STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

WELCOME!

Thank you for choosing our practice to serve your medical needs. We are looking forward to seeing you soon.

You may pre-register prior to your visit. Please complete the forms and bring them to your scheduled appointment along with your Driver's License, and Medical Insurance card.

If needed, directions to our office are on our web site (www.srosm.com) or you can use Yahoo's "Maps". Convenient parking is located at our office.

Please bring any of your X-Rays/MRI image CDs and reports with you to the visit. Your doctor will want to see those images. If you do not have the images with you, new ones will need to be taken.

And remember, if you can't make your appointment; call us one business day ahead so that another patient can be scheduled.

If you have questions or need more help, feel free to call our Woodlands office (281-364-1122), Spring office (832-698-0111), or Woodforest office (936-272-0790) at your convenience.

Sincerely,

The Doctors and Staff of Sterling Ridge Orthopaedics and Sports Medicine

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

Patient Information and Assignment of Benefits

Patient Last Name_____First Name_____Middle Initial_____

Street Address_____Home Phone _____

City_____State_____Zip_____Cell Phone_____Work Phone _____

Sex ☐ M ☐ F Age_____Date of Birth_____Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Email _____

Language_____Race_____Ethnicity_____

How did you learn about our clinic?_____Referring Physician _____

Person to contact in emergency (Name and Phone #)_____

EMPLOYER	Company Name_____Occupation_____ Address_____Phone_____Full-time ☐ Part-time City_____State_____Zip_____Years Employed_____
SPOUSE (PARENT)	Name_____Date of Birth_____SSN_____ Last Name First Name Initial Employer Name_____Years Employed_____ Address_____Phone_____Occupation_____ City_____State_____Zip_____Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list patient's primary medical insurance and/or employee health care plan coverage. Insurance Company or Health Care Plan Name_____ Policy ID # _____Group # _____ Name of Insured_____Insured Date of Birth_____ Insured's relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
SECONDARY INSURANCE INFORMATION	Please list any and all secondary health care plan coverage you may have. Insurance Company or Health Care Plan Name_____ Policy/Group #_____Effective Date_____ Name of Insured_____ID #_____ Insured's relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

Patient Information and Assignment of Benefits

PHARMACY INFORMATION	Current Pharmacy_____Phone _____
LEGAL INFORMATION	Are your present symptoms of condition related to or the result of an auto accident, work-related injury, or other personal injury someone else might be legally liable for? Yes No Your Initials _____ An accurate medication history is very important to helping us treat you properly and to avoid potentially dangerous drug reactions. Do you grant SROSM permission to access the National Pharmacy Database to retrieve your prescription history? Yes No Your Initials _____
ASSIGNMENT OF BENEFITS AND ASSIGNMENT OF ERISA RIGHTS	**Legal Assignment Of Benefits And Designation Of Authorized Representative** I, the undersigned, have insurance and/or employee health care benefits coverage with the above listed insurance carriers, and for good and valuable consideration I hereby appoint Sterling Ridge Orthopaedics & Sports Medicine (Provider) as my designated Authorized Representative(s) . In add I hereby assign and convey directly to the above named healthcare provider(s), all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for the actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby grant the above named provider(s) authority under HIPAA to release all medical information necessary to process my health claims. I hereby authorize any plan administrator, plan fiduciary, and/or insurer and to release to such provider(s) any and all insurance plan documents and a copy of my health insurance policy upon request. If requested, I also authorize my attorney to furnish to provider all third party settlement information upon written request. I also hereby authorize my provider permission to use my signature on all health insurance and/or employee health benefits claim submissions. To the full extent permissible under the law, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), I hereby assign and convey to the above named provider(s), my benefits in any applicable employee group health plan(s), individual health insurance policy, personal injury protection policy, medical payments policy, underinsured/underinsured motorist policy, third party tort recovery, in order to satisfy any and all medical expenses legally incurred by me for medical services I received from the above named provider(s). Furthermore, to the full extent permissible under the law, I grant to the provider a lien on such medical benefits, settlement, proceed and/or insurance reimbursements. Lastly I grant the provider authority to: (1) obtain information about the claim to the same extent as the assignor; (2) submit evidence and information on my behalf; (3) make statements about facts or law, if know; (4) make, request, give, or receive any notice about appeal proceedings; and (5) take any administrative, legal and judicial action, including filing suit, in my name with derivative standing, which the provider deems necessary to obtain payment of my health insurance benefits. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. The foregoing shall not be construed as an obligation of this medical provider to pursue any legal appeal or legal recovery. _____ _____ Signature of Insured / Guardian Date

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

Patient Medical History

Patient Name: _____

Date: _____

1.) Reason for Visit:

_____

2.) Current Medications:

_____ _____

_____ _____

_____ _____

3.) Allergies:

_____ _____

_____ _____

_____ _____

4.) Past Medical History:

ADD/ADHD	☐Yes ☐No	Heart Disease	☐Yes ☐ No
AIDS/HIV	☐Yes ☐No	Hepatitis	☐Yes ☐No
Anxiety	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Bipolar	☐Yes ☐No	Kidney Disorder	☐Yes ☐No
Cancer	☐Yes ☐No	Osteoarthritis	☐Yes ☐No
Coronary Artery Disease	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Depression	☐Yes ☐No	Pacemaker/Defibrillator	☐Yes ☐No
Diabetes	☐Yes ☐No	Respiratory Disorder	☐Yes ☐No
DVT/Clotting Disorder	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Elevated Cholesterol	☐Yes ☐No	Sleep Apnea	☐Yes ☐No
Epilepsy/Seizures	☐Yes ☐No	Stroke/TIA	☐Yes ☐No
GERD/Reflux	☐Yes ☐No	Thyroid Disorder	☐Yes ☐No

Other: _____

5.) Surgeries/Date of Surgeries

_____ _____

_____ _____

_____ _____

6.) Social History

- Do you have a medical power of attorney? ☐Yes ☐No
- Do you have an advance directive? ☐Yes ☐ No
- Do you or have you ever smoked tobacco? ☐Never Smoked ☐Former Smoker ☐Current Smoker
  If yes, how much do you smoke? _____
- Do you or have you ever used any other forms of tobacco or nicotine? ☐Yes ☐No
- Do you or have you ever used e-cigarettes or vape? ☐Never ☐Former User ☐Current User
- Do you have or have you ever used smokeless tobacco? ☐ Never ☐Former User ☐Current User
- What is your level of alcohol consumption? ☐None ☐Occasional ☐Moderate ☐Heavy
- Do you use any illicit or recreational drugs? ☐Yes ☐No
- What is your occupation? _____
- What types of sporting activities do you participate in?

  _____

  _____

7.) Family History

Has anyone in your family had any of these conditions?

Heart Disease	☐Yes ☐No
Diabetes	☐Yes ☐No
Cancer	☐Yes ☐No

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

8.) **For Women Only:**
Are you pregnant? ☐Yes ☐No
Are you breastfeeding? ☐Yes ☐No
Are you using prescriptive birth control? ☐Yes ☐No
Date of Last Pap Smear _____

9.) If you are age 65 or above, date of last bone density
_____

Review of Systems:
Do you have any of these symptoms? Please check either YES or NO for each condition.

Constitutional:
Fever ☐Yes ☐No
Weight loss/gain ☐Yes ☐No

Heart:
Chest Pain ☐Yes ☐No
Heart Murmur ☐Yes ☐No
Shortness of Breath When Walking ☐Yes ☐No

Genitourinary:
Urinary Frequency ☐Yes ☐No
Incontinence ☐Yes ☐No
Painful Urination ☐Yes ☐No

Neurological:
Weakness ☐Yes ☐No
Numbness ☐Yes ☐No
Dizziness ☐Yes ☐No
Frequent Headaches ☐Yes ☐No

Hematologic:
Bleeding Problems ☐Yes ☐No
Easy Bruising ☐Yes ☐No

Eyes:
Decreased Vision ☐Yes ☐ No
Cataracts ☐Yes ☐No

Respiratory:
Short of breath ☐Yes ☐No
Wheezing ☐Yes ☐No
Persistent Cough ☐Yes ☐No

Muscoskeletal:
Joint Swelling ☐Yes ☐No
Muscle Aches ☐Yes ☐No
Muscle Weakness ☐Yes ☐No
Joint Pain ☐Yes ☐No

Psychiatric:
Depression ☐Yes ☐No
Sleep Disturbances ☐Yes ☐No
Anxiety ☐Yes ☐No

Allergies/Immunologic:
Hives ☐Yes ☐No
Frequent Illness ☐Yes ☐No

Ears, Nose, Throat:
Loss of hearing ☐Yes ☐No
Sinus Problems ☐Yes ☐No
Ear Pain ☐Yes ☐No
Snoring ☐Yes ☐ No

Gastrointestinal:
Stomach Pain ☐Yes ☐No
Diarrhea ☐Yes ☐No
Vomiting ☐Yes ☐No
Decreased Appetite ☐Yes ☐No

Skin:
Rash ☐Yes ☐No
Eczema ☐Yes ☐No

Endocrine:
Fatigue ☐Yes ☐No
Hair Loss ☐Yes ☐No

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

Office and Financial Policies

Welcome and thank you for choosing Sterling Ridge Orthopaedics and Sports Medicine 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.

Department Information: Sterling Ridge X-ray, Sterling Ridge DME, Chiropractic, and Sterling Ridge Physical/Occupational Therapy are departments and employees of Sterling Ridge Orthopaedics and Sports Medicine. The information contained in this document applies to each department and medical provider in the Sterling Ridge Orthopaedics and Sports Medicine practice.

No Shows and Late Cancellations: Our office requires 24 hour advance notice if you are unable to keep your scheduled Clinic, EMG, Chiropractic, or Physical/Occupational Therapy appointment. We value our patients and their needs and when patients do not provide us with advance notice, our office is unable to offer this appointment time to another patient. If you miss a scheduled appointment or fail to cancel your appointment without 24 hour advance notice, your account may be assessed a $50 fee.

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 seeing a specialist, please contact your primary care physician so that you will have the referral in hand at the time of your appointment. If you do not bring your referral with you to your appointment, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full.

Insurance Claim Filing/Responsibilities: We will gladly file your insurance claim on your behalf. Deductibles, copays, and estimated coinsurance amounts will be collected at the time of service. If a service is provided that is not covered by your insurance, you will be responsible for those charges at the time of service. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does NOT pay within this time, you will be responsible for the entire balance. If your insurance processes the claim differently than expected, you will be responsible for any additional fees deemed the patient's responsibility. If you are a self pay patient without insurance you will be required to pay for services at the time of service.

Third Party Billing: SROSM is unable to bill for any third party billing or MVA related claims where medical insurance does not subrogate. Any services provided in relation to these instances will be treated as self pay and payment for services is expected at time of visit.

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 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.

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.

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 only obtain treatment from Sterling Ridge Orthopaedics and Sports Medicine medical providers if a parent or legal guardian signs a release to this effect.

Medical Records/Images: Copies of your medical records/images (MRI, X-ray) are available to you upon request at a nominal administrative charge.

Returned Goods (Durable Medical Equipment) Policy: DME is considered a personal use product and once it leaves the office it is considered non-returnable. The two exceptions to this rule are 1) if there is a manufacturer's defect and 2) if the product was not used for surgery due to a physician's request, and should be returned in excellent, unused condition containing all original pieces. If there is a manufacturer defect, the product may be remedied by replacing the product. Your insurance company may not pay for certain services/products based on their determination of "reasonable and necessary" per your insurance company medical policies. 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 non-payment occurs, you will be responsible for the amount due.

Patient Name: _____ DOB: _____

Responsible Person's Signature: _____ Date: _____

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

PATIENT RESPONSIBILITY NOTICE

As a courtesy, our office will verify your benefits prior to your appointment.

This is not a guarantee of benefits or coverage.

If your claim is processed differently than you expected, it is your responsibility to follow up with your insurance company directly.

Thank you!

I have read the above statement and understand I will be financially responsible for all charges.

_____ _____

Patient or Responsible Party Date

THE WOODLANDS
6767 LAKE WOODLANDS DRIVE, SUITE F
THE WOODLANDS, TX 77382
P: 281.364.1122
F: 281.210.3450

SPRING
20639 KUYKENDAHL ROAD, SUITE 200
SPRING, TX 77379
P: 832.698.0111
F: 832.698.0150

WOODFOREST
750 FISH CREEK THOROUGHFARE, SUITE 100
MONTGOMERY, TX 77316
P: 936.272.0790
F: 936.272.0791

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

PATIENT CONSENTS

Our "Notice of Privacy Practices for Protected Health Information" describes how medical information about you may be used and disclosed and how you can get access to this information. 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

☐ I,_____, acknowledge that I was provided access to a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

*** You may refuse to sign this acknowledgment***

☐ I refuse to sign this acknowledgement

CONSENT FOR RELEASE OF PHOTOS/RADIOGRAPHS/VIDEOS FOR WEBSITE PUBLICATION:

☐ I hereby give permission to Sterling Ridge Orthopaedics and Sports Medicine to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate scientific papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied.

☐ I understand that no identifying information will be used

☐ I **DO NOT consent** to the use of any pictures/videos/radiographs obtained during my treatment

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

☐ I hereby **authorize** the release of medical and billing information (by telephone, mail or otherwise) by physicians and staff of Sterling Ridge Orthopaedics and Sports Medicine to (please list name and relationship)

Name/Relationship	**Address/Phone Number**
_____	_____
_____	_____
_____	_____

☐ I **DO NOT** authorize the release of medical information to my family members.

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

DISCLOSURE TO PATIENTS
(as required by §102 of the Texas Occupations Code)

Texas law requires that, at the time of initial contact and at the time of referral, Texas physicians disclose to patients (i) any affiliation the physician has with a person or health care facility for whom the patient is secured or solicited, and (ii) that the physician may receive, directly or indirectly, remuneration for securing or soliciting the patients.
This disclosure is intended to help you make a fully informed decision about your health care: William M. Hayes, M.D.,FAAOS, Keith W.V. Johnson, M.D., FAAOS, William J. Jackson, D.O., N. Brian Flowers, M.D., FAAOS, FAAHKS, Paul Chin, M.D., PhD, FAAOS, and Mark A. Eilers, MD, MS have a direct or indirect ownership interest in one or more of the entities listed and may receive remuneration from such entities:

Sterling Ridge Orthopaedics and Sports Medicine (including Xray, DME, Physical Therapy/Occupational Therapy,and Chiropractic), Spring MRI, Alliance Woodforest MRI, Shoreline Surgical Center, Memorial Hermann Surgery Center-Pinecroft, LLC, and Memorial Hermann Surgery Center-Woodforest, LLC. Although your physician may recommend the services of an entity listed above, you may choose to obtain services from an alternative provider or facility; you will not be treated differently by your physician or our staff if you choose an alternative provider or facility. Please ask our staff if you have any questions.

ASSIGNMENT AND RELEASE

Your signature acknowledges your understanding of the Patient Consent section on this form. Your signature indicates your choices regarding the following acknowledgements, consents, authorizations, releases, and assignments:

- Receipt of Notice of Privacy Practices
- Release of Photos/Radiographs/Videos
- Release of Medical Information
- Disclosure to Patients

Your signature below also authorizes Sterling Ridge Orthopaedics and Sports Medicine 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 Name:_____Date of Birth:_____

Patient Signature: _____Date:_____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name:_____Relationship to patient:_____

Responsible Party Signature:_____Date:_____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barrier prohibiting obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other (please specify):_____