DALLAS ORTHO
DALLAS ORTHOPEDIC ASSOCIATES

Khawaja Nimr Ikram, DO
Board Certified Orthopedic Surgeon

We strive to provide quality, comprehensive care to our patients.

Patient Information

Date:_____

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print and **FILL OUT COMPLETELY**. All information is Confidential.

Name:_____
First Middle Last

Birth Date:_____ SS#:_____ Sex: [ ] M [ ] F

Address:_____Apartment#:_____

City:_____State:_____Zip:_____

Primary Phone #:_____ Type: [ ] Home [ ] Cell [ ] Work

Secondary Contact #:_____ Type: [ ] Home [ ] Cell [ ] Work

Email Address:_____

Employer name: _____

Employer address: _____

Employer Ph#: _____

Check Appropriate: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Race:_____ Ethnicity:_____

Emergency Contact:_____Relation:_____Ph.:_____

PCP/Treating Doctor: _____Ph.:_____

Address: _____

Pharmacy:_____ **Pharmacy Number**:_____

How were you referred to our office?_____

Financial Policy

It is customary to pay for professional services at the time of service. Patients with private health insurance must remember that they are responsible for the amount their insurance company does not cover. This is considered as copayment. If you have a secondary insurance please provide that in the above section as this will cover your co-pay if any. During the course of treatment by Dallas Ortho, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance company, patient co-pays, deductibles and co-insurance will be your responsibility and are due at the time of service. By signing below you are accepting financial responsibility for copayment, and/or all medical bills not covered by your insurance.

[ ] I certify that I have NO insurance and will be solely responsible for payment in full.

[ ] I certify that the insurance reported to Dallas Ortho is a complete listing. I understand that the office will not extend credit on, or submit a claim for any insurance not reported at the time of service. I will be responsible for any unpaid charges.

[ ] I certify that charges will be protected by an LOP provided by my attorney. I also understand that, if for any reason, I no longer have attorney representation, that I become fully responsible for all charges incurred.

Patient Signature: _____Date:_____
Parent or Guardian of child under age:_____Date:_____

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Assignment of Benefits

Primary Insurance Payer:	**Secondary Insurance Payer/Medicare Supplement:**
Insurance Name:_____	Insurance Name:_____
ID#:_____	ID#:_____
Group #:_____	Group #:_____
Ins. Co Phone:_____	Ins. Co Phone:_____
Primary Policy Card Holder's Information: Name:_____	Primary Policy Card Holder's Information: Name:_____
DOB:_____	DOB:_____
SSN:_____	SSN:_____
Relationship to patient:_____	Relationship to patient:_____

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster, for purposes of processing my claims for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court costs and interest from judgment upon violation.

STATUTE OF LIMITATIONS: I waive my rights to claim statute of limitations regarding claims for services rendered or to be rendered by the facility/physician named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

I have read and understand the above information and hereby authorize Dallas Ortho to prescribe and provide treatment. A photocopy of this instrument will serve as the original.

Print Name:_____ Date:_____

Signature of Patient:_____

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Comprehensive History & Physical

Please take a few minutes to complete this worksheet. This information will help us in providing your care.

Name:_____ Date of Birth:_____ Sex: F / M Height:_____ Weight:_____

Please list:

Drug Allergies: **[ ] N/A**	**Previous Surgeries:** **[ ] N/A**	**Current Medications: [ ] N/A**

Medical History:

Have you ever had or been told you have (Check all that apply): [ ] N/A

[ ] Chest Pain or angina
[ ] Heart Disease
[ ] MI, Heart attack, Blocked artery
[ ] Congestive heart failure
[ ] High Blood Pressure
[ ] Abnormal heart beat
[ ] Pacemaker
[ ] Angioplasty or heart cath
[ ] Damaged heart valve
[ ] HIV

[ ] Asthma
[ ] Shortness of breath
[ ] Emphysema
[ ] TB
[ ] Blood Disease
[ ] Glaucoma
[ ] Epilepsy/Seizures
[ ] Fainting Spells/Dizziness
[ ] Stroke
[ ] Mediport

[ ] Diabetes ___
[ ] Thyroid Disease
[ ] Adrenal Gland Problem
[ ] Steroid Use
[ ] Heat attack/Failure
[ ] Herpes
[ ] Cancer_____
[ ] Arthritis
[ ] Hepatitis _____

[ ] Ulcers, heartburn, reflux
[ ] Diverticulitis or Colitis
[ ] Hypoglycemia
[ ] Kidney Disease
[ ] Anemia
[ ] Dialysis
[ ] Blood thinners
[ ] STD_____
[ ] Other_____

Where is your pain? _____
Duration of pain:_____
Frequency of pain: [ ]Constant [ ]Rare [ ]Seldom

Quality of you Pain: [ ]Aching [ ]Cramping [ ]Dull [ ]Hot/burning [ ]Numbing [ ] Pins/needles [ ]Pressure
[ ] Sharp [ ] Shooting [ ] Stabbing [ ] Throbbing [ ] Tingling

Does your pain radiate? Y or N If so, where to:_____
Severity of pain: (On a scale of 1-10, 10 being unbearable what number would you rate it.)

At its **Worst**: 1 2 3 4 5 6 7 8 9 10 At its **Best**: 1 2 3 4 5 6 7 8 9 10
On **Average**: 1 2 3 4 5 6 7 8 9 10 At the **Moment**: 1 2 3 4 5 6 7 8 9 10

What makes you pain **worse**:
[ ] Bending
[ ] Changing Position
[ ] Defecation
[ ] Going up stairs
[ ] Going down stairs
[ ] Heat
[ ] Increased Activity
[ ] Lying Flat
[ ] Lifting
[ ] Movement
[ ] Sitting Long
[ ] Sneezing
[ ] Standing Long
[ ] Standing Straight
[ ] Turning Left
[ ] Turning Right

What makes your pain **better**:
[ ] Assistive devices
[ ] Changing Positions
[ ] Cold
[ ] Exercise
[ ] Heat
[ ] Injections
[ ] Lying Flat
[ ] Manipulation
[ ] Medication
[ ] Physical Therapy
[ ] Rest
[ ] Sitting
[ ] Standing
[ ] Walking

History of vertigo/dizziness: N/Y History of falls: N/Y History of fibromyalgia: N/Y
Use any supporting devices: N/Y [ ] Cane [ ] Crutches [ ] Walker [ ] Wheelchair

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Authorization to release Medical Records

Patient Name: _____ DOB: _____
SS#:_____ Ph#:_____

PLEASE RELEASE COPIES OF MY MEDICAL RECORDS TO THE INDIVIDUAL OR ORGANIZATION NAMED BELOW:
(Please note if requesting records for yourself there is a fee of $25 and will take 3-5 business days to obtain, if wanting to release to a Doctor's office it is free of charge.)

Release:

[ ] Entire Record [ ] Radiology /Imaging [ ] Laboratory Results [ ] Progress Notes DOS: _____

To: [ ] Self or

_____ _____ _____
Name/Family Member/Doctor's Office/Etc. Phone: Fax:

_____
Address City State Zip Code

This authorization gives Dallas Ortho permission to request/release your medical records from/to any healthcare provider that you may have received treatment from. Dallas Ortho is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State Laws and regulations. This includes any and alcohol and/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless specified above. Dallas Ortho is released and discharged from any liability, and the undersigned will hold Dallas Ortho harmless for complying this information.

I understand the following:

- **Incomplete forms will be null and voided: no exceptions.**
- I am not required to sign this authorization.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I may revoke this authorization at any time by presenting my written revocation to Dallas Ortho 10455 N Central Expy. #110 Dallas, TX 75231.
- The revocation will not apply to information that has already been used or released under this authorization.
- Physician's office has the right under Texas State Law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

_____ _____
Signature of patient or Legal representative Printed Name of patient or Legal Representative

_____ _____
Relationship to Patient or Legal Representative Date

Dallas Orthopedic Associates
Mesquite Location – 1102 N Galloway Ave, Mesquite, Tx, 75149
Plano Location - 5072 W Plano Pkwy, Ste 260, Plano, TX, 75093
Grand Prairie – 2507 Medical Row, Ste 103, Grand Prairie, Tx, 75051
P: (469) 518-7853 **F:** (469) 232-9917

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(HIPPA Release Form)

Patient Name: _____ DOB: _____

[ ] I authorize this release of information including the diagnosis, records; examination rendered to me and claims information. The information may be released to:

Full Name	Relation	Phone#

[ ] Release all Health Information
[ ] Release all Billing (including payments, collections, etc.)
[ ] Release Other (Specify):_____

Full Name	Relation	Phone#

[ ] Release all Health Information
[ ] Release all Billing (including payments, collections, etc.)
[ ] Release Other (Specify):_____

[ ] May NOT be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell phone: _____

If unable to reach me:

[ ] You may leave a detailed message regarding my test results.

[ ] Please leave a message for me to return your call.

Patient Signature: _____ Date:_____

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Office Policies

Appointments: _____ (initial)

- Our office hours are 8 am-12pm, and 1pm-5pm Monday through Friday. Please note that Fridays the Doctor does leave at 12pm for the rest of the day but staff does remain here until 5pm for any questions you may have.

Financial Policy: _____ (initial)

- An estimated payment is due at the time of service by cash, credit card (We do NOT accept American Express)
- Patients are responsible for copays, deductibles, and co-insurance if applicable at the time of service.
- Any balance on an account that is greater than 30 days old is considered past due. A statement will be mailed on a monthly basis and will reflect the current balance for all services rendered prior to the date on the statement, Payment is due upon receipt of statement.

Insurance: _____ (initial)

- Your insurance policy is a contract between you and your insurance company. While our billing professionals will do all they can to help our patients in communicating and negotiating with their insurance plan or other persons, we must inform patients that have any questions regarding coverage, benefits or payment for services provided, is their responsibility to resolve.
- *In the event of denials, errors, or non-covered services. (The patient is responsible for all services rendered.* If payment from your insurance carrier is not received within forty-five (45) days, we will seek full payment from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility after thirty (30) days. Dallas Ortho and its employees do not guarantee that payment will be authorized for medical services: therefore this office is not responsible for any adverse payment decisions or misuse of information.
- Notification of any change in your insurance status (i.e. new company, deductible, co-pay amounts) must be provided to the office forty-eight (48) hours in advance of next visit, or payment in full will be required.

Red Flag Policy: _____ (initial)

- Dallas Ortho store our patients' private medical, financial, and personally identifying data. We must therefore be vigilant
in protecting the patient information to which we have access including medical, financial, and any other personal information contained in medical, appointment or billing records."
- You must present a valid state issued photo identification card and if you would like us to bill your insurance carrier, you must present a valid insurance card and identification card prior to being seen at each appointment, or payment in full will be required.

Miscellaneous Charges: _____ (initial)

- For medical records you will be charged $25.00 and may take up to 3-5 business days to obtain.
- *If you do not cancel your appointment* 24 *hours in advance our policy is to charge the rate of $35.00 and is payable prior future visits.* These will not be billed to your insurance company. Please help us to serve you better by keeping your scheduled appointments or canceling in advance.

Refill Requests: _____ (initial)

- All requests for prescription refills must be made through your pharmacy. Your pharmacy will send us a refill request on your behalf, this will be the only way we can refill your medication if you are calling the office for them. If it is a narcotic you will need to schedule an appointment to be seen.

Emergency Situations | After Office Hours: _____ (initial)

- Any phone messages left after 4:00pm Monday through Friday will be returned the next business day.
- In the event that you call our office and the doctor is out, your call will be returned the next business day.
- If you feel that your call needs urgent attention you should go to the nearest emergency room or urgent care.

I have read and understand the Office/Practice, Privacy Policies and I agree to accept responsibility as described. If you have any questions, please feel free to ask our staff for assistance. Thank you for choosing us for your care.

_____ _____
Patient Name Date:

_____ _____
Patient Signature Witness

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Notice of Privacy Policies and Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

All items outlined in this policy apply to both paper and electronic formats of medical records and protected health information.

INTRODUCTION

Dallas Ortho is committed to treating and using protected health information about you responsibly. We are permitted to use and disclose health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive. This notice describes our privacy practices. We may change our policies and this notice at any time. You can request a copy of this notice or our revised copy at any given time. This notice applies to all protected health information as defined by federal guidelines.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We are permitted to use and disclose your health information to those involved in your treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, ad providing treatment. For example: results of laboratory tests or procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We are permitted to use and disclose your health information to bill and collect payment for the services we provided to you. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We are permitted to use and disclose your health information for the purpose of healthcare operations, which are the activities that support this practice and ensure that quality care is delivered. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION

These are situations in which we are permitted to use or disclose your health information without your written authorization or an opportunity to object.

Public Health: We may disclose your health information for public health activities mandated by federal, state, or local government for the collection of information about disease, vital statistics or injury by a public health authority.

Abuse or Neglect: Because Texas law requires physicians to report child abuse or neglect, we may disclose health information to a public agency authorized to receive reports of child abuse or neglect.

Law enforcement and legal proceedings: We may disclose your medical information if asked by a law enforcement official. We may also release information if we believe the disclosure is necessary to prevent or lessen imminent threat to the health or safety of a person. We may disclose your health information in the course of judicial or administrative proceedings in response to an order of court or other appropriate legal process.

Workers Compensation: We may disclose your health information as required by workers compensation law.
Required by law: We may release your health information if required by law.

YOUR RIGHTS UNDER FEDERAL LAW

These include:

- The right to request restrictions on the use and disclosure of your protected health information. We DO NOT have to agree to this restriction.
- The right to limit disclosure to family members, relatives, and friends who may or may not be involved in your care.
- The right to request that we send communications concerning health information by alternative means to an alternative location. The request must be submitted in writing to the person at the end of this document and we are required to accommodate only reasonable requests.
- The right to inspect and copy your protected health information that is within the designated record set. Texas law requires that request for copies are made in writing and we require requests for inspection also be made in writing. Texas law requires us to provide copies or a narrative report within 15 business days from receipt of your proper request. HIPPAA permits us to charge a reasonable cost-based fee.
- The right to amend or submit corrections to your protected health information in the designated record set.
- The right to receive an accounting of disclosures that are other than for treatment, payment, healthcare operations or made via am authorization signed by either you or your representative.

For more information or to report a problem

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of Dallas Ortho please contact:

Privacy Officer | Dallas Ortho | Mesquite Office – 1102 N Galloway Ave, Mesquite, Tx, 75149 | (469) 518-7853
Plano Office – 5072 W Plano Pkwy, Ste 260, Plano, TX, 75093
Grand Prairie-2507 Medical Row, Ste 103, Grand Prairie, Tx, 75051