Performance Orthopedics
Kenneth Jurist, MD
2720 N. University Dr.
Nacogdoches, TX 75965
(936) 205-9824

Patient Name	Sex	Date of Birth	Age	Marital Status S M D W
Social Security #	Cell Phone	Home Phone	Work Phone	
Physical Address	City	State	Zip	
Mailing Address (if different)	City	State	Zip	
Primary Care Physician	How did you hear about us?			
Parent or guardian, if patient is a minor	Relation	Phone Number		
Address of parent/guardian	City	State	Zip	
Emergency Contact	Relation	Phone Number		
Address of emergency contact	City	State	Zip	
Person responsible for payment, if not patient	Relation	DOB	Social Security #	
Address of person responsible for payment	Phone number			
Patient e-mail address				
What pharmacy do you use?	Address of pharmacy			

Primary Insurance	Policy holder name	Date of birth	Social Security #
Relation to patient	Policy holder address	Policy #	
Group #	Group name	Subs suffix	Effective Date

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PATIENT MEDICAL HISTORY

Name: _____ Date:_____

Referring Physician: _____

Please describe the reason for today's visit: _____
_____
_____
_____

Describe any problems or issues you have previously had (if any):
Weight Loss _____
Eyes/Ears/Nose/Throat _____
Heart _____
Lungs _____
Stomach/Bowel _____
Urinary/Incontinence _____
Muscles _____
Skin _____
Brain/Head _____
Mental Health _____
Thyroid/Pancreas _____
Blood/Lymph _____
Allergies _____

Height: _____ Weight:_____

Have you ever been diagnosed with any of the following:

___Arthritis	**___Asthma**	**___Autoimmune**	**___Cancer**
___Demyelinating Disease	**___Diabetes**	**___Dizziness**	**___Headaches**
___Heart Disease	**___High Blood Pressure**		**___ HIV/Hepatitis**
___High Cholesterol	**___Neuropathy**	**___Psychiatric Problems**	
___Seizures	**___Spinal Problems**	**___Stroke**	**___Thyroid Disease**

Other: _____

PATIENT MEDICAL HISTORY-CONTINUED

Name: _____ Date:_____

List date and type of any previous surgical procedures:

_____ _____
_____ _____
_____ _____

Please indicate a family history of any of the following disorders:

___Arthritis ___Asthma ___Autoimmune ___Cancer
___Demyelinating Disease ___Diabetes ___Dizziness ___Headaches
___Heart Disease ___High Blood Pressure
___High Cholesterol ___Neuropathy ___Psychiatric Problems
___Seizures ___Spinal Problems ___Stroke ___Thyroid Disease

Social History:
Patient left-handed or right-handed? _____

Occupation: _____ Marital Status: M S D Separated Widow Partner

Tobacco Use: Yes No If yes, how much/often: _____

Alcohol Use: Yes No If yes, how much/often: _____

Recreational Drug Use: Yes No If yes, what and how much/often: _____

Medication Allergies:

_____ _____
_____ _____
_____ _____

Current Medications: Name, Dosage, and Frequency

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Patient Signature: _____ Date: _____

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GENERAL OFFICE POLICIES

HOURS:

MONDAY–THURSDAY 8:00 AM--5:00 PM and FRIDAY 8:00 AM--4:00 PM
OFFICE IS CLOSED FOR LUNCH DAILY 12:00--1:00 PM

REFILLS AND TEST RESULTS:

PLEASE CONTACT YOUR PHARMACY FOR REFILLS PRIOR TO YOUR PRESCRIPTION ENDING. REFILLS MAY TAKE 24--48 HOURS. PLEASE ALLOW 1--2 WEEKS FOR TEST RESULTS. YOU WILL RECEIVE A LETTER FOR ALL NORMAL RESULTS. YOU WILL RECEIVE A PHONE CALL ON ALL ABNORMAL RESULTS.

NURSE CALLS AND QUESTIONS:

IT IS OUR DESIRE TO RETURN ALL PATIENT CALLS THE SAME DAY. HOWEVER, PLEASE ALLOW THE NURSE 24 HOURS TO RETURN ALL NON--EMERGENT CALLS.

HEALTH INFORMATION PAPERWORK:

PLEASE ALLOW 3--5 BUSINESS DAYS FOR THE COMPLETION OF ANY MEDICAL RELATED PAPERWORK SUCH AS DISABILITY FORMS, ETC. THERE IS A CHARGE FOR NARRATIVES AND FOR THE COMPLETION OF FORMS. MINIMUM CHARGE IS $25.00.

RELEASE OF MEDICAL RECORDS:

A RELEASE OF MEDICAL RECORDS MUST BE SIGNED BY THE PATIENT. PLEASE ALLOW 7--10 BUSINESS DAYS FOR COMPLETION. COPIES OF MEDICAL RECORDS ARE SUBJECT TO A CHARGE OF $25.00 FOR THE FIRST 15 PAGES AND $.15 PER PAGE THEREAFTER. THERE IS NO CHARGE FOR MEDICAL RECORDS SENT DIRECTLY TO ANOTHER PHYSICIAN. ALL MEDICAL RECORDS WILL BE MAILED UNLESS OTHERWISE SPECIFIED.

INSURANCE PLANS:

WE ACCEPT MOST MEDICARE, MEDICAID, AND PRIVATE INSURANCES. PLEASE CONTACT OUR OFFICE TO CONFIRM THAT YOUR INSURANCE PLAN IS ACCEPTED BY OUR OFFICE. INSURANCE INFORMATION WILL BE REQUIRED PRIOR TO SCHEDULING TO ENSURE PROPER VERIFICATION. ANY CHANGES TO YOUR INSURANCE COVERAGE SHOULD BE REPORTED TO OUR OFFICE PROMPTLY. AS THE PATIENT, YOU ARE RESPONSIBLE FOR KNOWING THE DETAILS OF YOUR PLAN AND ARE ULTIMATELY RESPONSIBLE FOR ANY CHARGES THAT MAY OCCUR AS A RESULT OF YOUR VISIT.

CO-PAYS AND DEDUCTIBLES:

ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR VISIT.

SCHEDULED AND MISSED APPOINTMENTS:

APPOINTMENTS ARE SCHEDULED ACCORDING TO TIME AVAILABILITY AND THE NATURE OF THE VISIT. PLEASE ARRIVE AT LEAST 15 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME TO ALLOW FOR THE COMPLETION OF ANY ADDITIONAL PAPERWORK. IF YOU ARE MORE THAN 10 MINUTES LATE FOR YOUR APPOINTMENT, YOU MAY BE ASKED TO RESCHEDULE. IF YOU NEED TO CANCEL YOUR APPOINTMENT FOR ANY REASON, WE ASK THAT YOU NOTIFY OUR OFFICE AT LEAST 24 HOURS IN ADVANCE. MISSING APPOINTMENTS OR FAILING TO NOTIFY US OF CANCELLATION MAY RESULT IN A CHAREGE OF $25.00.

I have read, agree, and acknowledge receipt of the above information.

_____ _____

Patient Signature/Guarantor Date

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Medication Risks

Medications are drugs. They are prescribed because of their intended benefit. However, all drugs may cause unwanted side effects. Fortunately, most patients experience little to no side effects. Medication side effects can occur when starting, changing dosage, or when stopping medication.

Medication side effects can range from minor to severe. These side effects can even result in death and/or serious problems in extreme cases. Fortunately, side effects are rarely life threatening. The doctor will inform you of the most likely and serious side effects when he or she starts you on a new medication.

Medication can also have very serious interactions with other medications. It is very important that you keep all of your doctors informed of your current medications.

There are numerous possible rare and usually mild side effects to medications. When you prescription is filled your pharmacist should give you a print-out about the medication, including possible side effects. There can include bone thinning, blood abnormalities, rash, and liver dysfunction.

The likelihood of having side effects may be related to our age, weight, gender, disease, medical condition, and/or any other drugs you may be taking.

Pregnancy is a unique condition in that most medications can affect the normal course of development of the embryo/fetus. Many women are not aware of their pregnancy in its early stages. Unfortunately, this is when the embryo/fetus is the most vulnerable to harm. This harm can be extreme, resulting in the loss of the pregnancy or fetus malformations resulting in permanent birth defects. Therefore, it is essential that you tell the doctor if there is any possibility of pregnancy. This includes any changes during pregnancy, or at any time during treatment by Dr. Jurist, and/or changes in medications prescribed by other physicians while under the care of Dr. Jurist.

If you suspect you are experiencing medication side effects, you should talk to your physician or nurse first. Do not stop taking the medication without talking to your physician first. If you think you are having a serious reaction to your medication, call 911 or go to the nearest emergency room.

By signing below, you are acknowledging that you have read the above statement and understand the risk of taking medication, and agree to follow the above conditions. Dr. Kenneth Jurist may withhold treatment if you do not agree with above statement.

If you have any questions regarding the above information, please discuss them with Dr. Jurist or his nurse.

X_____ _____

Signature of Patient (or responsible party if patient is a minor) **Date**

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FINANCIAL POLICY

Performance Orthopedics values our relationship with our patients. Our desire is to provide you with quality medical care in a timely and efficient manner. As a healthcare provider we accept most insurance plans. However, as a patient it is your responsibility to be aware of your coverage benefits, such as non-covered services, co-pays, deductibles, and co-insurance. We emphasize that our relationship is with you, not with your insurance carrier. You, as the patient, are responsible for notifying our office of any changes to any information concerning your insurance coverage, name, address, or contact information. All insurance carriers have requirements for timely claim filing; failure to provide correct and update information could result in denial of insurance claims.

Performance Orthopedics will file your insurance claims on your behalf as a courtesy. Co-pays, deductibles, and co-insurance are due and payable prior to services being rendered. You will be financially responsible for any claim that your insurance carrier denies for timely filing due to insurance information not being received within the specified time period, deemed not medically necessary, or non-covered. It is you responsibility to make sure our physician is a participating provider in your plan.

All payments are due when services are rendered unless other arrangements have been made in advance. Any outstanding patient balances will be collected prior to being seen by the physician. Any patient balances that are over 30 days old will be considered past due. If your account is not maintained in a current status, you may be asked to reschedule. In the event that the account falls into a delinquent status due to broken payment arrangements, the account may be turned over to a professional collection agency, a collection service fee will be added to your account, not to exceed 50% of the delinquent amount. You will be additionally responsible for any attorney's fee associated with the collection of the debt. You will no longer be able to receive services from our physician or other healthcare providers.

We accept cash, check, credit and debit cards. In the event that a check is returned for any reason from your bank, a $25.00 returned check fee will be applied to your account. In addition to this fee, we may seek additional legal remedies if the returned check remains unpaid for more than 30 days.

Appointments are scheduled based on physician availability and patient convenience as time permits. It is important to keep and arrive on time for your scheduled appointment. In the event you must cancel, we require 24 hour notice. We may charge a No-Show fee of $25.00 if you fail to cancel or reschedule your appointment at least 24 hours in advance.

We thank you for choosing Performance Orthopedics. If you have any questions, please contact our office at 936.205.9824.

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Performance Orthopedics and Dr. Kenneth Jurist to bill my insurance carrier and for my insurance carrier to direct payment for my healthcare treatment to Performance Orthopedics and Dr. Kenneth Jurist on my behalf.

I hereby authorize my insurance carrier to furnish Performance Orthopedics and Dr. Kenneth Jurist any information obtained for the adjudication of any claim in regard to services furnished to me, by them

I further authorize Performance Orthopedics ad Dr. Kenneth Jurist to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered.

This authorization will remain in effect and valid until rescinded by me in writing.

X_____ _____

Signature of patient (or responsible party if patient is a minor) **Date**

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HIPAA ACKNOWLEDGEMENT AND ALTERNATE CONTACT AUTHORIZATION

PRIVACY PRACTICES AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my Protected Health Information (PHI), which may include information regarding HIV/AIDS status or mental health records, may be used or shared. ___ *Initial*

I hereby authorize my insurance carrier to furnish Performance Orthopedics any information obtained in the adjudication of any claim in regard to services furnished to me by them. This authorization is valid until rescinded by me in writing. I authorize Performance Orthopedics to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. ___ *Initial*

I acknowledge that Performance Orthopedics, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information including prescription history with others in order treat me, in order to arrange for payment of my bill, and for issues that concern other business operations and responsibilities. ___*Initial*

I further authorize the disclosure of my Protected Health Information to the following individuals/family members:

Name and Relationship to Patient _____
Name and Relationship to Patient _____
Name and Relationship to Patient _____

I give permission that Performance Orthopedics may:
___ Leave a detailed message on my home answering machine or voicemail
___ Call my workplace phone number and leave a message
___ Call my workplace phone number and speak only to me
___ None of the above

X _____ _____
Signature of Patient (or responsible party if patient is a minor) **Date**

Patient Authorization for Use or Disclosure of Protected Health Information

I, _____, hereby authorize Performance Orthopedics (Dr. Jurist) to:

-Use the following Protected Health Information, and/or
-Disclose the following Protected Health Information to:
My primary care physician, my referring physician and their affiliates, specialty hospitals and/or clinics I am referred to, my insurance company, diagnostic or imaging facilities I am referred to.

Protected Health Information includes office notes, relevant diagnostic results, contact and insurance information, and any reported or prior medical history forwarded or disclosed to Performance Orthopedics.

This Protected Health Information is used or disclosed for the following purpose(s):

- -Treatment: We may use or disclose your health information to a physician or other health care provider issuing treatment for you.
- -Payment: We may use or disclose your health information to obtain payment for services we provide to you.
- -Health Care Operations: We may use and disclose your health information as necessary for our own health care operations to facilitate the function of Performance Orthopedics and to provide quality care to all patients. Health care operations include quality assessment and improvement activities, employee review, training programs, accreditation, certification, and licensing of credentialing activities.
- -Other Uses and Disclosures: As part of treatment, payment, and health care operations, we may also use or disclose your health information for the following purposes: to remind you of your surgery or appointment date, to inform you of potential treatment alternatives, or to inform you of health related benefits.

This Authorization shall be in force and effective beginning on _____ and ending at the calendar year.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Performance Orthopedics at 2720 N. University Dr. Nacogdoches, TX 75965. I understand that a revocation is not effective to the extent that Performance Orthopedics has relied on the use or disclosure of the Protected Health Information.

X_____ _____

Signature of Patient (or responsible party if patient is a minor) **Date**

Dr. Kenneth Jurist, M.D
Performance Orthopedics
2720 N. University Dr.
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CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination in clinic.
This form has been fully explained to me and I certify that I understand its contents.

If patient is a minor or otherwise unable to give consent, please refer to bottom portion of page.

Patient Signature_____ Date:_____

Witness_____

Patient is either a minor, or is unable to consent because: _____
_____

I hereby consent on his/her behalf and in his/her stead:

_____ _____
Signature of Person Responsible for Patient or Legal Guardian Date

_____
Printed Name of Person Responsible for Patient or Legal Guardian

Witness_____Date_____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____

Name of Patient **Signature of Patient**

_____ / _____ / _____

Date Signed

_____ _____

Name Patient's Personal Representative **Signature of Patient's Personal Representative**

_____ / _____ / _____

Date Signed

_____

FOR INTERNAL USE ONLY

_____ _____

Name of Employee **Signature of Employee**

If applicable, reason patient's written acknowledgement could not be obtained:

- **o Patient was unable to sign.**
- **o Patient refused to sign.**
- **o Other** _____

_____