Rock

Orthopedic and Hand Center

Robert Launikitis, M.D.

Welcome to our practice

Please fill in current information for the patient

Patient Name_____Date_____

Patient Address_____

City_____State_____Zip code_____

Email address_____

Sex: M F Home # _____ Drivers license # _____

Work #_____ Cell or Alternative_____

Date of Birth_____ Age: _____ SSN:_____

Marital Status: Single Married Divorced Widowed

PatientsEmployer/School_____Occupation_____

Patients Primary Insurance:_____

Insurance ID#_____Group Number_____

Policy holders Name:_____Date of Birth:_____

Policy holders SSN_____Relationship To Patient_____

Patients Secondary Insurance:_____

Insurance ID #_____Group Number_____

Policy Holders Name:_____Date of Birth:_____

Policy Holders SSN_____Relationship to Patient_____

Emergency Contact_____

Emergency contact relationship_____

Emergency contact phone number_____

PAYMENT IS EXPECTED AT TIME OF SERVICE

Injury/Pain Questionnaire

Name_____ Sex M F DOB_____

AGE_____ Height____ ____ Weight_____

Present injury or orthopedic problem_____
Is this a work related injury? YES_____ NO_____
How did this injury occur_____
Date of injury_____ Referring Physician_____
Were you seen in the Emergency room? Yes _____ No_____
What hospital or E.R/Clinic_____Referring Dr_____
Were x-rays taken? YES NO Did you bring X-ray / MRI / CT _____
Have you ever had an evaluation by another physician for this problem? YES NO
If so by DR _____Date_____ Is this a recurrent problem? YES NO
Ever had Surgery for this problem? YES NO
If so by what DR_____ Date_____ Surgery performed_____

Please list:

Current medications:_____

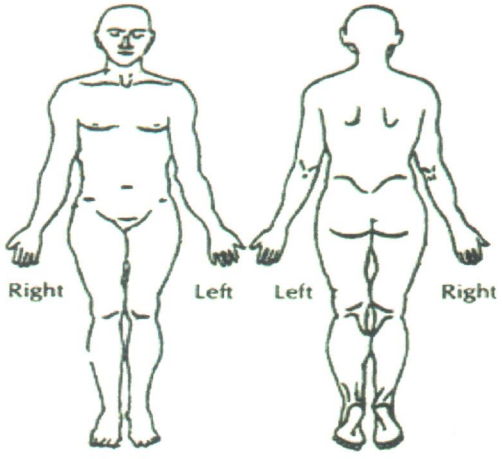
_____

Allergies:_____

_____

BODY CHART

Please fill in body outline to show where your pain is.



ROCK ORTHOPEDIC AND HAND CENTER

Patient Name:_____

Pharmacy Name:_____Pharmacy phone number:_____

Past Medical History:

High Blood Pressure	YES NO
Heart disease	YES NO
Stroke	YES NO
Obstructive pulmonary disease	YES NO
Kidney disease	YES NO
Thyroid Disease	YES NO
AIDS/HIV	YES NO
Hepatitis	YES NO
Rheumatoid arthritis	YES NO
Arthritis	YES NO
Diabetes	YES NO

Social History: Do you use:

Tobacco	YES NO
Recreational drugs	YES NO
Alcohol	YES NO

Family History: anyone in your family had any of these conditions?

Heart disease	YES NO
Stroke	YES NO
Cancer	YES NO
Bleeding disorder	YES NO

Surgical History:
Please list any past surgeries:_____

Review of systems: Do you have any of these symptoms?

Constitutional:	
Depression	YES NO
Fever	YES NO
Weight loss/gain	YES NO
Heart:	
Chest pain	YES NO
Irregular heart beat	YES NO
Poor circulation	YES NO
Genitourinary:	
Bloody urine	YES NO
Pain on urinating	YES NO
Unable to urinate	YES NO
Neurological:	
Paralysis	YES NO
Frequent Headaches	YES NO
Blood:	
Bleeding problems	YES NO
Blood transfusion	YES NO
Eyes:	
Decreased vision	YES NO
Cataracts	YES NO
Lungs:	
Shortness of breath	YES NO
Wheezing	YES NO
Persistent cough	YES NO

Musculoskeletal:	
Joint swelling	YES NO
Muscle aches	YES NO
Joint pain	YES NO
Psychiatric:	
Depression	YES NO
Bipolar disorder	YES NO
Allergies:	
Allergies to food	YES NO _____
Allergies to things other than medicine	YES NO _____
Ears, nose, throat:	
Loss of hearing	YES NO
Sinus problems	YES NO
Gastrointestinal:	
Stomach pain	YES NO
Diarrhea	YES NO
Persistent vomiting	YES NO
Skin:	
Rash	YES NO
Dryness of skin	YES NO
Endocrine:	
Thyroid problems	YES NO
Diabetes	YES NO

Any other conditions:_____

FEMALES:
Any chance you may be pregnant: YES NO

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Office and Financial Policies

Welcome and thank you for choosing ROCK Orthopedic and Hand Center for your care. We are committed to providing you with the highest quality medical care in an efficient, timely, and cost effective manner. We hope that by providing you with our policies in advance will help prevent any misunderstanding or frustration at the time of your visit.

Initial_____ Consent to Treatment: Knowing that I have a condition requiring health care, I voluntarily authorize and consent to any and all medical treatments as may be deemed advisable by any and all ROCK Orthopedic and Hand Center healthcare providers.

Initial____ Insurance Requirements: When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you have a referral prior to seeking a specialist, please contact your primary care physician so that you will have the referral in hand at the time of the appointment. If you do not bring your referral with you to your appointment, we will need to reschedule your visit.

Initial____ Insurance Claim Filing Responsibilities: As a courtesy, we will gladly file your insurance claim on your behalf. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance company does NOT pay within this time, you will be responsible for the entire balance. Balances are due upon receipt. There will be an 18% APR applied monthly to all balances greater than (30) days. Balances of (90) days or greater will be considered delinquent and subject to a monthly statement processing fee of $75. Accounts referred to collections will be subject to a collection fee of 35%, which will be added to the total balance due at the time the account is transferred.

Initial____ Payment of co-pays, insurance deductibles, and patient out-of-pocket responsibilities are expected at time of service. If a surgical procedure is required all deductibles, and patient out-of-pocket responsibilities, to include any balances must be paid no later than close of business the day before. If not, your surgical procedure may be postponed or cancelled.

Initial____ Check In: Please arrive for your appointment at least 15 minutes prior to your appointment time so that all paperwork may be completed before you are scheduled to see one of our medical providers. Please be prepared for co-pays, deductibles, and any past balances or fees for any non-covered services prior to seeing your scheduled provider. Also, bring your current insurance card with you to EACH VISIT. Without the insurance card, we will be unable to file your insurance, and you will be responsible for the full amount of the charges accrued for the day. On follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up to date. For your convenience, we accept all major credit cards in addition to cash and check.

Initial_____ Late Arrivals: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, we reserve the right to reschedule your appointment so that other patients are not inconvenienced.

Initial____ No Shows and Late Cancellations: We ask that you give us the courtesy of a 24-hour advance notice if you must cancel your appointment to allow us to offer the appointment time to other patients. No shows with out proper notice may be subject to a $35 no call/no show penalty fee.

Initial_____ Minors: The parent(s) or legal guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Additionally, unaccompanied minors may obtain treatment from ROCK Orthopedic and Hand Center providers if a parent or legal guardian initials the designated space at the beginning of the section and signs the designated space at the end of this document.

Initial_____ Medical Records/ Imaging: Copies of your medical records/ imaging (MRI, X-Ray) are available to you upon request at a nominal administrative charge. The production of records may be subject to a $25 or greater fee in certain circumstances.

Initial_____ Returned Goods (Durable Medical Equipment) Policy: A patient may return any brace or soft good within (2) days from the date of service (*custom or special items are not returnable*). If your insurance company determines that a particular service is not "reasonable and necessary" under your insurance company program standards, your insurance company will deny payment for that service. If you receive the service/product and this insurance nonpayment occurs, you will be responsible for the amount due.

Initial_____ Any forms that are requested for completion or signature that is not directly related to current treatment will be subject to an administration fee of $25 per form, i.e.... FMLA, short or long-term disability forms, and temporary handicap applications.

My initialing of each of the above policies means that I have read, understand, and agree to the office and financial policies outlined. I hereby attest that I have agreed to provide current demographic and insurance information as well as authorizing the release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name_____

Responsible Person's Signature_____Date_____

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PATIENT FINANCIAL RESPONSIBILITY NOTICE

As a courtesy our office will provide insurance billing and verification services for you. This is not a guarantee of benefits or coverage. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

Patients have two options:

1. Insured: You can pay regular insurance/government mandated fee schedule and we will bill insurance for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is met, your plan will most likely switch to a co-pay or percentage based status.
2. Self-Pay / Non-Insured: You can pay our Cash Pay fees, which are significantly less than the insurance/government mandated fee schedule. Since we will not need to pay staff to bill and follow up with insurance companies we can pass these savings on to you.

We will strive to work out feasible payment options for anyone who is in need of care. There will be an 18% APR applied to any monthly balances greater than (30) days. Unless other prior written agreements have been made, any outstanding balance more than (90) days old is considered delinquent. A statement-processing fee of $75 (based on the outstanding balance, per month) will also be added to all accounts that fit this criterion. Office policy dictates that delinquent accounts may be transferred to collections, which may include possible blemishes on your credit record. If this happens, an administrative collection fee of 35% will be added to your total balance to cover our costs and you specifically authorize us to run your credit report.

If your insurance denies payment for any reason, we will offer you a Cash Pay discount for any outstanding charges that are paid in full within (10) days of notice.

I authorize payment of insurance benefits directly to Rock Orthopedic and Hand Center and or Dr. Robert Launikitis. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understand, and agree with the terms on this page.

_____ _____

Signature of Patient or Responsible Party Date

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Patient Consent

Our "Notice of Privacy Practices and Rights of Patients" provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act.

The Patient/Guarantor understands:

- ***Protected health information may be disclosed or used for treatment, payment, or health care operations.***
- ***The Practice has a "Notice of Privacy Practices and Rights of Patients" and that the patient has the opportunity to review this notice.***
- ***The Practice reserves the right to change the Notice of Privacy Policies.***
- ***The patient may revoke this consent in writing at any time and all future disclosures will then cease.***

Patient/Guarantor initials to acknowledge:_____

Assignment and Release

Your initials and signature acknowledges your understanding of the Patient Consent section on this form. Your signature also authorizes ROCK Orthopedic and Hand Center to release medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when an assigned claim is filed. "I authorize that any benefits due be paid directly to my physician. I also understand payment is expected at the time of service (all co-pays and balances due must be paid when the service is given)."

_____	_____	_____
Patient Signature	Guarantor Signature (if patient is a minor)	Date

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NOTICE OF PRIVACY PRACTICES

Patients' disclosures and records shall be treated with confidentiality and privacy as required by federal and state law. The patient's written permission will be obtained before their medical records are made available to anyone not directly concerned with their care. The exceptions to written permission will be for suspected abuse, neglect and public health hazards when reporting is permitted or required by law.

Uses and disclosures of health information

- Physicians and other healthcare providers providing treatment to you.
- To obtain payment for the services we provide you.
- Healthcare operations such as quality assessment, improvement activities, review of overall service and treatment, conducting training programs, accreditation, certification licensing or credentialing activities,
- Your written authorization will release your health information to anyone for any purpose and can be revoked by you at any time with a written response.
- Health information can be released to family and friends for treatment, payment or healthcare operations with your authorization.
- Your information may be used to assist in the notification of (including identifying and locating) a family member, personal representative or another person responsible for your care, of your location, your general condition or death. If present you will have the opportunity to object to such uses or disclosures. In the case of incapacity or emergency circumstances, we will disclose health information based on professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. Professional judgment will also be used to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- Health information may be used to provide you with appointment reminders on postcards, letters or voicemail. Please notify us in writing if you prefer another method of notification.

The Privacy Policy is intended to provide an understanding to new policies concerning protected health information (PHI). We reserve the right to change our privacy practices and the terms of this notice at any time, provided applicable law permits such changes. Prior to making changes, a new notice will be made available upon request.

You may request a copy of our Privacy Policy Notice at any time. Additional information regarding Health Insurance Portability and Accountability Act (HIPAA) of 1996 can be found at http:/www.hhs.gov/ocr/hipaa/.

Patient Signature: _____ Date: _____

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PATIENT'S RIGHTS

Patients shall be provided, to the degree known, appropriate information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information shall be given to a person designated by the patient or to a legally authorized person.

Patients will have access to copies of their health information with a written request for a reasonable cost-based fee for expenses such as copies and staff time. Patients can request format and we will attempt to meet it. In the case we are unable to meet format requested, paper copies will be provided.

Patients shall be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

Patients have the right to request an alternative means of communication or location regarding health information. Request MUST be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Patient has the right to request a list of instances in which their health information was disclosed for purposes other than treatment, payment, healthcare operations, and certain other activities beginning 2/15/12. If request is made more than once in a twelve-month period, a reasonable cost-based fee will be charged.

Information will be available to patients and staff of ROCK Orthopedic and Hand Center concerning:

1. Patient Rights, including those specified in this section.
2. Patient Conduct and Responsibilities
3. Services available
4. Provisions for after-hours and emergency care
5. Fees for services
6. Payment policies
7. Patients' right to refuse to participate in experimental research
8. Options for reporting complaints and suggestions

Information provided in advertising or marketing regarding the competence of the staff will not be misleading to patients.

Patient Signature: _____ Date: _____

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original..

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient signature_____Date_____

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Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Doctor or Facility with affiliation and remuneration: Benjamin Agana, M.D., Creekside Surgery Center , Humble Surgical Hospital Spring Imaging and Med-Tech Pharmacy.

I certify that I was informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

Patient Name (print) _____ Signature of Patient _____ Date _____