Central Texas
Sports Medicine & Orthopaedics
A part of Brazos Valley Physicians Alliance

Consent for Treatment

Permission for Treatment: I hereby give permission to receive medical treatment from the physicians and staff of Central Texas Sports Medicine and Orthopaedics I understand that this permission is for general treatment only and that my further consent must be obtained prior to the performance of any office visits or special procedures.

Permission to Release Information: I authorize Central Texas Sports Medicine and Orthopaedics to release any protected health information, including medical records which pertain to treatment for drug abuse or alcoholism, necessary to treatment, billing, or health care operations related to treatment plans at Central Texas Sports Medicine and Orthopaedics.

Blood Exposure: In the event of an accidental needle stick or exposure to my blood or body fluids to an employee of Central Texas Sports Medicine and Orthopaedics or other health care professionals, I authorize the testing of my blood for the Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV), and Hepatitis C virus (HCV). This testing will be done at no expense to me as the patient as facilitated by Central Texas Sports Medicine and Orthopaedics. I understand that consent to blood testing does not infer or imply that I may be a carrier, have been exposed to, or am in a high-risk group for exposure to HIV, HBV, or HCV.

Personal Valuables/Belongings: I acknowledge Central Texas Sports Medicine and Orthopaedics is not responsible for my personal property which is lost or damaged.

I understand and accept the terms of this agreement and certify that I am duly authorized by the patient or by law to execute the above agreement in his/her behalf.

_____
Patient's Printed Name

_____ _____
Signature of Patient / Parent or Guardian of Minor Date

_____ _____
CTSM Staff Witness Signature Date

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

Patient/Legal Guardian Signature: _____ Date: _____

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

Texas: Comprehensive Balance Billing Protections

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond innetwork level of cost sharing
- Above protections apply:
  - To HMO, PPO, and EPO enrollees
  - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of health care professionals • State provides dispute resolution process • Protections do not apply to:
  - ground ambulance services
  - enrollees who consent to out-of-network non-emergency services ○ enrollees of self-funded plans

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was innetwork). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers. ○ Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Helpdesk at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Visit https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/statebalance-billing-protections for more information about your rights under Texas laws.

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Last Name: _____ **Primary Care Physician:** _____

First Name: _____Preferred Name:_____ Referring Provider: _____

Address: _____ APT/Unit:_____ DOB: ____/_____/_____ Age: ___

City: _____ Sex (circle): *Male / Female* Marital Status (circle): *Single / Married / Other*

State: _____ Zip: _____ SSN: _____ - _____ - _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Your phone number is consent to receive appointment reminders via automated voicemail. To refuse, please write "No voicemail reminders" at the top of this form.

Email Address: _____

Pharmacy:_____ Pharmacy Location:_____

Billing Statement Recipient:
Relationship: _____DOB: ____/____/_____
Last Name:_____ First Name: _____
Address:_____ APT/Unit:_____
City: _____State: _____ Zip: _____
Primary Phone: _____

HIPAA Approved Emergency Contact:
Relationship: _____
Last Name:_____
First Name: _____
Primary Phone:_____

Is this visit due to a school / sports-related injury? (circle) **Yes No** If **Yes**, date of injury: ___/___/_____

Is this visit due to a work-related injury? (circle) **Yes No**

Insurance

Primary Insurance Carrier: _____ Coverage Dates: ___/___/_____ to ___/___/_____

Subscriber #_____ Group #_____

Policy Holder's Name:_____ DOB:___/___/_____ Your Relationship:_____
Policy Holder's Address: _____ APT/Unit:_____ City: _____State: _____Zip: _____

Secondary Insurance Carrier:_____ Coverage Dates: ___/___/_____ to ___/___/_____

Subscriber #_____ Group #_____
Policy Holder's Name:_____ DOB:___/___/_____ Your Relationship:_____
Policy Holder's Address: _____ APT/Unit:_____ City: _____State: _____Zip: _____

Do you have any **Advance Directives**? (circle) **Yes / No**

If **Yes** please circle:

DNR (Do Not Resuscitate) LW (Living Will)
DPA (Durable Power of Attorney) DTP (Directive to Physicians) MPA (Medical Power of Attorney)

Assignment of Benefits

I hereby authorize Central Texas Sports Medicine & Orthopaedics to furnish information to an insurance carrier concerning me and/or my dependent's illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and/or my dependents for any professional services rendered. I understand that I am responsible for any amount not covered by insurance. I certify that the information I have provided to Central Texas Sports Medicine & Orthopaedics is true and correct to the best of my knowledge and I will notify Central Texas Sports Medicine & Orthopaedics of any changes. A copy of this authorization shall be valid as the original. Your receipt will provide all the necessary information for you to file with your insurance company if our office is not contracted with or filing to your insurance carrier.

Patient/Legal Guardian Signature: _____ Date: _____

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Patient Privacy Notice (HIPAA Policy)

This Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Protected health information includes any information maintained by Central Texas Sports Medicine and Orthopaedics that could identify you and your health condition.

You have the right to review our notice before signing this consent. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. Individuals who have your permission to access your protected health information are listed below:

Name	Relationship
Name	Relationship
Name	Relationship

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and healthcare operation. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

Patient/Legal Guardian *Signature*	Patient/Legal Guardian Name *Printed*

Authorization to Treat a Minor

If the patient is under 18 years of age, his/her parent or guardian must read and sign below:

I hereby give permission to CENTRAL TEXAS SPORTS MEDICINE & ORTHOPAEDICS and its staff to provide my daughter/son with evaluation (including x-rays) and treatment for his/her injuries.

Parent/Legal Guardian Name *Signature*	**Patient/Legal Guardian Name *Printed***

External Medication Consent Form

Patient medication history is a list of prescription medications that our practices providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important; as it helps healthcare providers treat your symptoms and/or illness properly while avoiding potentially dangerous drug interactions. Please discuss your medication list with your provider to ensure all medications are properly documented. Over the counter drugs and supplements may not be included in the external medication history. I give permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient/Legal Guardian *Signature*	Date

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Last Name: _____ First Name: _____

Date of Birth: _____

Height ____'_____'' Weight _____ Reason for appointment: _____

Cardiologist: _____ Location: _____

Current Medications: *Please list all current medications.*

Medication	Dosage	Frequency (Daily, 2x Daily, etc.)

Medication Allergies: *Please list all medications you are allergic to.*

Medication	Reaction (Hives, Anaphylaxis, Rash, Stomach Upset, Dizziness)

Past Medical History: *Please circle all that apply.*

Hypertension	*HIV/AIDS*	*Headaches*	*Hepatitis A*
Diabetes	*Lung Disease*	*Eye Disorder*	*Hepatitis B*
Heart Disease	*Sleep Apnea*	*Glaucoma*	*Hepatitis C*
Pacemaker	*Stroke*	*Depression*	*Liver Disease*
Rheumatoid Arthritis	*Seizures*	*Anxiety*	*Blood Clots/DVT*
Thyroid Disorder	*Concussions*	*GERD*	*Cardiac Arrhythmia*
Bleeding Disorder	*Migraines*	*Stomach Problems*	**Other:**

Have you ever had any problems with anesthesia (put to sleep/waking from anesthesia)? Yes / No
If yes, please describe what sort of problems. _____

Surgeries: *Please list all surgeries you have undergone.*

Date (MM/YY)	Surgery

Have you been hospitalized for a non-surgical problem before? Yes / No

If yes, list hospitalizations, the reason for admission and the date in the table below

Hospitalizations: *Please list all hospitalizations in which you have not undergone surgery.*

Date(MM/YY)	Reason for Hospitalization

Family History: *Please check all that apply. For mental illness and cancer, please specify in the indicated box marked with **.*

	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness**	Cancer**	Unknown
Father	□	□	□	□	□	□	□
Mother	□	□	□	□	□	□	□
Siblings	□	□	□	□	□	□	□
Paternal Grandfather	□	□	□	□	□	□	□
Paternal Grandmother	□	□	□	□	□	□	□
Maternal Grandfather	□	□	□	□	□	□	□
Maternal Grandmother	□	□	□	□	□	□	□
Children	□	□	□	□	□	□	□

** Specific Mental Illness or Cancer:_____

Social History Questionnaire

Name:

Please check the answer that most accurately describes your behaviors for each question. The answers to these questions provide valuable information to your doctor regarding factors that affect your health status.

Smoking/Tobacco/Drug Assessment

1. Are you a current tobacco user?
   ❑ Yes ❑ No
2. If no, are you a former tobacco user?
   ❑ Yes ❑ No
   If former smoker, when did you start smoking? _____(year)
   When did you stop smoking?_____(year)
3. If yes, what type of **tobacco** do you/did you use?

❑ Chain smoker

❑ Chews loose leaf tobacco

❑ Chews tobacco

❑ Heavy cigarette smoker (20-39 cigs/day)

❑ Moderate cigarette smoker (10-19 cigs/day)

❑ Rolls own cigarettes

❑ Trivial cigarette smoker (less than one

❑ Chews fine cut tobacco

❑ Chews plug tobacco

❑ Chews twist tobacco

❑ Light cigarette smoker (1-9 cigs/day)

❑ Pipe smoker

❑ Snuff User

❑ User of moist powdered tobacco

❑ Electronic Cigarettes/Vape

4. Do you have a history of substance abuse?
   ❑ Yes ❑ No

Alcohol Assessment

1. Did you have a drink containing alcohol in the past year?
   ❑ Yes ❑ No
2. If yes, how often do you have a drink containing alcohol?
   ❑ Never ❑ Monthly or less ❑ 2-4 times a month ❑ 2-3 times a week ❑ 4 or more times a week
3. If yes, how many drinks did you have on a typical day when you were drinking in the past year?
   ❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 or 8 ❑ 9 or more
4. How often do you have six or more drinks on one occasion?
   ❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or almost daily

Review of Systems

Have you had a bone density scan in the past two years? Y / N
If yes, where? _____ When? _____
Have you had X-ray/MRI for this injury? Y / N
If yes, where? _____When? _____
Have you fallen in the last year? Y / N
If yes, did you sustain any injuries from your fall? Y / N

Please check all that apply

General Health Problems:
❑ Fever
❑ Chest pain
❑ Sleeping problems
❑ Headaches
❑ Unintentional weight loss
❑ Unintentional weight gain

Eye Problems:
❑ Double vision
❑ Itchy eyes

Ear Problems:
❑ Ear pain
❑ Ear drainage

Nose/Sinus Problems:
❑ Chronic congestion
❑ Hay fever
❑ Post nasal drainage

Mouth/Throat Problems:
❑ Change in voice
❑ Snoring
❑ Sore throat
❑ Ulcers

Heart/Blood Vessel Problems:
❑ Blacking out or fainting
❑ Bluish discoloration of lips/fingernails
❑ Chest pain
❑ Irregular heartbeat
❑ Leg cramps
❑ Swelling of ankles
❑ Blood Clots/DVT

Lung/Respiratory Problems:
❑ Frequent non-productive cough
❑ Frequent productive cough
❑ Shortness of Breath
❑ Wheezing

Muscle/Bone Problems:
❑ Muscle pain
❑ Back pain
❑ Cramping
❑ Popping joints
❑ Stiffness in joints
❑ Bruising
❑ R / L / Bilateral Shoulder pain
❑ R / L / Bilateral Knee pain
❑ R / L / Bilateral Ankle pain
❑ R / L / Bilateral Hand/wrist pain
❑ R / L / Bilateral Hip pain
❑ R / L / Bilateral Elbow pain
❑ Other: _____

Stomach (Gastrointestinal) Problems:
❑ Abdominal pain
❑ Diarrhea
❑ Heartburn
❑ Nausea,
❑ Vomiting

Brain/Nervous System Problems:
❑ Numbness
❑ Seizures
❑ Severe face pain
❑ Weakness

Glands/Hormones Problems:
❑ Feel cold all the time
❑ Feel hot when others do not
❑ Increased appetite
❑ Increased fatigue
❑ Neck has enlarged
❑ Unwanted weight change

Blood/Lymph Nodes Problems:
❑ Bleeds excessively after injury
❑ Bruises easily

Allergy Problems:
❑ Food intolerances