

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
DrAubreySmith.com

Phone: 806-359-0718

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.

Patient or Legal Representative or Guardian Signature

DATE: _____

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."

Patient or Legal Representative or Guardian Signature

DATE: _____

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 expire 1-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
1600 Coulter Bldg. B Amarillo, Texas 79106

CIRCLE ONE:
RIGHT / LEFT / BOTH

TELEPHONE: 806-359-0718

DrAubreySmith.com

FAX PHONE: 806-359-9613

PATIENT NAME: _____ DATE: _____

REFERRING PHYSICIAN: _____ DATE OF INJURY: _____

INITIAL SHOULDER PATIENT QUESTIONNAIRE

PLEASE DESCRIBE YOUR PROBLEM:

WHEN AND HOW DID THIS PROBLEM START?

DESCRIBE ANY PREVIOUS TREATMENT, X-RAY, TESTS (ex: MRI), OR SURGERIES YOU HAVE HAD FOR THIS PROBLEM AND BY WHOM:

DESCRIBE YOUR JOB OR WORK REQUIREMENTS:

WHAT CAN YOU NOT DO BECAUSE OF YOUR PROBLEM?

USING THE SCALE BELOW PLEASE RATE YOUR PAIN: (CIRCLE YOUR ANSWER)

- 5 = none
4 = slight
3 = after usual activity
2 = moderate
1 = marked
0 = severe

_____ (x3) Office use only

WHAT PERCENT OF A NORMAL SHOULDER DO YOU ESTIMATE YOU HAVE? _____

PLEASE RATE THE FUNCTION OF YOUR SHOULDER USING THE SCALE BELOW:

- A. Use back pocket.....
B. Perineal Care (managing toileting).....
C. Wash opposite axilla (armpit).....
D. Eat with utensil.....
E. Comb hair.....
F. Use hand with arm at shoulder level.....
G. Carry 10-15# with arm at side.....
H. Dress.....
I. Sleep on affected side.....
J. Pulling.....
K. Use hand overhead.....
L. Throwing.....
M. Lifting.....
N. Do usual work.....
O. Do usual sport.....

_____ (1/2) Office use only

- 4 = normal
3 = with compromise
2 = difficulty
1 = with aid
0 = unable

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

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ASES (American Shoulder and Elbow Surgeons) Score

Modified ASES questionnaire

ANSWER THE QUESTIONS BELOW BY FILLING IN THE CORRESPONDING BUBBLES:

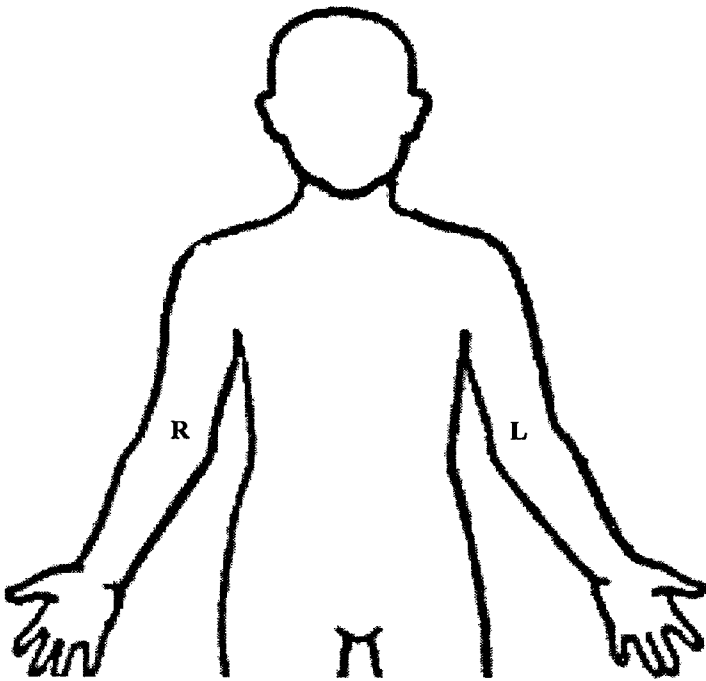
Moderate ASES questionnaire	Yes, no trouble	Slight trouble	Moderate trouble	No, I can't	
Can you throw a ball overhand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Can you sleep on your shoulder comfortably?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Can you put on your coat unassisted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Can you wash your back/fasten your bra?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Can you manage toileting on your own?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Can you comb/wash your hair?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Can you lift ten pounds (a full gallon container) above the level of your shoulder?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Can you reach a shelf over your head?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Does your shoulder allow you to Work full time at your regular job (or if not working-your regular activities)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Does your shoulder allow you to do your regular sports?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I don't play sports <input type="radio"/>
On average, how much shoulder pain have you experienced in the last week?					
No pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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NAME: _____

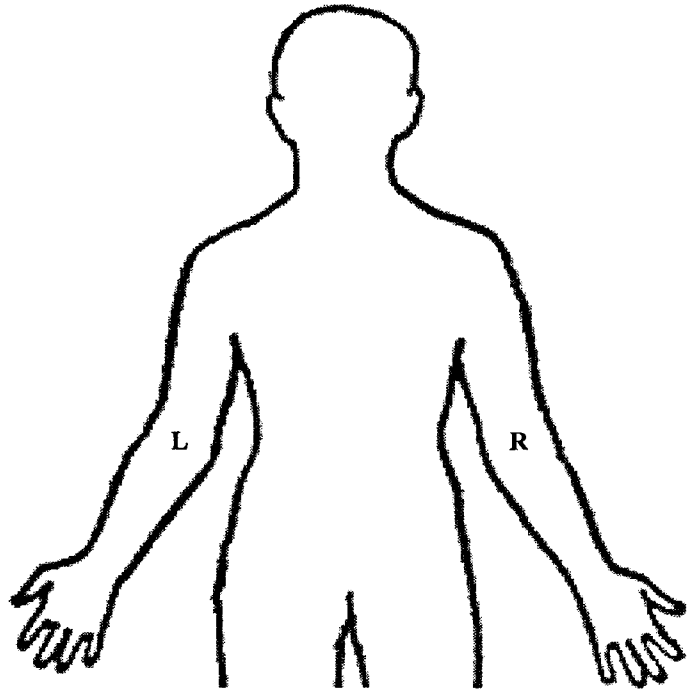
USE THE PICTURE BELOW FOR THE FOLLOWING INSTRUCTIONS:

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



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

If so, what kind : _____

Treatment : _____

Who treated: _____

HIV: YES NO

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:
