

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE

This acknowledgment of notice and consent authorizes **URGENT ORTHOPEDIC SPECIALISTS** to use and disclose health information for treatment, payment and health care operation purposes.

Notice of Privacy Practice. Urgent Orthopedic Specialist has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information (PHI) and how you can access your PHI and exercise other rights concerning your PHI. You may review our current notice prior to signing this acknowledgment and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all PHI that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer. You can contact our Privacy Officer by Mail, phone or facsimile: Urgent Orthopedic Specialists 4304 Andrews Hwy Midland Texas 79703 or Telephone: (432) 520-3020 Facsimile: (432) 699-1981.

The following person (s) may receive the health information designated below:

1. _____
Name Phone Relationship
2. _____
Name Phone Relationship

The following health information may be disclosed to the person (s) listed above:

- Medical - My Health Care Providers are expressly authorized to answer questions posed by the Personal Representatives listed below and openly discuss with them my condition, treatment, test results, prognosis, and all other information pertinent to my health care, even if I am fully competent to ask questions and discuss my medical condition. This document constitutes a full authorization to disclose any Individually Identifiable Health Information to the Personal Representatives named in this authorization.
- Billing/Financial Information Other _____

I hereby release Urgent Orthopedic Specialists Physician's, doctors, nurses and staff who acts in reliance on this Authorization from any liability that may accrue from releasing my Individually Identifiable Health Information and for any actions taken by my Personal Representatives. I understand that I may revoke this authorization at any time by providing a written notice.

Consent for Treatment: I hereby voluntarily consent to the evaluation, diagnostic testing and treatment by authorized members of the staff or their designees. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations and treatment.

Ownership Disclosure: Disclosure of Interest: Dr. Floyd has ownership interest in D1 Physical Therapy and the Texas Surgical Center (TSC) and as a result, may financially benefit from the referral of services to D1 and TSC in the form of increased dividends or distributions. Please let us know if you have any concerns regarding the financial relationship between the Doctor listed above and his affiliations. You do have the option of using an alternative health care facility.

Patient Signature or personal authorized representative

Date

Printed Name

Relationship to patient (or other authority)

Urgent Orthopedic Specialists

New Ailment Form

Referred by: _____

Name: _____ DOB: _____ AGE: _____ DATE: _____

Female Male Right Handed Left Handed Height _____ Weight _____ Family Physician _____

• Describe your current Problem/Complaint (be specific, for example right vs left) _____

• Describe how the injury or problem occurred _____

• Date of Injury or date problem began? _____ Have you been treated for the current problem? Yes No

• If yes, by whom? _____ Describe treatment: _____

• Was this an on the job injury? Yes No If yes, was Employer notified? Yes No

• Is the injury/problem due to an auto accident? Yes No If yes, were you at fault? Yes No

• Have you had any of the following diagnostic studies for this injury?

X-rays Yes No Date _____ Where? _____ MRI Yes No Date _____ Where? _____

• Is there any possibility of being pregnant? Yes No NA (If yes, please tell X-ray Tech prior to any x-rays)

ALLERGIES/REACTIONS: No known allergies

Medications allergies _____

Food /Latex/Environmental _____ IV contrast Topical Iodine

MEDICATIONS: (Please list any herbs, vitamins or supplements) None

Medication	Dose Times/Day		Medication	Dose Times/Day	

Pharmacy: _____ I DO DO NOT give Authorization for Urgent Orthopedic Specialists to obtain my prescription history electronically. This order will remain in effect until revoked by me in writing.

PAST MEDICAL HISTORY: (Please check the box if yes to any of the following)

- | | | |
|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes: Type 1 or Type 2 | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallbladder Attacks: Removal Y or N | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack/Problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis: Type _____ | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood Clot/DVT | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stents |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Disease |
| | | Other: _____ |

SURGICAL HISTORY: None

Surgery	Date	Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DATE

SIGNATURE of PATIENT (or Parent/Legal Guardian if Patient is a minor)