NTOS
NORTH TEXAS
ORTHOPAEDIC & SPINE

**Patient Information** **Date**: _____

**Please do not leave anything blank. Mark n/a if not applicable.**

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

Primary Care Physician:_____

Phone.:_____

Pharmacy and Zip Code: _____ Pharmacy Number:_____

How were you referred to our office? _____

## Insurance Information

Primary Insurance:_____ Subscriber's Name: _____ ID# _____ Group # _____

Secondary Insurance:_____ Subscriber's Name: _____ ID# _____ Group # _____

## Consent to Release Claims Information and Assignment of Benefits

- I hereby assign, transfer and set over to NTOS, LLC all my rights, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company(ies).
- I hereby consent for NTOS, LLC or any of its employees or agents to release and disclose any information required about me (or the above-named patient) to my insurance carrier, claims administrator, managed care company, or review agency, their employees or agents for the purpose of treatment, healthcare operations, and evaluating claims for payment.
- I understand insurance billing is a service provided as a courtesy and that I am always personally responsible for any fees not covered by my insurance carrier. Should any insurance payment be made directly to me or to the insured for monies due on this account, I agree to immediately pay over these funds to NTOS, LLC. I also acknowledge I am responsible for any deductible, copay or other balance not covered by my insurance carrier.
- I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by NTOS, LLC, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

**Patient Name:**_____**Date:** _____

***Patient Signature (parent or guardian if patient under 18:** _____

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## Communication Preferences

| | | | |
|---|---|---|---|
| May we contact you by phone for appointment reminders? | YES NO | HOME WORK | BOTH |

Please let us know who we may share your information with:

Please complete the fields below and select the appropriate checkboxes based on your approval for each person you list.

Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information**

Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information**

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's ***Billing Account*** and ***Medical Conditions*** to the patient or legal guardian. The duration of this authorization indefinite unless otherwise revoked in writing. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

## Acknowledgement of The Receipt of North Texas Orthopaedic & Spine Notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIIPPA) is a federal government of regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. NTOS, LLC will furnish you with a notice (by request only) which provides information about how NTOS, LLC may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have been informed / offered a copy of NTOS, LLC Notice of Health Information Practices.**

***Patient Signature**: _____ **Date**: _____

## NARCOTIC POLICY

Certain narcotic medications can only be filled/refilled with a handwritten prescription or token code sent over by the physician. Therefore, prescriptions will only be written or sent during normal business hours and we CANNOT accommodate walk-in requests. You will need to call in and allow up to 48 business hours for us to obtain a signature/token. We will call when your prescription can be picked up or has been sent in to the pharmacy. Beginning September 1, 2019, the Texas Legislature passed a bill limiting opioid prescriptions to 10 days.

By signing below, I understand that if I do not list someone to pick up my prescription on my behalf below, they will NOT be allowed to pick it up on my behalf.

I authorize _____ and/or _____ (full legal name) to pick up narcotic prescriptions on my behalf. I and they understand they will be required to show valid ID before the office will release the prescription.

***Patient Signature**: _____ **Date**:

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# Cancellation Policy/No Show Policy for Doctor Appointments and Surgery

## I. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

**If an appointment is not canceled at least 24 hours in advance you will be charged a seventy-five dollar ($75) fee; this will not be covered by your insurance company.**

## 2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

**If a patient is l 5 minutes past their scheduled time we will have to reschedule the appointment.**

## *3. Cancellation/ No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

**If surgery is not cancelled at least 10 days in advance you will be charged a ($250) fee: this will not be covered by your insurance company.**

## *4. Account balances*

We will re-quire that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concern.

Patients with balances over $l00 must make payment arrangements prior to future appointments being made.

| _____ | _____ | ____/____/____ |
|---|---|---|
| **Print Name Patient** | **Signature Patient/Guardian** | **Date** |

Patient Account# _____

(Office Use Only)

# North Texas Orthopaedic & Spine – Office Policies

## Appointments & Office Hours

- **We can only see you for one condition per visit due to increased regulated documentation requirements.**

## Financial Policy

- ***Payment is due at time of service. We accept cash, Visa, MasterCard or Discover.***
- For patients with health insurance, co-payments, co-insurance and/or deductibles will be collected at the time services are rendered. Your insurance policy is a contract between you and your insurance company. In the event of denials, errors, service caps, policy exclusions or non-covered services, the patient is responsible for payment of all services rendered. **It is the patient's responsibility to know whether our providers are in-network with their insurance plan.** Patient will be responsible for any charges incurred whether in or out of network. Please notify the office of any changes in insurance coverage before services are rendered.
- If you do not have insurance, the office staff can provide you with a cost for services which is due in full, at time of service.
- Any account balance you may have must be paid in full prior to scheduling surgery.
- We reserve the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery.
- If you have multiple primary insurance policies, you are responsible for coordinating primary vs. secondary with your insurance companies. Failure to do so will result in claim denials and refusal to pay.

## Identity Verification

- If you would like us to bill your insurance carrier, you must present a valid insurance card AND identification prior to being seen at check-in **at every visit** or payment in full will be required.

## Fees for Services

- Medical records: $25.00 for first 30 pages, $.25 each page thereafter. Please allow up to 15 business days.
- Disability, FMLA, employer-related or legal forms are $25.00, per occurrence. **(**Our physicians do NOT perform complete disability evaluations for military or worker's compensation reviews.)**

## Medication Refill Policy

- All requests for prescriptions must be made 48 hours in advance. Please have your pharmacy request your refill. Medication refills are only addressed during office hours. Narcotic prescriptions must be picked up in person and cannot be mailed or called in. *By signing below, you are authorizing us to view your external Rx history.

***I have read and understand the Office Policy and I agree to accept responsibility as described above. I also understand the Policy may be amended from time to time by the practice***

| Printed Name | Signature | Date |
|---|---|---|

**I, _____(print name) have read and understand this Financial Policy. I understand and agree to this Financial Policy. I further understand and agree that my failure to follow this Financial Policy may result in North Texas Orthopaedic and Spine terminating my patient-physician relationship.**

_____ _____

**Patient's Signature (or Parent/Guardian Signature as applicable)** **Date**

## Work-Related Injury?

**The patient is responsible for:** Providing our office with accurate information about the reason for seeking care today. If you feel this visit is or may be covered by **Workers' Compensation** (did your injury occur on or near your office/jobsite or while working for your employer?) it is your responsibility to notify our office at your **first visit**. If you fail to notify our office at your first visit, *you will be responsible for paying for any related, previously billed charges and any further charges up to and if we obtain payment from the work comp insurance company.* If we receive payment from the workers' comp insurance company, we will issue the patient a refund for the claim(s) paid.

**DECLINATION: I have read and fully understand this form and by my signature I am attesting that my current medical condition/injury did not happen while at work and/or while at my place of employment.**

_____ _____

Patient Signature (parent/guardian if patient under 18) Date

**OR**

**If you think your injury may be or is covered by your employer's workers' compensation policy, please fill out the below sections:**

Employer: _____

Name of Supervisor/HR Director: _____ Email: _____

Supervisor/HR Phone: _____

What was the date of your accident? _____

Name of Worker's Comp Insurance Company Accident claim #: _____

Adjuster name: _____

Contact info: _____

_____ _____

Patient signature (parent/guardian if patient under 18) Date

_____

Patient name (please print)

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

**Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.** Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

**NAME OF PATIENT OR INDIVIDUAL**

_____
Last First Middle

**OTHER NAME(S) USED** _____

**DATE OF BIRTH** Month _____ Day _____ Year _____

**ADDRESS** _____

_____

**CITY** _____ **STATE** _____ **ZIP** _____

**PHONE** (_____)_____ **ALT. PHONE** (_____)_____

**EMAIL ADDRESS** (Optional): _____

**I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:**

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

**WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?**

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

**REASON FOR DISCLOSURE**
**(Choose only one option below)**

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

**WHAT INFORMATION CAN BE DISCLOSED?** Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

**Your initials are required to release the following information:**

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURE X**_____ _____
**Signature of Individual or Individual's Legally Authorized Representative** **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

**SIGNATURE X**_____ _____
**Signature of Minor Individual** **DATE**

# IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

**Definitions** - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

**Health Information to be Released** - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

**Note on Release of Health Records -** This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

**Authorizations for Sale or Marketing Purposes** - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

**Limitations of this form -** This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

**Charges -** Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

**Right to Receive Copy -** The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

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## Comprehensive History & Physical

**Please do not leave anything blank. Mark n/a if not applicable.**

**Height**: _____ **Weight**: _____ **Shoe Size:** _____

**Please list:**

**Drug Allergies:** **[ ] N/A**

_____
_____
_____
_____
_____

**Environmental / Food Allergies: [ ] N/A**

_____
_____
_____
_____
_____

**Previous Surgeries: [ ] N/A**

_____
_____
_____
_____
_____

## Medical History:

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

[ ] Anemia
[ ] AIDS/HIV
[ ] Alcoholism
[ ] Angina or Chest Pain
[ ] Anxiety
[ ] Asthma
[ ] Atrial Fibillation
[ ] Arthritis
[ ] Bilpoar Disorder
[ ] Cancer
[ ] Coronary Artery Disease
[ ] Congestive Heart Failure
[ ] Colitis
[ ] COPD
[ ] Crohn's Disease
[ ] Depression
[ ] Diabetes
[ ] Dialysis
[ ] Deep Vein Thrombosis
[ ] Fibromyalgia
[ ] Fainting Spells/Dizziness
[ ] Gallbladder Disease
[ ] GERD
[ ] Gout
[ ] Heart Attack / Failure
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Kidney Disease
[ ] Liver Disease
[ ] Lupus
[ ] Migraine Headaches
[ ] Multiple Sclerosis
[ ] Obesity
[ ] Osteoarthritis
[ ] Osteoporosis
[ ] Peptic Ulcer Disease
[ ] Pacemaker
[ ] Peripheral Vasular Disease
[ ] Seizures
[ ] Sleep Apnea
[ ] Stroke
[ ] Schizophrenia
[ ] Thyroid Problems
[ ] Other_____

## ARE YOU CURRENTLY EXPERIENCING? (REVIEW OF SYSTEMS)

[ ] Fever
[ ] Significant Weight Change
[ ] Vision Problems
[ ] Cold / Cough Symptoms
[ ] Shortness of Breath
[ ] Chest Pain
[ ] Heart Palpitations
[ ] Diarrhea
[ ] Constipation
[ ] Urinary Inconsistance
[ ] Pain with Urination
[ ] Joint Pain
[ ] Chronic Headache
[ ] Rash on affected Limb

| Social History | Circle your responses | | |
|---|---|---|---|
| Females – Any chance you may be pregnant? : Yes No | Do you live alone or with family? | | |
| Receiving Hospice Care? Yes No | Are you in Skilled Nursing or an Inpatient Rehab Facility? Yes No | | |
| Activity Level: Low Moderate Active | | | |
| Current Smoker Former Smoker Non-Smoker | If former how long ago did you quit? | | |
| If current how often? | How many per day: | Interested in Quitting? Yes No | |
| Do you consume alcohol? Yes No | How Often: | How Many Drinks? | |
| Have you ever used illegal drugs? Yes No | Type: | Currently? | |
| Have you been addicted to prescription medications? Yes No | Type? | | |
| Do you drink caffeinated beverages? Yes No | How many cups per day? | | |

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**Please list ALL Current Medication:** (including non-prescription, vitamins, and herbal supplements)

| **Medication Name** | **Dosage:** | **Freuency:** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Family History:** (Condition, Family Member, and Comment)

_____ _____ _____
_____ _____ _____
_____ _____ _____

**Reason for Visit:**

Where is your pain? _____
Which side is affected? _____ Was this a result of an accident/injury? [ ] No [ ] Yes
When did they pain start? _____The pain: [ ] started suddenly [ ] progressively became worse
Does the pain move to other ares? [ ] No [ ] Yes
Have you had prior surgery at site of pain? [ ] No [ ] Yes If yes, type of surgery and when:_____
Frequency of pain: [ ] Constant [ ] Rare [ ] Seldom

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

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

Histoy or Vertigo / dizziness? [ ] No [ ] Yes
History of falls? [ ] No [ ] Yes
History of Fibromyalgia? [ ] No [ ] Yes

Do you use any supporting devices? [ ] No [ ] Yes
[ ] Cane [ ] Crutches [ ] Walker [ ] Wheelchair

Have you done any Physical Therapy? [ ] No [ ] Yes If yes, when and for what reason? _____
Have you ever received any pain injections? [ ] No [ ] Yes

Does your pain radiate? [ ] No [ ] Yes If yes, where to? _____

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

**Where is your pain located <u>NOW?</u> Mark the areas below where you feel the described sensations using the symbols provided. Include all affected areas.**

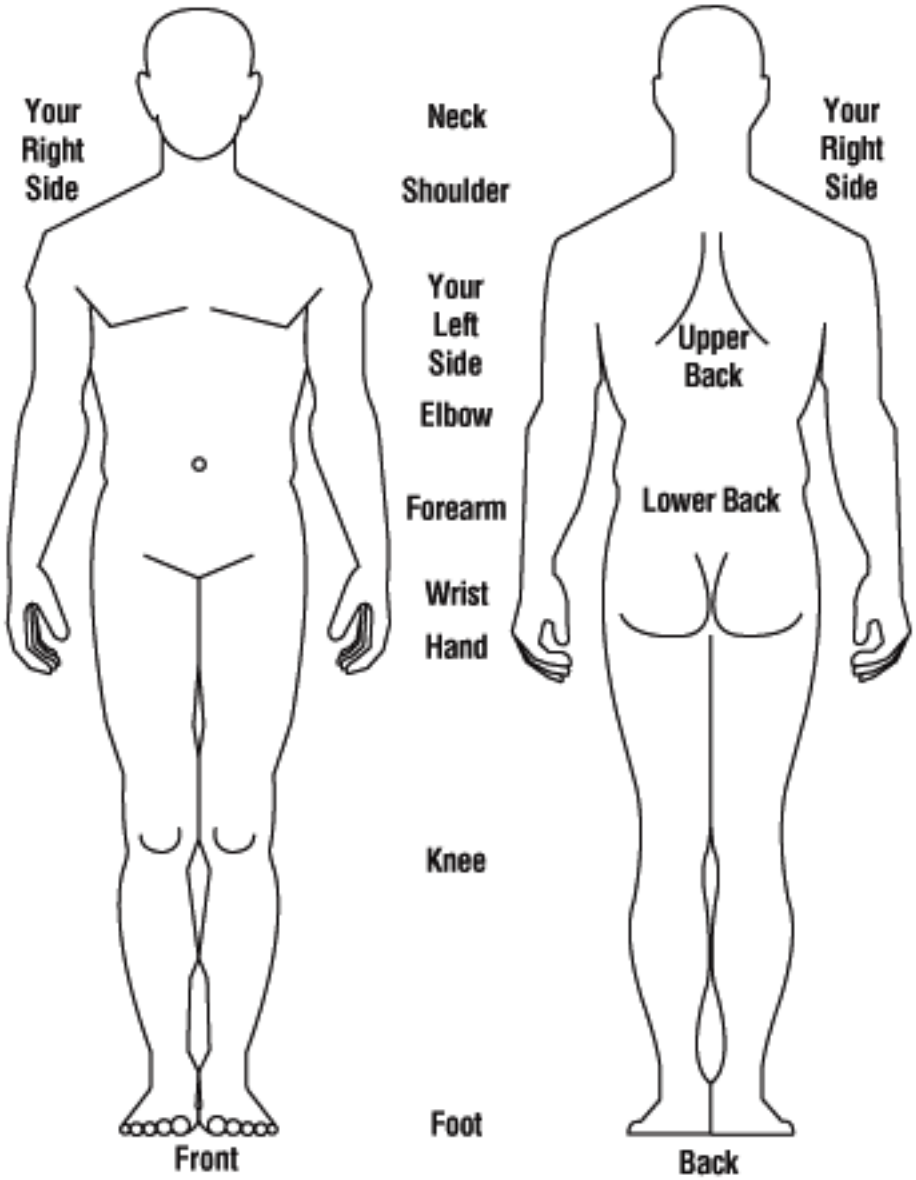
/\/\/\ Ache

ooo Numbness ===

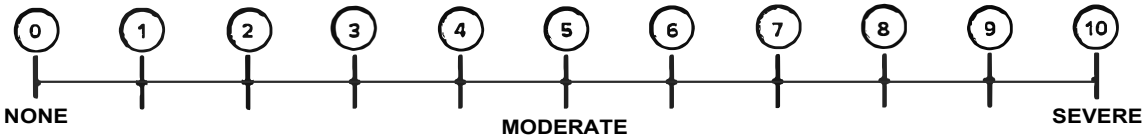
Pins & Needles / /

/ Stabbing

**xxx** Burning




**PLEASE INDICATE BELOW: How bad is your pain on a scale from O to 10?**



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## Disclosure of Physician Ownership

Vudhi Slabisak, MD is the owner NTOS, LLC and has ownership and/or investment interests in:

Legent Health: Legent Hospital for Special Surgery, Plano, TX. & Legent Outpatient Surgery, Frisco, TX.
Clover Anesthesia, LLC
NTOS Physical Therapy d/b/a Rise Physical Therapy
NTOS Durable Medical Equipment

Bruce Markman, MD has investment interests in:

Peak Health Surgicare Richardson
Legent Hospital for Special Surgery
NTOS Durable Medical Equipment

Rahul Banerjee, MD has investment interests in:

Peak Health Surgicare Richardson
NTOS Durable Medical Equipment

James Stanley, MD has investment interests in:

Peak Health Surgicare Richardson
NTOS Durable Medical Equipment

Khawaja Ikram, DO has investment interests in:

NTOS Durable Medical Equipment

Amir Malik, MD has investment interests in:

NTOS Durable Medical Equipment

Steve Hong, MD has investment interests in:

NTOS Durable Medical Equipment

Services provided by these facilities may be out of network, and as a result you may receive an out of network bill. However, you have the right to choose the provider of your healthcare services and you have the option to choose the healthcare facility.
You will not be treated differently by Dr. Slabisak, Dr. Markman, Dr. Banerjee, Dr. Stanley, Dr. Ikram, Dr. Malik, and Dr. Hong if you choose to have services performed at a different facility.

I have read and acknowledged the Disclosure of Physician Ownership at NTOS

_____
Patient / Legal Guardian Signature

_____
Print Name

_____
Date