or bowel? YES or NO

Does your pain increase with coughing or sneezing? YES or NO

Does your pain increase with:

Sitting? YES or NO

Standing? YES or NO

Laying? YES or NO

Have you had any diagnostic testing?

X-rays YES or NO

MRI YES or NO

EMG(nerve studies) YES or NO

CT Scan YES or NO

Myelogram YES or NO

MARK THE AREAS OF YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS: USE THE APPROPRIATE SYMBOL AND INCLUDE ALL THE AREAS, WHICH ARE AFFECTED:

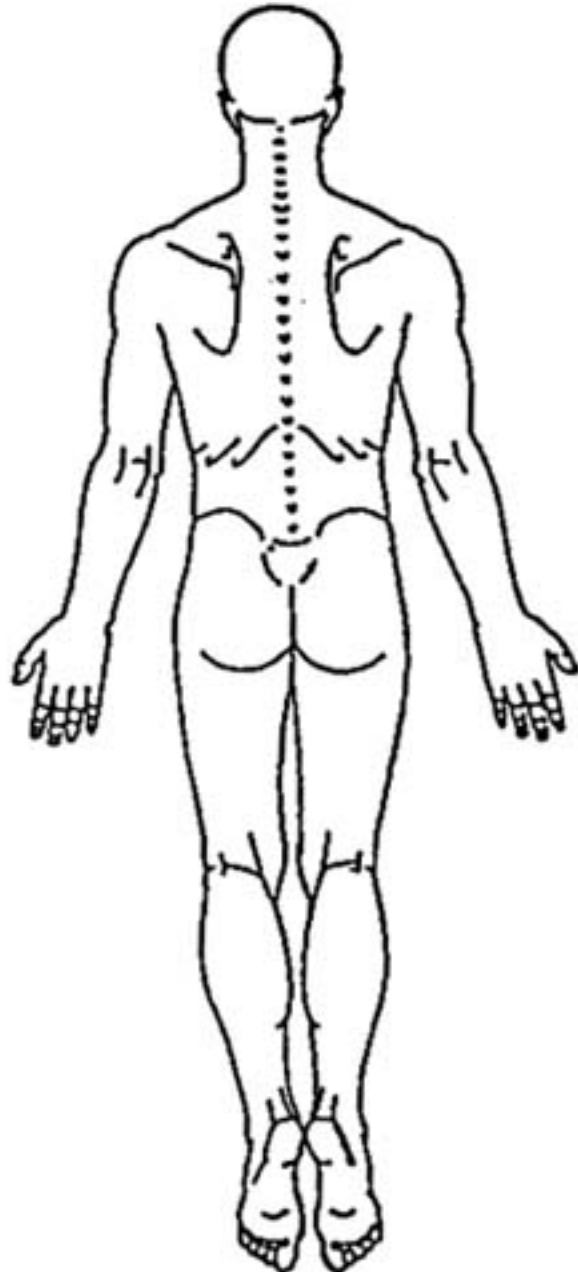
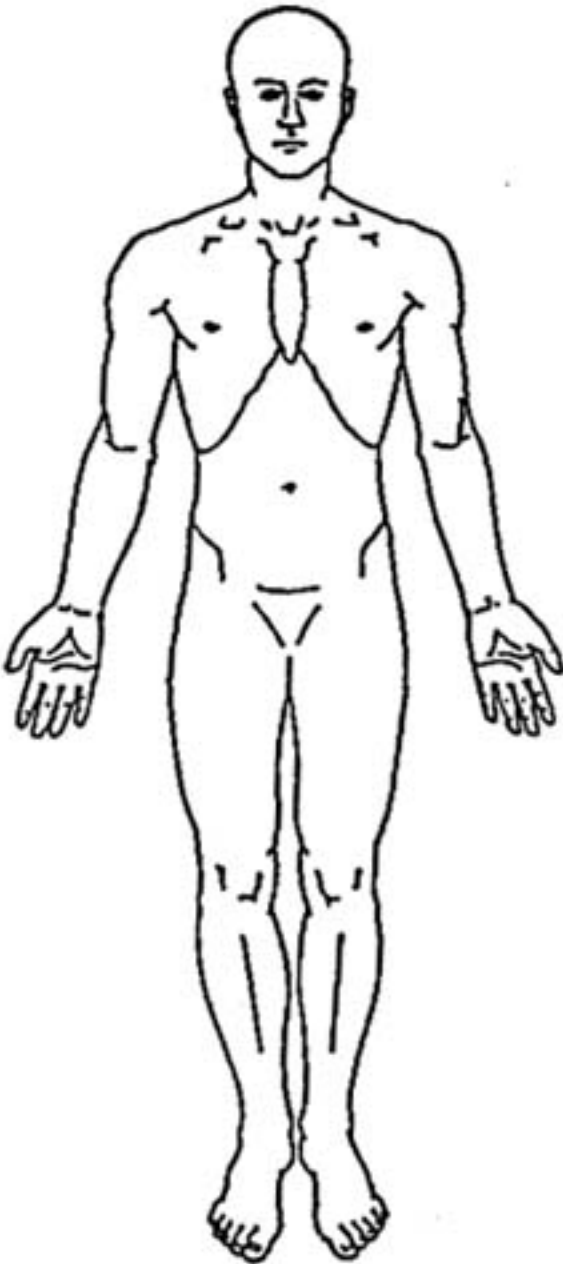
ACHE
++++

NUMB
=====

PINS/NEEDLES
00000000000000

BURNING
XXXXXXXX

STABBING
////////////////////



NEW PATIENT KNEE QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

Please Circle One:

RIGHT KNEE

LEFT KNEE

BOTH KNEES

How long has your knee(s) bothered you? _____

Is this an injury? **YES** **or** **NO**

Date of injury: _____

How injury occurred: _____

Have you seen other physicians for this? **YES** **or** **NO**

(If yes, please list) _____

What treatments have you had? Please include self treatment.

NONE

MEDICATIONS (list) _____

BRACE

PHYSICAL THERAPY

HOME EXERCISE PROGRAM

Does your knee:

Y or N POP

Y or N CLICK

Y or N SWELL

Y or N GIVE OUT

Y or N CATCH

Y or N GET STIFF AFTER SITTING

Y or N WAKE YOU UP AT NIGHT BECAUSE OF PAIN

PLEASE USE GRAPH BELOW TO DEMONSTRATE WHERE YOUR KNEE HURTS

