AUBREY L. SMITH, M.D.
ORTHOPAEDIC SURGERY
SHOULDER SURGERY
ARTHROSCOPIC AND RECONSTRUCTIVE SURGERY
1600 COULTER BUILDING B
AMARILLO, TEXAS 79106

Lisa Snow, PA-C　　Jay Longino, RN RNFA

Appointment Date and Time: ______________________________

Welcome New Patient:

Enclosed are the new patient forms for Dr. Smith. Please fill the forms out **completely** and bring them with you to your appointment. In order to make your appointment go as smooth as possible, we do ask that you bring all **medical records and x-rays** from all other physicians that you have seen for this particular problem. This information could also be faxed to our office at **806-359-9613**. If you have had any previous diagnostic testing such as a **MRI, arthrogram, CT Scan, or nerve conduction test please bring the reports AND actual films or a CD with the images on it.** We are currently linked to BSA, Northwest Texas Hospital, Advanced Imaging Center, Texas Diagnostic Imaging Center, Amarillo Diagnostic Clinic, and Open Air MRI, so we will be able to get those images on-line, but will still need the written report. **Please have all your information with you and all paperwork completed at the time of visit, or your appointment may be delayed.**

We do ask that you bring your **driver's license, social security card, and your current insurance card** with you so we can make a copy for our records. If your insurance plan requires that you have a referral, we also ask that you make sure you bring us a copy for our records. We will be more than happy to file your claim with the insurance company, but **payment is expected at the time of service. The office accepts Visa, MasterCard, Discover, American Express, cash, and checks.** We will also be happy to make payment arrangements if needed.

If you are coming for knee problems, please bring a pair of shorts with you so that Dr. Smith can examine you thoroughly.

We are very excited to be able to take part in your healthcare, we are honored that you have chosen our office and look forward to serving you. If you have any questions or need any further information, please do not hesitate to call us at 806-359-0718.

Thank you,
Kim Keene
Office Manager

Our office is located at:
1600 COULTER, BLDG B
Amarillo, TX 79106
806-359-0718

Patient Name:____________________

DOB:____________________

Medical Record # ____________________

Meaningful Use Patient Registration Form

In compliance with the HITECH Act (EHR), to attain Meaningful Use we are required to capture demographic data that includes but is not limited to, preferred language, race, ethnicity, and tobacco use. This is an important part of your medical history and will assist us during our quality improvement process. Please choose only one answer per question. Thank you.

Tobacco Use:

- ☐ Never
- ☐ Current smoker
- ☐ Former smoker (give an approximate quit date) ___/___/____

Have you been diagnosed with high blood pressure or hypertension in the last year?

- ☐ Yes
- ☐ No

AUBREY L. SMITH, M.D.
1600 Coulter, Building B
Amarillo, Texas 79106
Phone: 806-359-0718 DrAubreySmith.com Fax: 806-359-9613

FULL LEGAL NAME: ______________________ NICK NAME: ____________

ADDRESS: ______________________________ APT #: ____________

CITY: ____________________ STATE: ________ ZIP CODE: ____________

DATE OF BIRTH: ______________ AGE: ______ SOCIAL SECURITY#: ____________

SEX: MALE OR FEMALE MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

HOME PHONE #: (   ) ______________ CELL PHONE #: (   ) ______________

EMPLOYER: ____

ADDRESS: ______________________________ PHONE #: (   ) ____________

PERSON/PARTY RESPONSIBLE FOR THE BILL: ______________________________

EMERGENCY NOTIFICATION:

NAME: ______________________ PHONE # : ______________________

RELATIONSHIP : ________________ CELL/WORK # : ______________________

NAME: ______________________ PHONE # : ______________________

RELATIONSHIP : ________________ CELL/WORK # : ______________________

SPOUSE'S INFORMATION:

SPOUSE'S FULL NAME: ______________________________________

DATE OF BIRTH: ________________ SOCIAL SECURITY #: ______________

EMPLOYER: ____

ADDRESS: ______________________________ PHONE #: ______________

INSURANCE INFORMATION: (PLEASE PRESENT CARDS FOR PHOTOCOPY)

1. INSURANCE CO NAME: ______________________ ID #: ______________
2. INSURANCE CO NAME: ______________________ ID# : ______________

IF THE PATIENT IS A MINOR OR STUDENT:

FATHER: ______________________ DATE OF BIRTH: ______________

SOCIAL SECURITY #: ________________ PHONE #: ______________

ADDRESS: ____

MOTHER: ______________________ DATE OF BIRTH: ______________

SOCIAL SECURITY #: ________________ PHONE #: ______________

ADDRESS: ____

IS THIS INJURY DUE TO:

ACCIDENT: ____________________ WORK RELATED INJURY : ______________

MOTOR VEHICLE ACCIDENT: ________________ DATE OF INJURY: ____________

CONSENT TO TREATMENT

1. I hereby voluntarily consent to outpatient care at the office of Aubrey L. Smith, MD encompassing routine diagnostic procedures, examinations, and medical treatment including taking of x-rays and administration of medicines prescribed by the physician.

2. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Aubrey L. Smith, MD, Lisa Snow, PA-C, his assistants, or their designees as is necessary in the medial staff's judgment.

3. I further consent to allow photographic pictures to be taken and correlated into my medical record to solely be used in routine practice of Aubrey L. Smith, MD.

4. **RELEASE OF INFORMATION:** I authorize Aubrey L. Smith, MD to release medical information to third party insurance carriers for the sole purpose of filing insurance claims related to my/his/her medical care.

5. **AUTHORIZATION TO PAY PHYSICIAN DIRECTLY:** I hereby authorize my insurance carriers to pay directly to Aubrey L. Smith, MD all benefits due to me. If, by any reason, of service described in the statement rendered and as provided for in the policy of my contract with my insurance carrier.

6. **LIABILITY INSURANCE AUTHORIZATION TO PAY PHYSICIAN DIRECTLY:** If payment is due from a liability insurance carrier, I hereby direct and authorize my attorney(s) to pay all unpaid medical bills presented to them before the distribution of any proceeds to me, out of the sums received by them to which I am entitled. A copy of this authorization shall have the same force and effect as the original.

7. **RESEARCH:** I authorize Aubrey L. Smith, MD to use patient information acquired in the clinic, in surgery, and radiographic and other miscellaneous testing that may be ordered pertaining to treatment to determine clinical outcomes. The purpose of research is to analyze results, and your course of treatment will not be different from the standard of care for your diagnosis and procedure. Research that is done in this office involves clinical outcome of standard of care and proven state of the art medical and surgical intervention. No patient specific identifiable information will be utilized in research.

8. **CHOICE OF LAW AND FORUM CLAUSE:** The patient, including patient's representative and heirs of beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:
   - A. That all health care rendered shall be governed exclusively and only by Texas Law, and in no event shall the law of any other state apply to any health care rendered to patient; and
   - B. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought only in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

____ DATE: ____________

Patient or Legal Representative or Guardian Signature

MEDICARE PATIENTS:

"I understand that Medicare and/or Medicaid or their insuring agent determines the medical necessity of the services or items that I request and/or receive. I also understand that I am responsible for payment of the services or items I request and/or receive if these services or items are not covered by, or fees denied payment by the Medicare Medical Review Board and/or Texas Department of Human Services or their health insuring agent."

____ DATE: ____________

Patient or Legal Representative or Guardian Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: ______________________________ Date of Birth: ________________

Address: ____

Phone #: ____________________ Social Security # : ___________________________

I, ________________________________ authorize to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by the federal and state privacy regulations.

Information to be released FROM:

____
____
____
____

To: Aubrey L. Smith, M.D.
1600 Coulter, Building B
Amarillo, Texas 79106
Phone: 806-359-0718
Fax: 806-359-9613

Information to be released: (check all that apply)

_______ History & Physical Exam Notes
Dates: ______________

_______ Lab Results
Dates: ______________

_______ X-ray Reports
Dates: ______________

_______ Diagnostic Reports
Dates: ______________

_______ Surgical Clearance
Dates: ______________

_______ Other (please specify)
____

Reason of Purpose for Release: (check appropriate category)

_______ Surgical Clearance
_______ Continued Patient Care
_______ Insurance Claim/ Application
_______ Attorney/Legal
_______ Personal Use
_______ Disability Determination/Social Security
_______ Other (please specify)
_______ ________________________

I understand that the information released is for a specific purpose stated above. Any other use of this information without written consent of the patient prohibited. I further understand that I may revoke this consent (in writing) at any time except in the extent that action has been taken in reliance on it. This consent will expire1-year after the date of my signature unless otherwise specified.

____ ______________________________
Signature of Patient or Patient's Legal Representative Date

-- FOR OFFICE USE ONLY --

Records picked up __________ Records sent __________ Date: __________ Initials__________

AUBREY L. SMITH, M.D.
Orthopaedic Surgery
Arthroscopic and Reconstructive Surgery Shoulder Surgery
1600 Coulter Building B
Amarillo, Texas 79106

FINANCIAL POLICY

We are committed to providing you with the best possible care. Since payment of your bill is part of your treatment, we want you to be sure that our financial policies are clearly understood.

Payment of your account is your responsibility regardless of your insurance coverage. Your insurance is a contract between yourself and the insurance carrier; we are not a party to that contract.

It is your responsibility to obtain the necessary referrals from your primary care physician. Any co-payments are due at the time of service. **For your convenience, we accept VISA, Mastercard and Discover Card, American Express, as well as Cash or Check.**

You will receive a monthly statement from our clinic for the remaining balance after your insurance pays the claim. Payment in full will be expected within 30 days of receipt. If you are unable to meet your financial obligations, arrangements will need to be made. To partake in any payment arrangements, you will be responsible for contacting our office and signing a separate agreement.

Our office does have guidelines we have to follow for every patient who needs a payment plan; which will be based upon the amount of your bill, if your bill is $1,000.00 or less we will expect a monthly payment of at least $100.00. If your balance is more than $1,000.00 we will expect a monthly payment of at least 15% of your bill. Financial procedures are standardized and the same for every patient

You will be required to pay up front at least 20% of your surgical cost estimate.

Your account can be sent to collections due to non-payment or failure to keep a payment arrangement. If this is the case, it will be documented in your financial record. You will not be scheduled for future appointments without approval from the business office.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

Signature ________________________________ **Date**____________________

________________________________ ________________________________

RESPONSIBLE PARTY (PRINT) **RELATIONSHIP TO PATIENT**

DR AUBREY SMITH, M.D.
1600 COULTER BUILDING B
AMARILLO, TX 79106

Prior to seeing the physician, all balances, copayments, coinsurance, and deductibles will be due at the time of service.

There will be a $10.00 charge for any forms that the physician must fill out and a $10.00 charge for a CD with your x-ray or MRI images. There will be a charge for a copy of Medical Records based on the situation and circumstances

Your account will be charged a fee of $25.00 for cancellations with less than 24 hour notice.

Effective 11/1/2015

AUBREY L. SMITH, M.D.
ORTHOPAEDIC SURGERY
ARTHROSCOPIC AND RECONSTRUCTIVE SURGERY
OF THE UPPER AND LOWER EXTREMITIES
1600 COULTER BLDG B
AMARILLO, TEXAS 79106

FAX PHONE: (806) 359-9613 DrAubreySmith.com TELEPHONE: (806) 359-0718

NAME: WHO REFERRED YOU TO THIS OFFICE?

PLEASE DESCRIBE YOUR PROBLEM:

WHAT WAS THE DATE THAT THE PROBLEM STARTED AND HOW DID YOU GET THIS PROBLEM? IF YOU HAVE BEEN TREATED FOR THIS PROBLEM, WHO TREATED YOU AND WHAT DID THEY DO?

WHAT IS YOUR JOB DESCRIPTION AND WHAT DO YOU DO AT WORK THAT IS HARD OR NOT POSSIBLE BECAUSE OF YOUR PROBLEM?

1. Please slash in all the areas that are painful.
2. Draw one arrow on each diagram to the one place that hurts the most.
3. Color in any areas that you experience numbness, tingling, burning, "shooting" or "electric-like" pains or sensations.
4. Circle any areas that swell

FRONT BACK

R L L R

R L L R

IS THIS A WORK RELATED INJURY: **YES** **NO**
IS THIS FROM A CAR ACCIDENT: **YES** **NO**

PAST MEDICAL HISTORY

List **ALL** of your current medications to **include the dosage and instructions**. Please include all over-the-counter medications such as: aspirin, Tylenol, Ibuprofen, Advil, Aleve, vitamins, and herbal supplements.

NAME	DOSAGE/FREQUENCY	PRESCRIBING DOCTOR

****PREFERRED PHARMACY **** **(address)** ____

CIRCLE any of the following kinds of medications you have taken in the *past year*

Oral/Injectable Steroid/Cortisone
Diet Pills
Breathing Medications
Antiarrhythmic Medications
Diabetes Medications
High Blood Pressure Medication include Diuretics (Water Pills)
Antibiotics
Other:____

Please list **ALL** of your physicians (family physician, cardiologist, internist, etc.)

____

____

____

____

____

Tobacco use: YES or NO

If yes, then please answer the questions below:
What do you use?______________________________
How often per day?______________________________
How long have you used product?________________________

Alcohol use: YES or NO

If yes, then please answer the questions below:
How often per day?______________________________
How long have you used product?________________________

If you are female, is there a chance that you could be pregnant? YES or NO

Are you **ALLERGIC** to any medications? If so, what happened when you took this medication?

____

____

____

Have you ever had any **previous SURGERIES, PROCEDURES, or BROKEN BONES**? Please list **ALL** below along with the date they occurred and the doctor who provided the service.

____

____

____

____

____

____

____

____

Medical problems: Please list below (i.e.: high blood pressure, diabetes, etc.)

____

____

____

Do you currently or have you ever had: (Circle one)

Hepatitis:	**YES**	**NO**	**HIV:**	**YES**	**NO**
If so, what kind :					
Treatment :					
Who treated:					

Do you have a family history of any diseases? (heart disease, cancer, diabetes, etc)

____

____

____

REVIEW OF SYSTEMS

Do you *CURRENTLY* have any problems related to the following systems? Circle YES or NO. Please *explain* any answered YES in the space provided.

Constitutional symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other:________________________

Explain:________________________

Eyes

Blurred vision	Y	N
Double vision	Y	N
Eye pain	Y	N

Other:________________________

Explain:________________________

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other:________________________

Explain:________________________

____

Gastrointestinal

Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N

Other: ________________________

Explain: ________________________

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other:________________________

Explain:________________________

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other:________________________

Explain:________________________

Ears/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N

Other:________________________

Explain:________________________

Psychologic

Are you satisfied with your life?	Y	N
Are you severely depressed?	Y	N
Have you ever considered suicide?	Y	N

Other: ________________________

Explain: ________________________

Have you *EVER* experienced any problems related to the following systems? Circle YES or NO. Please *explain* any answered YES in the space provided.

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/Tingling	Y	N

Other:________________________

Explain:________________________

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired sluggish	Y	N

Other:________________________

Explain:________________________

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High Blood Pressure	Y	N

Other:________________________

Explain:________________________

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other:________________________

Explain:________________________

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of breath	Y	N

Other:________________________

Explain:________________________

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting	Y	N
Blood thinners	Y	N

Other:________________________

Explain:________________________

MEDICAL PROBLEMS LIST

Please check all that apply or have applied in the past

High Blood pressure ___	Heart Bypass Surgery ___	Neurologic Disease ___
Coronary Artery Disease ___	Coronary Stent Placement ___	Kidney Disease ___
Heart Attack ___	Irregular Heart Beat ___	Kidney Infections ___
Congestive Heart Failure ___	Pacemaker/Defibrillator ___	Prostate Problems ___
Deep Venous Thrombosis ___	Seizures ___	Asthma ___
Multiple Sclerosis ___	Stroke ___	COPD ___
Sleep Apnea ___	TB ___	Lung Disease ___
Blood Clots in Lungs ___	Diabetes ___	Thyroid Disease ___
Stomach Ulcer ___	Hiatal Hernia ___	GI Disease ___
Liver Disease ___	Hepatitis ___	HIV ___
Bleeding Disorder ___	Malignant Hypothermia ___	Rheumatoid Arthritis ___
Cancer ___	MRSA ___	Latex Allergy ___
Diet Meds ___	High Cholesterol ___	Clotting Disorder ___
Migraines ___	Fainting ___	Brain Disorder ___
Autoimmune Disease ___	Dizziness ___	Shortness of Breath ___
Visual Disturbances ___	Abnormal Bleeding ___	Anesthesia Problems ___

Please provide further information for the items checked:

____

____

____

____