



ORTHOPEDIC CLINIC

A clinic of Parker Sports Medicine & Orthopedics

7000 W. 9TH AVE., AMARILLO, TEXAS 79106 • P.O. BOX 52230, 79159
806-350-BONE (2663) • FAX: 806-350-2664
www.drparker.com

Date: _____ Age: _____ M/F: _____ Race: _____
Patient Name: _____ Ethnicity: _____
E-Mail Address: _____ Primary Language: _____
Address: _____ City: _____ St: _____ Zip: _____
Phone: _____ Alternate Phone: _____
Social Security #: _____ Date of Birth: _____
Employer: _____ Occupation: _____
Employer Address & Phone: _____

Responsible party/Insured

Name: _____ Relationship to Patient: _____
Social Security #: _____ Date of Birth: _____
Employer/: _____ Occupation: _____
Employer/ Address & Phone: _____

Emergency Contact (OTHER THAN SPOUSE) Not in Same Household

Name: _____ Relationship: _____
Address: _____ City: _____ St: _____ Zip: _____
Phone: _____ Alternate Phone: _____
Employer: _____
Employer Address & Phone: _____

INSURANCE INFORMATION

Insurance Company: _____
Policy Holders Name: _____ Policy Holders Date of Birth: _____
Relationship to Patient: _____ Policy#: _____ Group: _____

Secondary Insurance: _____
Policy Holders Name: _____ Policy Holders Date of Birth: _____
Relationship to Patient: _____ Policy #: _____ Group: _____

I authorize release of any medical or other information necessary to process this claim.

I understand that services rendered today are my financial responsibility. Insurance is filed as a courtesy to you, there may be a difference between your benefits and fees.

I assign payment of medical benefits to: James R. Parker, M.D. - Parker Sports Medicine.

Signature: _____

Relationship: _____

PARKER PATIENT HISTORY

Name: _____ Age: _____ Today's Date: _____

Primary Care Physician: _____ Who referred you here? _____

What body part are we treating today? Left/Right/Both _____

DATE OF INJURY? _____ How, when and where did the injury occur? _____

Is this **WORK** related? Yes/No Is this **SCHOOL** related? Yes/No

What school do you attend? _____ What sport do you play? _____ Who is your coach? _____

Duration and description of symptoms: _____

Have you been seen by another doctor, clinic, or ER for this problem? List names, dates, or studies (ie: MRI, XRAYs)

Please circle the following that apply to you: Non-smoker Smoker Previous Smoker Use Smokeless Tobacco

Drink Alcohol: Never, Occasionally, or Frequently Use Illicit Drugs Dentures Contact Lenses

Are you currently having: headache excessive bleeding fever vomiting painful urination weight gain/loss

Does anyone in your family have/had bone or joint disease? YES/NO Have you ever had MRSA? YES/NO

Has Dr. Parker ever treated one of your family members? YES/NO If so who: _____

List all ALLERGIES to Medicine or Foods: _____

What SURGERIES have you had? (Include DATES and surgeon names): _____

Medicines you are taking/Medical problems you have: (if you need more space please use the back of the sheet)

Medication/Supplement <small>(example: DIOVAN)</small>	Reasons for taking Medicine <small>(example: high blood pressure)</small>	Treating Doctor/Prescriber <small>(example: Dr. John Doe)</small>

List any medical problems you are NOT taking medication for: _____

List all treating Physicians: _____

Pharmacy Name and Location: _____



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Authorization for the Disclosure of Health Information

This authorization is for the use or disclosure of health information:

Patient Name: _____
Date of Birth: _____ Phone Number: _____
Social Security Number: _____

I hereby authorize the use or disclosure of my health information to all parties involved in the treatment of my medical condition for which I have sought care by Parker Sports Medicine or the Direct Orthopedic Clinic. This pertains to medical records including progress notes, x-ray reports, imaging results, lab reports and operative records. This authorization applies to the following: hospitals, medical providers, school officials, athletic trainers, coaches and family members. Such records will be disclosed unless you specify information that you wish to be excluded or indicate a specific party you choose for exclusion.

Signature of Patient or Legal Guardian

Date

I understand that this authorization can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance upon this authorization. This authorization is for full disclosure of all health data which may include any information related to care for my impairment(s), information about how my impairment(s) affect my ability to complete tasks and activities of daily living. Information about how my impairment(s) affected my ability to work; and/or related to drug, alcohol, mental health, psychiatric conditions and /or sexually transmitted disease, Sickle Cell anemia, including AIDS/HIV information (42 CFR part2). Such records will be disclosed unless you specify information that you wish to be excluded.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this inform in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 16-524. If I have questions about disclosure of my health information I can contact Parkers Sports Medicine & Orthopedics.

Facsimile transmission of this form will be deemed as having the same force and effect as an original. The risks associated with the use of facsimile transmission are understood.

I have been offered the opportunity to ask questions about this form and I fully understand its content and meaning.

Patient or Authorized Representatives Signature

Date

If signed by legal representative, relationship to patient: _____

Witness Signature:



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of the Parker Sports Medicine & Orthopedics Notice of Privacy Practices.

Patient Signature

Date

Patient Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to patient

FOR OFFICE USE ONLY:

Parker Sports Medicine & Orthopedics has made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice Of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written Acknowledgement was not obtained.)

Name of Office Representative: _____

Date Placed in Patient Chart: _____



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ADVANCED BENEFICIARY NOTICE (ABN)

Patient Name: _____

NOTE: You need to make a choice about receiving these health care items or service.

Your private insurance may not pay for the item(s) or service(s) that are described below. Your private insurance does not pay for all of your health care costs. Your private insurance only pays for covered items and services when your private insurance rules are met. The fact that your private insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your private insurance probably will not pay for -

Items or Services:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

Ask us to explain, if you don't understand why your private insurance probably won't pay. Ask us how much these items or services will cost you (Estimate Cost: \$ _____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that my private insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my private insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my private insurance is making its decision. If my private Insurance does pay, you will refund to me any payments I made to you that are due to me. If my private insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally either out of pocket or through any other Insurance that I have. I understand I can appeal my private insurance's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not retrieve these items or services. I understand that you will not be able to submit a claim to my private insurance and that I will not be able to appeal your opinion that my private insurance won't pay.

Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your private insurance, your health information on this form may be shared with your private insurance. Your, health information which your private insurance sees will be kept confidential by your private insurance.