Ronak M. Patel MD

FONDREN ORTHOPEDIC GROUP
A DIVISION OF OrthoLoneStar

Date: _____

Knee Pain – New Patient Questionnaire

Who were you referred by: _____ ☐ Website/Social Media

Name: _____ **Age/Sex**: _____ **Occupation/Year in School**: _____

Is this a work-related injury? ☐ Yes ☐ No

Which knee is painful? ☐ Right ☐ Left **Where in the knee does it hurt?** ☐Front ☐Back ☐Side

Prior Surgery on Knee: _____
Date:_____ Surgeon/Hospital:_____

	YES	NO	
Specific Injury	☐	☐	Type_____
Sports-related	☐	☐	Sport_____

Pain Onset Date/Duration: _____ **Primary Problem(s)** ☐Pain ☐Weakness ☐Stiffness ☐Instability

Describe what happened or any other details:

What symptoms are you experiencing?

	YES	NO
Popping	☐	☐
Locking / Catching	☐	☐
Stiffness	☐	☐
Weakness	☐	☐
Numbness / Tingling	☐	☐

Nature of the pain: ☐Aching ☐Dull ☐Sharp ☐Shooting ☐Stabbing ☐Burning

Do you have:
☐Hip pain ☐Back pain

Severity of pain: Current: 1 2 3 4 5 6 7 8 9 10 (worst) At its worst: 1 2 3 4 5 6 7 8 9 10

Pain at Rest? ☐Yes ☐No **Pain at Night?** ☐Yes ☐No

What makes the pain worse? (Check all that apply)
☐ Sudden Turns ☐ Squatting ☐ Other: _____
☐ Kneeling ☐ Walking
☐ Stairs (up or down) ☐ Running

What treatments have you tried?
☐ NSAIDs (Aleve, Advil, Ibuprofen, Tylenol, etc) ☐ Physical Therapy
☐ Injection (most recent date: _____) ☐ Other: _____
☐ Brace(s)

What imaging studies have you had done?
☐ X-Rays ☐ MRI ☐ CT

What are your goals? What activity(s) do you enjoy?_____

What are your expectations for today's visit?_____

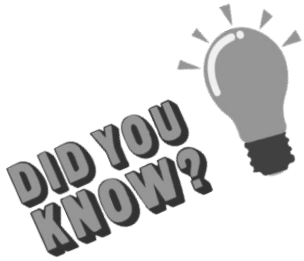
Ronak M. Patel MD

FONDREN ORTHOPEDIC GROUP
A DIVISION OF OrthoLoneStar

Date: _____

New Patient Questionnaire

You can save time by completing your patient questionnaires online via our patient portal!



You can also:

- ✓ Communicate directly with your provider's staff
- ✓ Request a copy of your Medical Records
- ✓ Request a Prescription Refill
- ✓ Submit a Payment Online
- ✓ View your Medical Summary

Please speak to a representative at the front desk for more information about verifying your enrollment in our patient portal.

Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____

Which joint or body part brings you in today? _____ (fill out details on separate form)

PAST MEDICAL PROBLEMS: Please review the ongoing medical problems, past major illnesses, and hospitalizations below and check the ones that apply to you.

____ Abnormal heart rhythm
____ Anemia
____ Angina
____ Anxiety
____ Aortic stenosis
____ Asthma
____ Back pain – chronic
____ Bipolar disorder
____ Bleeding disorder
____ Bleeding tendency
____ Blood clot
____ Cancer (please specify: _____)
____ Chest pain
____ Cirrhosis
____ Congestive heart failure
____ Constipation – chronic
____ COPD / Emphysema
____ Coronary artery disease
____ Degenerative arthritis
____ Depression
____ Diabetes
____ Diarrhea – chronic
____ Enlarged prostate / BPH

____ Fibromyalgia
____ Gout
____ Heart attack
____ Heart disease
____ Heart murmur
____ Heart stent
____ Hepatitis A, B or C
____ Hepatitis B
____ Hepatitis C
____ Hiatal hernia
____ High blood pressure
____ High cholesterol
____ HIV
____ Hyperthyroidism
____ Hypothyroidism
____ Irritable bowel syndrome
____ Kidney infection – chronic
____ Kidney stones – chronic
____ Low platelets
____ Low white cell count
____ Lupus
____ Menstrual problems
____ Migraines – chronic
____ Miscarriages – chronic
____ Neuropathy

____ Obesity
____ Osteoarthritis
____ Osteoporosis
____ Pneumonia – chronic
____ Poor circulation / Raynaud's disease
____ Poor circulation / Raynaud's disease
____ Protein in urine – chronic
____ Psoriasis
____ Pulmonary embolism – chronic
____ Reflux
____ Rheumatoid arthritis
____ Seizure – chronic
____ Sexual difficulty
____ Sinus Allergies
____ Sleep apnea
____ Stomach ulcers
____ Stroke
____ Tuberculosis exposure
____ Urinary tract infection – chronic
____ Varicose veins

Additional Problems:

_____
_____
_____

____ **I have no past medical problems.**

Ronak M. Patel MD

FONDREN ORTHOPEDIC GROUP
A DIVISION OF OrthoLoneStar

New Patient Questionnaire

PAST SURGICAL PROCEDURES: Please review the procedures listed below and check the ones that apply to you.

____ Abdominal surgery
____ Amputation
____ Angioplasty / Heart Stent
____ Aorto-femoral bypass
____ Appendectomy
____ CABG / Heart bypass
____ Carotid endarterectomy
____ Carpal tunnel release
____ Cataract surgery
____ Colon resection
____ Craniotomy
____ C-Section
____ Dilation and curettage
____ Femoral bypass
____ Fracture repair
____ Gallbladder removal
____ Gastric surgery
____ Heart valve replacement
____ Hernia surgery
____ Hip replacement
____ Hip Arthroscopy
____ Interventional pain
____ Kidney removal
____ Kidney transplant
____ Knee arthroscopy/meniscus
____ Knee ligament (ACL/PCL/LCL/MCL)
____ Knee replacement
____ Kyphoplasty
____ Liver transplant
____ Mastectomy
____ Mitral valve replacement
____ Pacemaker
____ Parathyroidectomy
____ Prostatectomy
____ PTCA
____ Rotator cuff repair
____ Shoulder arthroscopy
____ Shoulder replacement
____ Sleep apnea surgery
____ Spine surgery – Cervical
____ Spine surgery – Lumbar
____ Spine surgery – Thoracic
____ Thyroidectomy
____ Tonsillectomy
____ Tunneled dialysis catheter
____ TURP
____ Urinary incontinence surgery
____ Vasectomy

Other/Additional Surgeries:

_____
_____
_____
_____

_____ **I have not had any surgeries**

Have you had ANY complications with anesthesia in the past? ____ Yes ____ No

FAMILY HISTORY: Please list any family history relevant to your problem today

_____

SOCIAL HISTORY:

Occupation/Year in School: _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

Tobacco Usage: ____Never used ____Currently use (quantity: _____) ____Former use (year quit: _____)

Alcohol Usage: ____None ____Currently use (amount: _____ type: _____) ____Former heavy use (year quit:_____)

Drug Usage: ____Never used ____Currently use (type: _____) ____Former use (type: _____year quit: _____)

CURRENT MEDICATIONS: Please list any over the counter medications, prescribed medications and supplements you are taking. **Please include the name and dosage of the medications.** ____ **I am not currently taking any medications.**

_____ _____

_____ _____

PREFERRED PHARMACY: Please list the name and phone number of your preferred pharmacy.
Name/Location: _____ **Phone Number:** _____

ALLERGIES: Please list any allergies you have to medications. ____ **I have no known allergies to medications.**

_____ _____

Ronak M. Patel MD

FONDREN ORTHOPEDICGROUP
A DIVISION OF OrthoLoneStar

New Patient Questionnaire

REVIEW OF SYSTEMS: Please review the systems below and select your ***CURRENT*** symptoms

GENERAL:
____ chills
____ diffuse stiffness
____ fatigue / weakness
____ fever
____ night sweats
____ sweats
____ weight gain - abnormal
____ weight loss - abnormal

EYES:
____ blurred vision
____ double vision
____ dry eyes
____ eye discharge
____ eye inflammation
____ vision loss

EAR, NOSE, AND THROAT:
____ difficulty swallowing
____ dizziness
____ dry mouth
____ hearing loss
____ impaired hearing
____ mouth sores
____ nosebleeds
____ sore throat

CARDIOVASCULAR:
____ chest pain
____ fainting / syncope
____ leg swelling
____ palpitations
____ shortness of breath with exercise
____ swelling limbs

RESPIRATORY:
____ chest congestion
____ cough
____ painful breathing
____ shortness of breath
____ TB exposure
____ wheezing

GASTROINTESTINAL:
____ abnormal pain
____ black stool
____ blood in stool
____ constipation
____ diarrhea
____ heartburn
____ nausea/vomiting

GENITOURINARY:
____ abnormal kidney function
____ blood in urine
____ frequent urinary infections
____ incontinence
____ painful urination
____ urinary frequency
____ urinary hesitancy
____ urinary tract infection

MUSCULOSKELETAL:
____ arthritis
____ back pain
____ hip pain
____ joint pain
____ joint swelling
____ muscle soreness

DERMATOLOGIC:
____ hives
____ itching
____ mass / lesion
____ open sores
____ poor healing
____ rash
____ skin infection
____ tingling / prickly

NEUROLOGIC:
____ fainting / syncope
____ headaches
____ history of seizures
____ memory loss
____ numbness
____ temporary paralysis
____ tingling
____ tremors
____ vertigo / dizziness

PSYCHIATRIC:
____ anxiety
____ depression
____ eating disorder
____ feeling of hopelessness
____ paranoia
____ psychiatric diagnosis
____ sleep disturbances
____ suicidal thoughts
____ tension

ENDOCRINE:
____ blood sugar - abnormal
____ excessive hunger
____ excessive thirst
____ excessive urination
____ sensitivity to cold
____ sensitivity to heat
____ thyroid problems
____ weight change

HEMATOLOGY/LYMPHATIC:
____ abnormal bruising
____ bleeding
____ blood thinning medications
____ easy bruising
____ enlarged lymph nodes

ALLERGIC/IMMUNOLOGIC:
____ HIV exposure
____ persistent infections
____ sinus congestion

OFFICE USE ONLY

Entered: _____ Yes

By: _____

_____

FONDRENORTHOPEDICGROUP

A DIVISION OF OrthoLoneStar

FINANCIAL POLICY

The physicians and employees of OrthoLoneStar are dedicated to providing the best possible care to you at the best possible value; therefore, we regard your understanding of our financial policies an essential element of your treatment. Our intent is to be fair, transparent, caring and accessible. If you have any questions, please discuss them with one of our staff members.

Your signature below authorizes the following:

- I/we assign to OrthoLoneStar, PLLC ("OLS") all insurance benefits or Medicare benefits to which it may be entitled for services rendered by its providers and authorize direct payment to the practice. This assignment includes without limitation major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for personal injury caused by a third party. I/we agree to pay practice for all charges not paid pursuant to this assignment.
- For ERISA, out-of-network, and self-funded plans, I assign and convey directly to OLS, as my designated authorized representative, all insurance reimbursement for services rendered by OLS regardless of network participation status. I authorize OLS and its authorized agents to negotiate, discuss, appeal and, in any other way, communicate with my insurance company to determine final payment for services I received. OLS has full authorization to accept or reject any proposed reimbursement proposal, and to act as necessary to accomplish the final adjudication of any claims. The results of that determination are binding upon me/us.
- Release of pertinent medical information to your insurance carrier(s).
- Administrative charges for completion of forms such as disability and FMLA forms, medical records copies, CDs of images, printed films, or similar items. Please consult with a staff member for these charges.
- If, after all your claims have been paid, the resulting balance is a credit of $5.00 or less, you will authorize us to write off this balance. Amounts greater than $5.00 will be refunded to you.
- I/we understand that insurance coverage and verification is not a guarantee of payment. I/we agree that I/we am/are ultimately responsible for any balance due after my insurance has paid or denied my claim(s). I/WE UNDERSTAND THAT I/WE AM/ARE RESPONSIBLE FOR ANY CHARGES IF THE INSURANCE COMPANY DENIES A CLAIM FOR ANY REASON INCLUDING STATING THAT IT IS INVESTIGATIONAL, EXPERIMENTAL, A PRE-EXISTING CONDITION, AUTO RELATED OR ACCIDENT-RELATED WHERE LIABILITY INSURANCE IS INVOLVED, OR ANY OTHER NON-COVERED SERVICE(S).

Responsibilities and acknowledgement of financial policy specifics:

- Please present your insurance card and photo ID at each appointment. Please share address, telephone number and/or insurance information updates any time a change occurs.
- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, and most major credit cards. Other financing options may be available. Please ask our staff about these programs.
- Payment of your deductible and coinsurance will be required for your calculated portion of our fees, based on your insurance contract, in advance of any scheduled surgical procedures and diagnostic testing. Any balance remaining after your health plan pays its portion is your responsibility and payment for balance is due upon notification from our office. Any overpayment will be refunded directly to you.
- You may be asked to put a credit card on file, which will only be charged according to the terms you agree to when placing such card on file. By processing your insurance first, we will only charge you for your exact out-of-pocket responsibility. You will receive notification containing a summary of charges and an estimate of what we believe you will owe. After your insurance has processed your claim, you will receive a second notification informing you of the actual amount you owe and notifying you that your card will be charged. Contact the practice if you have questions once you receive this notification.
- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the practice. If your insurance does not pay, we will look to you for payment of your balance in full.

- All health plans are not the same and do not cover the same services. If your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. You are responsible for knowing and understanding your insurance benefits.
- You will be responsible for promptly responding to your insurance company to provide additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full, by you.
- Responsibility for payment for patients who are minors whose parents are divorced rests with the parent who seeks the treatment or the adult accompanying the minor for all services rendered to the minor patients regardless of any court order responsibility judgement.
- Appointment Cancellations within 24 hours of scheduled time may result in a charge.
- Failure to notify us 48 hours before canceling a surgery may result in a charge.
- Returned checks for any reason will result in a charge.
- Some orthopedic supplies are not covered by your insurance, in which case we will require payment at time of service. A deposit will be collected upon receipt of certain Durable Medical Equipment items.
- All HMOs and some PPOs require prior authorization or referral from your primary care physician for each visit. This is your responsibility. IF YOU DO NOT HAVE THIS REFERRAL NUMBER AT THE TIME OF YOUR APPOINTMENT, YOUR BENEFITS MAY BE PAID AT A REDUCED RATE OR NOT PAID AT ALL AND YOU WILL BE RESPONSIBLE FOR THE CHARGES.
- When you are charged a "global" fee for surgery or office care of a fracture, laceration repair, excision of an ingrown toenail, or other medical procedure, that fee includes the service on the day it is performed and routine follow up care as well. The global period ranges from 10 to 90 days depending on the procedure and your health plan. Injections, X-rays, and supplies (such as casting or dressing materials, splints, braces, etc.) are not included in the "global" fee and a charge will be made for these items. Services related to complications are not included in the global fee.
- Please note there are no refunds or returns on all braces/soft goods.
- If you do not pay your balance and we are required to use a third party to collect your balance, an administrative charge of up to 25% of the balance may be added to the amount you owe.

I have read and understand the financial policy outlined above, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by OLS.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

Patient Name: _____ Patient ID: _____

Consent for Care and Treatment

I hereby agree and consent for OrthoLoneStar, PLLC and its subsidiaries and affiliates (collectively "Fondren" as used throughout this form) to furnish medical care and treatment to the patient listed above considered necessary and proper in diagnosing or treating her or her physical condition. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the procedures or treatments. I understand that, should I leave the facility without written consent of my attending physician, I hereby relieve the physician and the facility of all responsibility of my action.

Medication Consent

I give permission for Fondren to access my pharmacy benefits data electronically through online services. This consent will enable Fondren to determine the pharmacy benefits and drug copayments for my health plan, check whether a prescribed medication is covered (in formulary) under my plan, display therapeutic alternatives that preference rank (if available) within a drug class for medications, determine if my health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to those pharmacies and download a historic list of all medications prescribed for me by any provider.

Physician's Assistant and Certified/Nurse Practitioner Consent

Fondren and its affiliates utilize Physician's Assistants and Nurse Practitioners (collectively known as "Non-Physician Practitioners") to assist in the delivery of orthopedic medical care. I acknowledge a Non-Physician Practitioner is not a physician. Texas licenses Non-Physician Practitioners. Non-Physician Practitioner can, under the supervision of a physician, diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care and assist at surgery. Supervision does not require the constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. Fondren, its employees, and affiliates, may bill your insurer or plan administrator fiduciary separately to obtain payment for the services of Non-Physician Providers. I acknowledge this information and consent to the services of Non-Physician Practitioners for my health care needs. I understand that, at any given time, I can request to see the physician instead of a Non-Physician Practitioner.

Patient Referral

I understand that, in some cases, my physician or Non-Physician Practitioner may refer me to an out-of-network provider and that I may have more out-of-pocket costs from such out-of-network provider. It is the patient's responsibility to ensure that any provider from whom the patient seeks treatment is in or out-of-network.

Disclosure of Physicians' Ownerships Interests

Our providers are committed to helping facilitate exceptional care at various healthcare facilities and through other health care providers. By maintaining ownership in other facilities and health care providers, our providers are able to have a voice in administrative and operational direction, resulting in a higher overall quality of care. Pursuant to Federal and Texas Law, I have been informed that either OrthoLoneStar, PLLC, or one or more of its affiliates, physicians, or owners, have a financial interest in one or more of the following organizations: Fondren Advanced Care PLLC and South Main Surgical Alliance, PLLC. You may receive separate billing from each entity. We want you to know that you do have the option to use an alternative health care provider should you choose.

Telephone Consumer Protections Act (TCPA) Notice

I agree that Fondren, or any other collection or servicing agency or agencies retained by Fondren (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers that may result in my incurring fees for the call or text message. I am consenting to communication by email as required by 15 U.S.C. §7001and related state regulations and statutes.

I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre- recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address that I provide to the facility or is otherwise associated with my account.

Email and Text Message Communications

I consent and state my preference to have Fondren communicate with me by email or standard SMS (text) messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. If you do not want to be contacted via email or text message, please indicated your preference by checking this box: ☐

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP
A DIVISION OF OrthoLoneStar

Release and Acknowledgement

Patient Name: _____ Patient ID: _____

Release of Photos/Radiographs/Videos for Website Publication

☐ I give permission to OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates 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 personally-identifying information will be used.

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

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 review on our website and our front desk.

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

☐ I refuse to sign this acknowledgement.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP
A DIVISION OF OrthoLoneStar

Friends and Family Information Disclosure

Patient Name: _____ Patient ID: _____

☐ I authorize the release of medical information (by telephone, mail or otherwise) by physicians and staff of OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates to:

Name and Relationship	Address/Phone Number
_____	_____
_____	_____
_____	_____

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

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP
A DIVISION OF OrthoLoneStar

Workers' Compensation Disclosure

Patient Name: _____ Patient ID: _____

IMPORTANT NOTICE

The following physicians are non-participating physicians in the Texas Workers' Compensation Program. Therefore, they are not listed as part of the ADL (Approved Doctor List) of the TWCC (Texas Workers' Compensation Commission) and are not authorized in any capacity to treat patients for any work-related injury under the TWCC system.

The following listed are Non-ADL Physicians:

Gary T. Brock M.D.
Jeffrey A. Kozak M.D.
Richard J. Kearns, M.D.

The following physicians do not accept Texas Workers' Compensation related patients:

Jeffrey A. Kozak, M.D.
Holly J. Jones, M.D.
Gregory W. Stocks, M.D.

According to Texas Labor Code § 413.042, the patient is responsible for ALL healthcare expenses incurred if he or she violates Texas Labor Code § 408.022 relating to the selection of a doctor and receives medical treatment from a physician NOT chosen from a list of doctors approved by the commission.

Patient Certification: I hereby certify that the information provided by me is truthful, accurate and correct. I fully understand the above-referenced state law as well as any related regulations.

I have read and understand the above statement regarding WORKERS' COMPENSATION BENEFITS coverage.

☐ This is a work-related condition, injury or symptom.

☐ This is NOT a work-related condition, injury or symptom.

I am scheduled to see Doctor: _____

Financial Obligation: I understand if the information that I provide is inaccurate, OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates (collectively, "Fondren") may not be able to collect payment from the insurance company. I also understand and acknowledge that providing false information on the completed forms will result in serious legal consequences for myself.

I hereby affirm that I am responsible to pay Fondren on demand for my medical services if I violated Texas law and knowingly selected a physician not chosen from a list of doctors approved by the Texas Workers' Compensation Commission. Further, I understand that I will be financially liable if my insurance company declares the service to be work-related resulting in a request for refund, if I do not dispute the issue to declare otherwise.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP
A DIVISION OF OrthoLoneStar

Patient Financial Disclosure Notice

Patient Name: _____ Patient ID: _____

Pursuant to the requirements of section §105.002 of the Texas Occupations Code, this is to inform you that each of the physicians listed below have a financial ownership interest in Texas Orthopedic Hospital, 7401 Main Street, Houston, Texas 77030 (the "Hospital") and may, indirectly, receive compensation for services you receive at the Hospital.

You, as the patient of one of these physicians, have the option of using an alternative health care facility, other than the Hospital, if you so desire.

James B. Bennett, M.D.
David M. Bloome, M.D.
Mark R. Brinker, M.D.
Gary T. Brock, M.D.
Barrett S. Brown, M.D.
Robert L. Burke, M.D.
C. Craig Crouch, M.D.
T. Bradley Edwards, M.D.
Hussein A. Elkousy, M.D.
Tomiko Fukuda, M.D.
Idris S. Gharbaoui, M.D.
Mufaddal M. Gombera, M.D.
Robin N. Goytia, M.D.
Richard J. Kearns, M.D.
Jeffrey A. Kozak, M.D.
David P. Loncarich, M.D.
Randy M. Luo, M.D.
Vasilios Mathews, M.D.
Michael T. McCann, M.D.
Thomas L. Mehlhoff, M.D.
Anay R. Patel, M.D.
Gregory W. Stocks, M.D.
Ryan M. Stuckey, M.D.
J. Bryan Williamson, M.D.
David W. Wimberley, M.D.

By signing below, you are attesting that you have read and understand the information provided above.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

FONDRENORTHOPEDICGROUP
A DIVISION OF OrthoLoneStar

Opioid (Narcotic) Prescription Policy

Patient Name: _____ Patient ID: _____

We understand that physical pain is interpreted differently among all of us and we are sensitive to the fact that many of our patients present to us with physically painful conditions. However, it is also our duty as physicians to minimize harm to patients. Narcotic addiction is a national epidemic. Physicians have been placed on the front line of managing this epidemic and are held accountable. In order to protect our patients and maintain our professional standing, OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates have an established policy for prescribing narcotics.

- Narcotics will not be prescribed for chronic pain conditions; however, they can be prescribed for acute conditions at the discretion of the treating physician.
- If you are under the care of a pain management physician, we expect you to disclose this information on your first visit. Failure to do so would violate your contract with your pain management physician.
- Narcotics will be prescribed post-operatively for a maximum of six to eight weeks depending on the type of surgical procedure performed.
- Prescriptions for narcotics will be dispensed in accordance with the Texas Prescription Monitoring Program. They may not be “called in” to your pharmacy.
- Your prescription history will be reviewed prior to the prescribing of any narcotic medication, pursuant to the Texas Prescription Monitoring Program.
- If you are taking narcotics prescribed by a pain management physician, you will need to receive your post-operative pain medicine from that physician.
- Long-term pain medication needs will require a referral to another physician, such as a pain management physician or primary care provider.
- Refills may take up to three days to process, so you must call well in advance. No refills will be authorized after hours or on weekends. NO EXCEPTIONS. On-call physicians are not authorized to refill narcotic pain medication. You may be asked to come to the office to be reevaluated prior to receiving a refill.
- Lost, damaged or stolen prescriptions will NOT be replaced.
- All medications are to be used as prescribed. Adjustments or increases in the amount of medication should not be done without discussion with the prescribing provider.
- Adverse reactions are to be reported to the physician’s office immediately.
- Combining narcotic pain medications may have unrecognized or unpredictable interactions with other pain medications.
- Operating heavy equipment or driving is not permitted when using narcotic pain medications.

We have created this policy to ensure the health and safety of our patients. We appreciate your cooperation.

Patient Signature: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: _____ **Relationship to Patient**: _____

Responsible Party Signature: _____ **Date**: _____

In Office Visit During COVID
Patient Authorization and Consent Form

During the COVID-19 pandemic, there is some increased risk for patients who visit a healthcare provider. Health problems can happen from being exposed to:

- other patients,
- healthcare staff, or
- healthcare facilities.

Some patients have a higher risk of complications from COVID-19, including those with:

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

If these high-risk patients get COVID-19, they may have a greater chance for having more health problems. These may be serious. Patients may need to be in the hospital. They could even die.

Other Evaluation and Treatment Choices

There may be other ways to meet with your doctor and be treated. You could have:

- a phone evaluation or
- a telehealth evaluation.

These other options may or may not be right for you. This depends on your health problem and overall health. If remote assessment and treatment are not appropriate, your doctor will explain why you need an in-person visit.

More Facts

Medical and office staff may help your doctor when you arrive and while you are evaluated and treated. They will follow state laws and recommendations from local, state, and national health officials related to caring for patients during the COVID-19 pandemic. However, they cannot eliminate risks, especially for high-risk patients.

Consent to Treatment

_x_____ The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you do not believe that you really understand the risks and choices, **do not sign the form until all questions have been answered.**

_x_____I understand the facts provided to me on the first page of this consent form. I give my consent for in-office evaluation and treatment. By signing below, I agree that staff/doctor has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions, and that all of my questions have been answered.

_____ _____
Signature of Patient or Responsible Party Date and Time

_____
Relationship to Patient (if Responsible Party is not Patient)

_____ _____/_____/_____
Witness Date and Time