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

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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NEW PATIENT - HEALTH HISTORY

3121 University Dr. E, Suite 100 Bryan, TX 77802
Phone: (979) 776-0169 | Fax: (979) 776-1372

NAME: ______________________ Date of Birth: ____________

Please complete the following form and give it to the medical assistant / staff once complete

ALLERGIES

Please list all medication allergies and your response

Do you have any medicine allergies? ☐ YES ☐ NO

Do you have an allergy to latex? ☐ YES ☐ NO

Medication: ____________ | Response: ________

Medication: ____________ | Response: ________

Medication: ____________ | Response: ________

MEDICATIONS

Please list medications and doses. If you have a medication list, we can make a copy and you can skip this section.

Medication: ______________________

Medication: ______________________

Medication: ______________________

Medication: ______________________

Medication: ______________________

Preferred Pharmacy: ______________________

Height:________ Weight: ________

MEDICAL HISTORY

Indicate all known medical conditions

- ☐ Type 2 Diabetes (T2DM)
- ☐ Type 1 Diabetes (T1DM)
- ☐ High Cholesterol (HLD)
- ☐ Hypertension (HTN)
- ☐ Heart Disease (CAD)
- ☐ Heart Failure (CAD)
- ☐ Atrial Fibrillation (AFib)
- ☐ Heart Valve Issues
- ☐ Blood Clots (DVTs)
- ☐ Chronic Lung Disease (COPD)
- ☐ Asthma
- ☐ Osteoporosis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Acid Reflux / Heartburn
- ☐ Gastric Ulcers or Bleeding
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Disorder

☐ OTHER: ______________________

☐ OTHER: ______________________

SURGICAL HISTORY

Please list previous orthopedic & non-orthopedic surgeries with approximate dates. Please use the back of the page if needed.

Surgery: ______________ | Date: ________

Surgery: ______________ | Date: ________

Surgery: ______________ | Date: ________

Surgery: ______________ | Date: ________

HEALTH CARE TEAM

Please list your doctors, including specialists, below so we can communicate with them as necessary

Primary Care: ______________________

Specialist: ______________________

Specialist: ______________________

Specialist: ______________________

REASON FOR VISIT

Please indicate the main reason for your visit: (Ex: Right shoulder pain)

REVIEW OF SYMPTOMS

Please indicate if you are experiencing any of the following symptoms:

Constitutional: ☐ Fever ☐ Sleep issues ☐ Weight changes

Respiratory: ☐ Wheezing ☐ Shortness of breath ☐ Productive Cough

Cardiovascular: ☐ Chest pain ☐ Irregular heart rate ☐ Palpitations ☐ Fainting ☐ Easy Bruising

Gastrointestinal: ☐ Gastric ulcers ☐ Acid Reflux/heartburn ☐ Nausea ☐ Vomiting ☐ Diarrhea

Musculoskeletal: ☐ Multiple joint pain ☐ Muscle pain ☐ Cramping ☐ Swelling

OUTSIDE IMAGING

Please give any outside imaging reports or CDs to the clinical staff for review and upload into your chart.

SOCIAL HISTORY

Answer each question as truthfully as possible.

Do you, or have you ever, smoked tobacco?

□ Never Smoker □ Former Smoker □ Current Smoker

- *If you smoke, how many years have you smoked tobacco? ____ years*
- *If you smoke, how much tobacco do you smoke?*

□ _____ packs per day □ _____ packs per week

- *When did you quit smoking? _______ -or- □ N/A*

Have you ever used any other forms of nicotine?

□ Yes □ No ... If yes, what form: ___________

Has tobacco cessation counseling been provided?

□ Yes □ No

What is your level of alcohol consumption?:

□ None □ Occasional □ Moderate □ Heavy

Do you use any illicit or recreational drugs?:

□ Yes □ No

Do you have an advanced directive?

□ Yes □ No

SURGICAL/IMAGING HISTORY

Please list previous orthopedic & non-orthopedic surgeries with approximate dates. Please continue writing below if needed.

Surgery: ____________________ | Date: __________

Surgery: ____________________ | Date: __________

Surgery: ____________________ | Date: __________

Surgery: ____________________ | Date: __________

Surgery: ____________________ | Date: __________

Surgery: ____________________ | Date: __________

MEDICAL HISTORY

Indicate all of your known medical conditions (personal medical history)

□ Type 2 Diabetes (T2DM) □ Osteoporosis

□ Type 1 Diabetes (T1DM) □ Gout

□ High Cholesterol (HLD) □ Fibromyalgia

□ Hypertension (HTN) □ Acid Reflux / Heartburn

□ Heart Disease (CAD) □ Gastric Ulcers / Bleeds

□ Heart Failure (CAD) □ Irritable Bowel Synd

□ Atrial Fibrillation (AFib) □ Crohn's Disease

□ Heart Valve Issues □ Ulcerative Colitis

□ Blood Clots (DVTs) □ Anxiety

□ Chronic Lung Disease (COPD) □ Depression

□ Asthma □ Mood Disorder

□ OTHER: ______________________________

□ OTHER: ______________________________

□ OTHER: ______________________________

REVIEW OF SYMPTOMS

Please indicate if you are experiencing any of the following symptoms at this time or recently...

Constitutional: □ Fever □ Sleep Issues □ Weight changes

Respiratory: □ Wheezing □ Shortness of breath □ Cough

Cardiovascular: □ Chest pain □ Irregular heart rate □ Palpitations □ Fainting □ Easy Bruising

Gastrointestinal: □ Gastric ulcers □ Acid Reflux/heartburn □ Nausea □ Vomiting □ Diarrhea

Musculoskeletal: □ Muscle pain □ Multiple joint pain □ Cramping □ Swelling

OUTSIDE IMAGING

Please give any outside imaging reports or CDs to the clinical staff for review and upload into your chart.

***Please Note**: If you have completed outside imaging and do not have reports/CDs, you will need to sign a medical record release for us to send you your imaging facility. We cannot guarantee that we will be able to access other healthcare facilities imaging reports the day of your appointment. We appreciate your understanding.*

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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

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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 ______________________

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 , like a , , or . 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 o 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. o 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 for more information about your rights under federal law.

Visit

for more information about your rights under Texas laws.